NHS Southwark CCG
Extended Primary Care Service Evaluation

May 2017
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## Background

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Background
Introduction

Southwark Clinical Commissioning Group commissioned Deloitte to undertake an evaluation of the Extended Primary Care Service

### Introduction

NHS Southwark Clinical Commissioning Group (CCG) has commissioned the Extended Primary Care Service (EPCS) to provide additional general practitioner (GP) and nurse appointments for Southwark patients from 8am - 8pm, 7 days per week. This service is delivered by groups of GP practices working together in GP Federations, Quay Health Solutions (QHS) in the north and Improving Health (IHL) in the south. The service is delivered at two sites:

- **North Southwark**: Spa Medical Centre – 50 Old Jamaica Road, London, SE16 4BN
- **South Southwark**: Lister Primary Care Centre – 101 Peckham Road, London, SE15 5LJ

The aim of the service is to improve patient experience and access to GP and nurse appointments to everyone registered with a GP practice in Southwark. The focus of the EPCS so far has been predominately on same-day and next-day appointments. To access these appointments, patients telephone their GP practice where a GP/nurse will speak to them. If the patient needs a same-day or next-day appointment, the practice can book the patient into the EPCS at a convenient time. The service is intended to be an extension of a patient’s GP practice, however, it is not aimed at patients with complex health conditions who require continuity of care from their regular GP practice. Part of the funding to launch the service came from the Prime Ministers Challenge Fund (see slide 7).

Southwark CCG has commissioned Deloitte to undertake an evaluation of the EPCS to inform developments and ensure the service fully delivers on its objectives (including improving access to general practice and providing a good patient experience). The evaluation is based on data analysis, stakeholder engagement and patient and staff surveys. This evaluation comprised two phases:

- **Phase 1**: Involves developing the evaluation framework which sets out the questions to be answered by the evaluation, along with the data and information required to answer these questions. The evaluation framework was signed off by Southwark CCG’s Primary Care Programme Board in September 2016.
- **Phase 2**: Involves undertaking the evaluation of the EPCS, based on the evaluation framework developed in Phase 1. This report presents findings and recommendations from Phase 2 of the project.

Source(s): EPCS specification document
EPCS was designed against the backdrop of the national challenge around primary care access which was cited in multiple studies.
National context

EPCS was designed against the backdrop of the national challenge around primary care access which was cited in multiple studies.

The NHS is facing unprecedented challenges in delivering high quality health services during a time of ageing population, increasing incidence of long-term conditions, lifestyle risk factors in the young and greater public expectations of healthcare services, ultimately increasing demand whilst financial resources become more limited.

In order to meet these challenges, it was recognised that a more radical shift in the way healthcare is delivered was required. In 2013, ‘A Call for Action’ collected public and NHS staff views, which helped form the context in which the EPCS was conceived.

The provision of urgent and emergency care services formed a key element of these discussions. The National Urgent & Emergency Care Review led by NHS England states that a change is needed in the way such services are delivered. In the years 2015 to 2016, national performance against the 4 hour waiting time has deteriorated significantly relative to previous years. This has been subject to considerable scrutiny, as the measurement is seen as an indicator of how the wider health system is functioning. National and local analysis has identified multiple contributing factors including increasing complexity of patients, discharge processes and lack of clear information regarding services. This shows that there are system-wide issues and any proposed solutions must consider the whole of the urgent and emergency care pathway, including a focus upon patient communication, self-management and primary care in addition to the acute and community elements. The first phase report from the national review reflects this in the four principles of care:

• Supporting self-care;
• Helping people with urgent care needs to get the right advice or treatment in the right place, the first time;
• Providing a highly responsive urgent care service outside hospitals so people no longer choose to queue in A&E; and
• Ensuring that people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and a good recovery.

In October 2013, a new £50 million Prime Minister’s Challenge Fund (now the GP Access Fund) was announced to help improve access to general practice and stimulate innovative ways of providing primary care services (Wave 1). The first wave of 20 pilots was announced in April 2014. The goals of the Fund include (1) To provide additional hours of GP appointment time (2) To improve patient and staff satisfaction with access and (3) To increase the range of contact modes. Southwark was selected as a Wave 1 pilot, and was awarded c. £975k towards set-up & infrastructure costs, with the CCG contributing recurrent service delivery costs of circa £2.5 million per year across both sites A second wave of the GP Access Fund has since taken place.

Source(s): EPCS specification document, NHS Choices (2013) Urgent and Emergency Care Review Phase 1, GP Access Fund website
Local context

Previous local reviews identified the need for improvement in ease of primary care access and variation in the quality of services.

Local context

Primary and community care services are the first point of contact with the NHS for most people. The Primary and Community Care Strategy (2013/14 – 2017/18) set out how Southwark CCG would achieve its aims to improve outcomes for patients, ensure consistency and equity of services as well as providing better value for money. A key facet of this Strategy was a shift towards population-based commissioning, which resulted in the development of local GP Federations.

Prior to commissioning the EPCS, there were a number of local urgent care services that treated minor illnesses in and out of GP hours (OOH), including general practice, Guy’s and St Thomas’ (GSTT) Urgent Care Centre, SELDOC (South East London Doctors Cooperative Limited, which provides OOH GP services), Lister Walk-in Centre, and community pharmacy.

Local engagement with patients, GPs and other key stakeholders highlighted the importance of:

- Placing general practice at the heart of providing consistent and equitable local health services;
- Providing clear and responsive access to clinical advice and treatment in and out of core GP hours;
- Providing the appropriate capacity within primary care to support the delivery of this vision;
- More effective alignment of services across settings including acute, community and pharmacy; and
- Providing and accessing care in a flexible way that caters to individual patient needs, supports patient education and effective communication.

In 2013/14, Southwark CCG undertook reviews of both the GSTT Urgent Care Centre and Lister Walk-in Centre, which included engagement with patients. This demonstrated that the model for accessing primary care for urgent care needs was not optimal, with variation in both provision of services and the quality of care. Also, the primary care system was found by patients to be confusing and difficult to navigate with multiple access points.

As a result, the CCG’s commissioning intentions and the principles underpinning the EPCS service specification focused on developing new ways to improve access to primary care and offer patients consistent access to urgent and unplanned care within primary care on a population (as opposed to individual practice) basis.

Source(s): EPCS specification document, Southwark CCG (2013) Southwark’s Primary and Community Care Strategy
Service design
The EPCS is designed to improve access and patient experience in primary care for residents in Southwark

Improve access to primary care services through commissioning of additional primary care capacity. The first phase of the service focused on same-day and next-day appointments.

**Patients**
- Ensure improved and consistent access to high quality primary care services via the patient’s GP practice.
- Improve patient experience and health outcomes.
- Provide care in a flexible and effective way that responds to patient needs, e.g. exploring use of technologies and non-face to face contacts.
- Promote consistency and reduce variation in access arrangements and treatment across GP practices.

**Providers**
- Facilitate information sharing between primary care settings enabling greater continuity of care.
- Promote closer and more effective working with local pharmacists and other services.
- Support patients to find the right service at the right time, through integration of access routes to urgent and core primary care services, with consistent redirection at all points from GP practices, A&E and any other urgent access to NHS services.
- Enable capacity within practices which will support them to manage scheduled care and patients with long-term conditions.

**Commissioners**
- Improve and increase current primary care capacity through provision of additional Commissioner’s funds to enable the EPCS.
- Facilitate information sharing between primary care settings enabling greater continuity of care.
- Promote closer and more effective working with local pharmacists and other services.
- Support patients to find the right service at the right time, through integration of access routes to urgent and core primary care services, with consistent redirection at all points from GP practices, A&E and any other urgent access to NHS services.
- Enable capacity within practices which will support them to manage scheduled care and patients with long-term conditions.

**Service overview**
- 8am – 8pm, seven days a week, 365 days a year.
- Access to patient records (with consent).
- Both GP and nurse appointments.
- At full capacity provides an additional 87,000 primary care appointments annually across the two sites.
- To date, focus has been on improving access for patients requiring same-day or next-day appointments.
- Patients with same-day or next-day needs are referred following telephone management by their GP practice or SELDOC (GP OOH), or can be redirected from local A&E departments.

Source(s): EPCS specification document
Service background (1/3)

Two hubs were established, one in North and one in South Southwark, with services delivered by groups of practices working in GP Federations

<table>
<thead>
<tr>
<th>Services available in EPCS access hubs</th>
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</thead>
<tbody>
<tr>
<td>• At present, the EPCS predominately offers same-day or next-day unscheduled GP and nurse appointments</td>
</tr>
<tr>
<td>• Both EPCS providers are expanding the service to include routine appointments and specialised clinics (with service developments currently underway)</td>
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<table>
<thead>
<tr>
<th>North – Quay Health Services (QHS)</th>
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</thead>
<tbody>
<tr>
<td>• North EPCS hub: Spa Medical Centre</td>
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<tr>
<td>• Service launch: April 2015</td>
</tr>
<tr>
<td>• Address: 50 Old Jamaica Road, London, SE16 4BN</td>
</tr>
<tr>
<td>• Practices: 21 practices</td>
</tr>
<tr>
<td>• Access: Bus routes 47, 188, 381, N199, C10; Bermondsey Tube station</td>
</tr>
<tr>
<td>• Referral Source(s):</td>
</tr>
<tr>
<td>- GP Federation practices</td>
</tr>
<tr>
<td>- SELDOC</td>
</tr>
<tr>
<td>- Guy’s and St Thomas’ Urgent Care and A&amp;E</td>
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</table>

<table>
<thead>
<tr>
<th>South – Improving Health Limited (IHL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• South EPCS hub: Lister Primary Care Centre</td>
</tr>
<tr>
<td>• Service launch: November 2014</td>
</tr>
<tr>
<td>• Address: 101 Peckham Road, London, SE15 5LJ</td>
</tr>
<tr>
<td>• Practices: 20 practices</td>
</tr>
<tr>
<td>• Access: Bus routes 12, 36, 136, 171, 343, 345, 436, N89; Overground station: Peckham Rye</td>
</tr>
<tr>
<td>• Referral Source(s):</td>
</tr>
<tr>
<td>- GP Federation practices</td>
</tr>
<tr>
<td>- SELDOC</td>
</tr>
<tr>
<td>- King’s A&amp;E</td>
</tr>
<tr>
<td>- Some walk-in Centre redirections*</td>
</tr>
</tbody>
</table>

*Note that the Lister Walk-in Centre was decommissioned at the same time as the IHL hub was established in the same place. While EPCS does not cater for walk-ins, it was anticipated that some patients might continue to present in person. These patients are seen by the EPCS or redirected to the appropriate services as required.

Service background (2/3)
A telephone management system was implemented, which requires changes to the way individual practices operate

Service access

Service overview
Most patients access the EPCS via their practice or SELDOC. Patients calling with same-day or next-day care needs are transferred to, or called back by, a clinician who will assess the patient over the telephone (telephone management). They will either provide advice over the phone or book an appointment within the practice or EPCS hub. It should be noted that:

- The EPCS is not a walk-in service;
- Patients access the service after telephone assessment by a GP or senior nurse in their own practice (or SELDOC during the out-of-hours period);
- Urgent Care or A&E (King’s A&E and GSTT) will also redirect patients clinically assessed as suitable for this service;
- 111 does not have direct booking to this service at this time, but work is ongoing to enable this; and
- SELDOC will directly book patients into the service during the out-of-hours period.

Patients calling for a routine clinical need will communicate with the practice receptionist who will book an appointment within the practice or the EPCS hub according to the inclusion criteria for routine appointments (currently this only occurs for IHL).

Inclusion and exclusion criteria

- The initial focus of EPCS was on patients requiring same or next-day care in general practice.
- Clinicians may decide that a patient would be better seen in their own practice. This would apply to patients who a) are vulnerable or have complex needs; b) may need further routine investigation or routine onward referral; or c) require administrative tasks to be completed, e.g. sick notes or medical forms.
- The service is designed to manage the many single episode acute illnesses which may arise in primary care.
- Severely ill patients should be sent to A&E as is the usual practice.

Source(s): QHS EPCS training materials
Service background (3/3)
The patient is first directed by reception staff; if needed, a clinician will carry out telephone management to assess if EPCS would be appropriate.

- **Patient calls practice or SELDOC**
  - Nurse routine clinical appointment
  - Urgent GP or Nurse appointments
  - Non-clinical need

  **Patient is suitable for EPCS**
  - **Receptionist** books the patient an appointment at practice
  - **Receptionist** books appointment at EPCS

  **Patient is not suitable for EPCS**
  - **Patient referred for telephone management by receptionist**
    - Patient called back by **clinician** and assessed
      - Patient needs to be seen
      - Patient does not need to be seen

  **Initial triage by receptionist staff**
    - Non-clinical call closed by **receptionist** or **call handler**

  **Patient is either given medical advice over the phone, booked into the practice or EPCS**

  **Clinician refers patient as appropriate** (i.e. own practice for appointment/ SELDOC base during GPOOH)

  **Clinician** or **receptionist** books appointment at EPCS

  **Patient accepts**

  **Patient offered EPCS appointment at the EPCS**

  **Patient declines**

Source(s): Federation EPCS training materials
Timeline

The first EPCS hub started operations in November 2014

- **2011**
  - Inception, scoping and design of EPCS – including procurement and engagement

- **2013**

- **2014**
  - Apr. - Nov.
    - Southwark CCG Urgent Care Review & review of Urgent Primary Care Access and Primary and Community Care Strategy developed

- **Mar.**
  - Improving Health Limited (IHL) established
  
- **Nov.**
  - NHS England National Urgent & Emergency Care Review – Phase 1 published
  
- **Apr.**
  - Funding secured
    - £2.1 million annually for three years from CCG
    - £975K from Challenge Fund to support setup/infrastructure costs

- **2015**
  - Nov. IHL South site live
  
- **2016**
  - Apr. QHS North site live
  
- **Jul.**
  - Evaluation Phase 1

- **2017**
  - Sep. Evaluation Phase 2 report

- **Mar.**
  - EPCS evaluation

Source(s): Interviews with stakeholders, EPCS communication documents, EPCs business case and specification documents
Differences in the IHL and QHS hubs
Differences between the hubs are useful context for analysis

<table>
<thead>
<tr>
<th>South Southwark Hub Profile (IHL)</th>
<th>North Southwark Hub Profile (QHS)</th>
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</thead>
<tbody>
<tr>
<td><strong>Patient referral sources</strong></td>
<td><strong>Patient referral sources</strong></td>
</tr>
<tr>
<td>• Practices, King’s College Hospital A&amp;E, SELDOC referrals.</td>
<td>• Practice and SELDOC referrals, and from October 2016 GSTT Urgent Care and A&amp;E referrals can be received.</td>
</tr>
<tr>
<td>• Replaced a walk-in centre on the same site, therefore a transitional arrangement is in place to manage walk-ins and to support patient education.</td>
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<tr>
<td><strong>Operational experiences</strong></td>
<td><strong>Operational experiences</strong></td>
</tr>
<tr>
<td>• The service replaced a decommissioned walk in centre on the same site, and so when the service was launched, the hub was launched with 100% contracted appointment capacity and 8am – 8pm opening hours 7 days per week from day one.</td>
<td>• A phased launch was carried out, and available capacity (appointments offered) increased over time. The phased launch approach incorporated lessons around lower than expected utilisation in the south, and the fact that the north site did not replace a pre-existing walk-in centre.</td>
</tr>
<tr>
<td>• Subsequently, the capacity was scaled back to better meet lower than expected demand for the service.</td>
<td>• Initially the QHS hub opened 4pm - 8pm during the week and 8am - 8pm on weekends, with an additional 8am to midday session on Friday mornings.</td>
</tr>
<tr>
<td>• Utilisation (i.e. the number of offered appointments that are booked) of the service is gradually increasing over time, with a 2016 monthly average of 1,700 referrals.</td>
<td>• Utilisation of the service is increasing significantly over time, with a monthly average of 950 referrals in 2016.</td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td><strong>Workforce</strong></td>
</tr>
<tr>
<td>• IHL has staffed the service using many locum GPs and nurses. Based on stakeholder interviews, this was partly due to availability of local GPs, difficulties in obtaining NHS pensions status initially, and that local contracts offer a flexible and reliable workforce. IHL EPCS sessions are ring-fenced for local clinicians for a period of time before they are opened up more widely.</td>
<td>• The North hub is staffed mainly by GPs and nurses that work, or have worked recently in local practices. Since January 2017, QHS directly employs a management/reception team and 20 GP sessions each week. In April, recruitment will be widened to include nursing staff and health care assistants, however this will be managed in collaboration with member practices so that practices are not destabilised.</td>
</tr>
<tr>
<td><strong>Supporting practices</strong></td>
<td><strong>Supporting practices</strong></td>
</tr>
<tr>
<td>• Following responses collected from practice visits, a centralised telephone management system pilot was launched in September 2016 with 3 practices, where IHL provided telephone management for practices. However, the pilot was not extended due to relatively low utilisation which was felt to be due to practice ways of working. There are plans to revisit this.</td>
<td>• QHS has been commissioned by NHSE and Southwark CCG to provide a caretaking service from EPCS clinic rooms for a local practice that had its registration cancelled following CQC inspection. This has impacted QHS’ ability to increase EPCS capacity.</td>
</tr>
<tr>
<td>• According to interviews with Federation staff and recent service development report, there are current plans to recruit more local clinicians to the EPCS.</td>
<td>• QHS tested a scheme of joint employment cross EPCS and practices for nurses during 2016 and will roll this out from April 2017.</td>
</tr>
<tr>
<td>• QHS has also provided additional support to four further practices with capacity (e.g. telephone management support)</td>
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</tbody>
</table>

Source(s): Interviews with stakeholders, finance and workforce, patient and staff surveys on EPCS feedback, EPCS documents on ongoing development plans
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Executive Summary
Evaluation framework

This report presents an evaluation of the four key phases of the EPCS, as outlined in the evaluation framework and summarised below:

**Design**

This stage spans from the inception of the idea, to stakeholder discussions and eventually the development of the service specification (late 2013 to early 2014).

It focuses on the early days of the service:

- Scoping
- Aims and Objectives
- Metrics Design
- Resourcing
- Management
- Risks
- Co-design
- Culture Change

**Implementation**

This stage starts from when the service specification was finalised, dealing with the implementation of the service (mid-2014 to April 2015).

It focuses on the preparations for and delivery of the service:

- Provider Understanding
- Practice readiness/Training
- Launch Campaign
- Workforce/Recruitment
- Contract Negotiation
- Mobilisation
- Infrastructure

**Operation**

This stage starts from when the services went live (different for North/South until now).

It focuses on the current, day to day running of the service:

- Service Model Implementation
- Utilisation
- Patient Communication
- Access Opportunities
- Patient Experience
- Staff Satisfaction
- Clinical Outcomes
- General Practice
- Pressure on Rest of the System
- Integration of Services
- Collective Working
- Workforce
- IT

**Sustainability**

This stage focuses on the long-term sustainability of the service:

- Service Model Evaluation
- Cost Effectiveness
- Resource Sustainability
- Feedback Collection
- Wider System
### Approach

This evaluation draws on a range of data and information sources as outlined in the diagram below.

#### Evaluations Sources

<table>
<thead>
<tr>
<th>Health data</th>
<th>Surveys</th>
<th>EPCS materials</th>
<th>Interviews</th>
<th>Case studies</th>
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<tbody>
<tr>
<td>Deprivation index across England (2015)</td>
<td>Snap-shot survey (referred to as the EPCS patient survey in this report), with 279 patient responses received across Southwark following an alternative survey undertaken by Deloitte to inform the evaluation (data collected over the period January – February 2017).</td>
<td>Urgent care review findings EPCS specification documents EPCS Business Case EPCS communication strategy EPCS advertising materials EPCS practice training materials EPCS stakeholder engagement events findings EPCS development plans Minutes from Patient Participation Group (PPG) meetings and practice visits Overview and Scrutiny Committees (OSC) documents Commissioning Support Units (CSU) documents Equality and Human Rights Analysis (EHRA) documents Engagement and Patient Experience Committee (EPEC) documents Practice risk assessment calls register Contract monitoring reports and pilot evaluations</td>
<td>20+ interviews carried out across different stakeholders over the period June 2016 – February 2017: ✓ 10 practice or EPCS GPs ✓ 2 SELDOC staff GPs ✓ 10 CCG or Federation staff members</td>
<td>5 practice level case studies, collected between November 2016 – February 2017: ✓ 3 in South Southwark ✓ 2 in North Southwark</td>
</tr>
<tr>
<td>England prescription mix data (2015)</td>
<td>✓ Utilisation by date, time, source(s) of referral ✓ Available appointments ✓ Financial statements ✓ Prescription mix ✓ Contract evaluation reports</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>England Primary Care practice level data – list size, cost per patient, staff mix (March 2015 data)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>GP-patient survey, Friend and Family tests results (2015 data)</td>
<td></td>
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<tr>
<td>EPCS data (November 2014 – December 2016 for IHL, April 2015 – November 2016 for QHS) on:</td>
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<tr>
<td>✓</td>
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Limitations

The analysis and conclusions should be considered in the context of the following limitations

- Data on appointments within GP practices to inform the impact of the service on general practice demand and capacity has not been collected as part of this study. This is because there is no systematic, comparative way of collecting this data due to differential appointment booking data at a practice level. This limits the extent of quantitative data analysis undertaken and the ability to measure the impact of EPCS on practice level access (e.g. patient wait times for appointments, ability to offer longer appointments for patients requiring continuity of care, impact of telephone management etc.). In recognition of this, a series of in-depth qualitative interviews was undertaken across a small number of case study practices.

- For the purposes of this evaluation, prescribing data was used as a proxy to understand the case-mix of EPCS appointments, given that historical case mix data is not available at this time.

- Certain findings in this report are based on the views of specific stakeholders and interviews. Their views and experiences may not be representative of all stakeholder groups. Where evidence of this type is used, this is flagged in the report. Where possible these findings have been triangulated using input from other sources.

- Because of a systems’ issue that is now being resolved, the granularity of data on booked appointments (e.g. the number of referrals booked in per day and per session) was not available historically for QHS. Data on the number of booked appointments by month was not affected by the systems issue.

- As EPCS is an integrated care pathway, metrics focus more on process (rather than outcomes, which are measured at different points in the pathway by different providers). The limited availability of outcomes metrics for the service has in turn limited the ability of this report to comment on the impact of EPCS on outcomes.

- The data and information included in this report was collected in the period from August 2016 to February 2017.
Focus of the conclusions
Meeting the commissioning objectives and areas for improvement

Focus of the conclusions

• The evaluation framework was designed to assess how the EPCS service was developed, what has and hasn’t worked well since the service was launched, and what the challenges are to the ongoing sustainability of the service. The conclusions set out in this report are designed to provide insight into these areas, testing whether the service is meeting its objectives and what the challenges have been.

• In line with the conclusions, the report sets out a number of specific recommendations around areas that the service could expand or improve. These recommendations focus on specific areas that have proved challenging so far for EPCS, service developments to further improve access and sustainability, and suggestions to focus data collection to provide ongoing evaluation of the EPCS’ core objectives.

• Commissioners have requested that the evaluation inform whether the EPCS was the correct service model to commission. At the time of writing, there was not sufficient data available to draw a conclusion on this question. In view of this, a recommendation would be to collect data on areas such as access to practice appointments (once this data is available in a more standardised way) to provide a fuller view on whether this was the right service model and to inform future commissioning decisions (see recommendations section).
1. Design findings

Tight timelines in the design phase created momentum for change, however additional time might have increased practice readiness

**High level of engagement within tight commissioning timeframes created momentum**

Southwark CCG targeted an ambitious timeframe for implementation, which was designed to coincide with Lister WiC’s closure in the South of the borough and to take advantage of start-up funding from the PMCF. In the context of tight timeframes, there was extensive engagement with patients, practices, and staff through stakeholder engagement events held between May 2013 and September 2014 (in addition to regular CCG practice engagements such as locality meetings and locality PPGs). This created momentum and enabled co-production and co-design of the service delivery model with practices. However, practices commented in practice readiness assessments and in interviews that they might have been better prepared to implement the service from day one if they had had more time.

**Commissioners developed high level service objectives to allow negotiated dialogue with practices and federations**

During the design phase, commissioners deliberately developed a high level specification, which enabled the co-design of a locally fit-for-purpose service model between federations and practices to be agreed with commissioners before implementation. In recognition of the tight timeframes for the design phase within the Prime Minister’s Challenge Fund (PMCF) pilot, which resulted in prioritisation of a service model for same day/next day unscheduled care, service development plans for each EPCS provider were incorporated into formal contracting arrangements. These service development plans allowed scope for future expansion of the service model during the contract period in line with commissioning objectives.

**Performance metrics could have been further tailored to the integrated pathway**

23 contractual indicators were collected for EPCS, including 9 that reflect areas mandated by the PMCF. In practice, some of the key performance indicators (KPIs) were difficult to collect because EPCS is part of an integrated pathway across multiple care settings. Because of the number of providers in the pathway, collecting data (in particular outcomes data) is challenging. Data on telephone call-back times by clinicians is not consistently or routinely provided by practices. A recent audit on call-back times was carried out, and will inform how to review KPIs within the contract. While patient satisfaction metrics in relation to the EPCS are routinely collected and reported through contract monitoring, KPI #4 (patient satisfaction (access)) was a requirement for reporting under the PMCF linked to patient satisfaction with core general practice, which is collected through the national GP survey & only reported twice a year.

**Even with a strong co-design process, enabling practice change proved more challenging than anticipated**

Based on feedback from practice readiness assessment reports and interviews, practices were engaged early, with feedback on the proposed system taken on board in the design phase. However, the move towards telephone management proved more difficult than practices expected, suggesting that not all practices anticipated the extent of changes the new pathway would entail (as evidenced in the wide variability of EPCS referrals among practices across Southwark).

Source(s): Interviews with stakeholders, finance and workforce, patient and staff surveys on EPCS feedback, EPCS documents on ongoing development plans, NHSE, GP Access fund - https://www.england.nhs.uk/gp/gpfv/redesign/improving-access/gp-access-fund/
2. Implementation findings (1/2)

The EPCS required practices to change the way they worked, the scale of change was significant.

**The EPCS is an integrated pathway that required new ways of working for practices**

The CCG commissions *GP Federations* to deliver the EPCS. However, GP practices, which have no contractual obligation to deliver for EPCS and which are individual businesses with their own considerations, are required to change their ways of working to adopt the telephone management system for same-day/next-day appointments. As such, implementation of EPCS depended on resources, capacity and willingness at the practice level, and Federations had no contractual levers to ensure practices made the required changes. At the moment, some practices have successfully implemented telephone management processes, but this is not consistent across all practices.

**There was extensive support to prepare practices for EPCS, however preparedness at launch varied between practices**

A significant amount of planning and outreach was undertaken by the Federations, aimed at preparing practices for the launch of EPCS. However, not all practices were well prepared to use the EPCS. For instance, around 16% of respondents to the EPCS staff survey noted that their practices only use telephone management slots on an ad hoc basis, and currently 10 out of 41 practices have average monthly referrals per 1,000 patients of less than 2. It takes time for practices to adapt to the new system with data showing that referrals have increased over time. However, in feedback following implementation training and in practice risk assessment calls, several practices said a longer roll out period or more practical EMIS training could have been beneficial.
2. Implementation findings (2/2)
The EPCS required practices to change the way they worked, the scale of change was significant

‘Soft’ launch of the service to patients was an intentional decision based on patient feedback

In order to manage communications around a service that was accessed through GP practices (as opposed to direct patient contact with EPCS) and initially managing more urgent conditions, and to avoid the risk of an influx of calls to practices, a "soft" public launch was undertaken. This was an intentional decision, but it did result in patients’ not necessarily being aware of the service or its appropriateness for their needs. This meant that clinical staff often had to take more time to explain the service to patients prior to referral to the EPCS. From the EPCS patient survey, c. 72% of around 220 surveyed patients who had visited a GP in the past year were not aware of the EPCS, two years after its launch. This may indicate that further communication and engagement is required to support wider awareness of the service.

Service contracts took longer than expected due to contractual complications

From interviews with CCG and Federation staff, the Alternative Provider Medical Services (APMS) contract is designed for delivering list-based services, but the EPCS service does not hold a registered list. As such, contracts required significant amendment to be fit for purpose for all parties. This required higher than expected legal fees and led to more protracted contract negotiations.

Information sharing system was implemented successfully

The clinical system (EMIS) used by both EPCS and practices has enabled patient records to be shared across both services. This is in contrast to many PMCF sites that stated having difficulties in implementing their data sharing system. Southwark EPCS was one of the first sites to achieve read access to patient notes in the EPCS hubs (with consent). In case study practice discussions, some GPs noted that going a step further to allow for better synching of EPCS data with practice systems would be beneficial: at present, patients receive a discharge letter after and EPCS appointment, which must be manually input in the practice system. In the North, an EMIS tool has been piloted, which will rectify this issue.

Source(s): Interviews with stakeholders, meeting minutes from CCG practice visits, patient participation groups, EPCS business case documents, patient and staff surveys on EPCS feedback
3. Operation findings (1/4)
Feedback from patients using the EPCS has been positive across both North and South hubs

**North and South Southwark have different experiences working with EPCS**

The South site has been operational since November 2014, and accepts patient referrals from practices, SELDOC, and King’s College Hospital A&E. A transitional arrangement is in place to manage walk-ins, as it replaced a pre-existing WiC on the same site.

The North service launched 5 months later in April 2015, and accepts patients referred from practices, SELDOC and more recently GSTT’s A&E. Building on utilisation experience from the launch of the South service, and in recognition that the north site did not replace a pre-existing walk-in centre on the same site, a phased approach to appointment capacity was taken in the North. QHS has also supported caretaking arrangements for a local practice, and provided support for other practices, which has further impacted on its ability to increase capacity. It is important to consider these differences when making comparisons across the two hubs.

**There is a high variation among practices in the utilisation of the EPCS**

There is still significant variation in practice utilisation of the EPCS across both sites. Average monthly referrals for IHL practices range from 1 patient to 22 patients per 1,000 patients on the practice list (November 2014 to December 2016). For QHS the figure ranged from 1 to 14 per 1,000 patients over April 2015 to December 2016 (excluding St James’ Surgery which is an outlier). It should be noted that some practices have changed their EPCS utilisation level over time after they have changed their appointment systems.

*Source(s): EPCS data, Interviews with stakeholders, EPCS business case documents, patient and staff surveys on EPCS feedback*
3. Operation findings (2/4)
Feedback from patients using the EPCS has been positive across both North and South hubs

As the EPCS hubs offer additional services, clear clinical governance will be increasingly important
In discussions, clinical leadership in Southwark noted that a clear clinical governance structure that all staff are familiar with will be increasingly important as the hubs move into delivering new types of service. For instance, managing different levels of urgency and ensuring sufficient capacity to manage for urgent alongside planned appointments. In addition, it will be important to ensure that the telephone management system continues to be used in the right way across all practices, with the right types of referrals coming through.

EPCS was welcomed by both practices and patients
Patients have had a positive experience with EPCS; those that use the North EPCS consistently report high satisfaction of over 90% each month through the friends and family test (FFT), while IHL’s contract monitoring also reports a similar level of satisfaction. In interviews and in the EPCS patient survey, practices and patients welcomed the sharing of data between EPCS and the practice (around 59% of respondents reported interest in the EPCS service with access to their data).

Practices also feel that the EPCS has helped their patients access primary care. From the EPCS staff survey, c. 87% of staff noted that the EPCS has helped reduce demands on their practice.

Photo reproduced with the permission of Southwark CCG
Source(s): EPCS data, Interviews with stakeholders, EPCS business case documents, patient and staff surveys on EPCS feedback
3. Operation findings (3/4)

The utilisation of the EPCS continues to increase over time

**Overall, EPCS hubs are being used in a way consistent with the scope of service**

At present, the majority of patients referred to the EPCS are young children and working age adults, in line with service specifications and the current focus on same-day/next-day appointments. Prescribing data suggest that many cases referred to EPCS for urgent appointments and requiring medication relate to complaints such as infections and not to long term conditions, which could indicate appropriateness of referrals based on the service’s initial focus on same/next day appointments.

**Patient usage of the EPCS may depend on accessibility and the way practices communicate**

From interviews and case studies with practices, whether or not a patient is willing to visit the EPCS hub depends on convenience and how the service is communicated to them by the practice clinician. Anecdotally, location has been cited as a factor preventing uptake of the EPCS. However, this is not fully borne out in the evidence, which shows that some practices located relatively further away from the EPCS have successfully been able to use the service (e.g. The Gardens Surgery). Familiarity with transport links may play a role, as for example The Gardens Surgery has direct transport links to Peckham. Engagement with practices indicates that the way the service is communicated persuasively to patients is critical, i.e. the way the GP explains the service will have an influence on patient behaviours or willingness to attend the EPCS, where clinically appropriate.

**Although utilisation was initially low, utilisation, total referrals, and capacity have increased over time**

Overall, the EPCS has delivered against the objectives to increase capacity, providing c. 57,000 additional booked consultations since inception.

In IHL, capacity was initially scaled back from launch levels due to the observed level of activity, which had been set high because the IHL hub was located the same place as a decommissioned WiC, and commissioners wanted to ensure appropriate provision at the very beginning. In QHS, a phased approach was implemented to bring on additional capacity as demand increased.

As the service progressed, provision and referrals increased from practices. In the first six months after the EPCS was launched, QHS utilisation was approximately 40% (of a monthly average of 960 appointments offered) and the corresponding figure for IHL was 52% (of around 2,800 appointments offered monthly). In the six months from July 2016 to December 2016, average monthly utilisation for QHS is 58% of 1,800 appointments offered and for IHL is 61% of 2,700 appointments offered.

*Source(s): EPCS data, Interviews with stakeholders, EPCS business case documents, patient and staff surveys on EPCS feedback*
3. Operation findings (4/4)
Although utilisation is increasing, there is variation in utilisation across days, times and seasons

Daily and seasonal variation in utilisation is high
There remains variation in utilisation (appointments booked as a percentage of appointments offered) across day of the week, time of year, and time of day, suggesting scope to further tailor capacity to referral patterns:

• For both hubs, the weekday utilisation percentage is significantly higher than at weekends. In IHL, the average weekday utilisation in 2016 was around 70% (up to 90% in some parts of the day), while weekends utilisation was only around 50% on average. Referrals are particularly low on Sunday evenings and early mornings, with an average utilisation of below 40% of available appointments.

• Anecdotally, GPs report higher activity during winter and less during summer. It is expected that demand for urgent care increases during this period. This pattern is reflected in EPCS referrals, which have been higher in winter compared to other seasons. Winter 2015 had 2,505 average monthly EPCS referrals, compared to 1,768 in the summer of the same year.

• Data indicates that utilisation is very high in the evenings. However, this is driven in part by the limited number of nurse appointments available in the evenings to accommodate demand. In 2016, IHL had a monthly average of around 220 nurse appointments in the morning (8am – 12pm) and around 180 sessions in the afternoon. In the evening (4pm – 8pm), there were only 46.

The service is being utilised by GPOOH and A&E, however, there is scope for this to increase
SELDOC referrals to the SELDOC base have dropped since EPCS was launched, from a monthly average of around 620 in 2015 to 430 in 2016 (or a 30% decrease). However, this is still lower than expected as the SELDOC base continues to have significant activity even though the Federations agreed that all out-of-hours appointments would go to the EPCS hubs.

Also, whilst total referrals to the EPCS have increased, the absolute number of referrals from SELDOC has remained relatively constant (see the Operations section for more). SELDOC accounts for more than half of referrals to the EPCS on weekends (which is expected given that many practices are not open on weekends).

A&E referrals to EPCS have increased significantly in IHL, from an average of 35 per month in 2015 to 92 per month in 2016. QHS has also started taking referrals from GSTT A&E in October 2016. However, the level of minor A&E attendances at King’s and GSTT indicate that there is potential to generate additional referrals to the EPCS via re-direction from A&E. This depends on Emergency Department re-direction protocols.
The EPCS has improved access to primary care services but there are challenges around workforce and future service scope

### Service model, service expansion and wider system integration

The EPCS model has been based on stakeholder engagement and activity modelling. To date, it has achieved its objective of providing additional capacity for same-day and next-day primary care services, and the type of referrals (children, one-off needs) suggest the service is being used appropriately for urgent referrals. Telephone management has successfully been implemented in many practices. However, some practices still find this aspect of the service model resource intensive. Further data relating to telephone management is required in order to ascertain whether it is delivering the intended benefits of providing access to healthcare support and information at the right time, and from the right place.

Moving forward there are plans to further develop the service, in accordance with the national PMCF specifications:

- Both Federations are developing the EPCS to offer more routine appointments in a flexible way alongside same day/next day appointments. QHS has tested and identified specific routine appointment offerings (including practice nurse appointments for wound dressings) based on engagement with practices and are starting to offer these new services as they increase their capacity and are able to recruit additional GP/nursing staff. IHL have piloted a wide-ranging routine appointment offering to 9 practices, and are planning to make this available to all practices by the end of May 2017.
- There are plans to introduce 111 referrals. This is not currently integrated into the EPCS referral system due to system interoperability issues, which are being addressed.

It is possible that these service developments will increase patient awareness and practice referrals as current knowledge of EPCS is still low. There will be implications for capacity, and both federations will need to model service developments and additional referral mechanisms to ensure appointments are flexed according to need.

### Workforce

There are challenges in securing GPs and nursing staff for the EPCS. This is a national issue, and with many more extended services coming online the issue will likely get more challenging. The issue is further complicated because Federations do not want to exacerbate staffing challenges for practices. In IHL, the staffing service uses a locum model; however, initiatives to utilise more local sessional/salaried staff are being explored. QHS uses mostly local GPs and nurses, and since January 2017 QHS directly employs a management/reception team and 20 GP sessions each week where GPs are employed across the EPCS and local practices.

### Financial sustainability

The ongoing financial sustainability of the hubs is tied to workforce and utilisation. As noted above, the hubs have faced challenges recruiting substantive staff. Over time, engaging non-agency staff on a more sustained basis will likely decrease costs. In addition, if EPCS hubs can increase utilisation (perhaps by offering more routine appointments), the cost per appointment will decrease. At present, the cost per appointment is broadly in line with other primary care services operating outside of standard business hours.

### Wider system benefits

In addition to supporting SELDOC and Urgent Care and A&E by diverting some of their demand to the EPCS hubs, the EPCS has generated wider benefits in supporting Federations. In particular, the three year commitment from the CCG provided certainty which has enabled both Federations to grow and develop. For example, in QHS, the EPCS APMS contract enabled QHS to provide a caretaking service for a practice closed suddenly by CQC, guaranteeing patients access to primary care. Also, IHL has used the hub to deliver centralised Ambulatory Blood Pressure Monitoring with high take up. There is likely to be more scope for both SELDOC and A&E/UCC departments to refer those more appropriately managed within the EPCS to the service.

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**Source(s):** Interviews with stakeholders, meeting minutes from CCG practice visits, patient participation groups, EPCS business case documents, patient and staff surveys on EPCS feedback
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<td><strong>Summary findings</strong></td>
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<td>Case studies</td>
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</table>
Summary findings
Operation findings – total referrals

Over 57,000 appointments were booked at the EPCS since the service began, with increasing activity over time.

### Evaluation

- In 2016, IHL had a higher average monthly usage rate (around 1,700 out of 2,738 appointments provided) compared to QHS (950 out of 1,752 appointments provided). Peak EPCS appointments were on March 2016, with close to 2,000 patients seen in the IHL hub.

- Over the last two years, there has been an increasing trend in use for both QHS and IHL. Year-on-year, the average monthly booked appointments at QHS almost doubled from around 490 to 950 (92% increase) while IHL increased from around 1,500 to 1,700 (13% increase). Information on utilised capacity is presented later in the next slide.

- From interviews and case studies, the increase in activity may be a result of increases in referrals as practices buy-in to the EPCS hubs and adapt to ways of working so that patients are more familiar to the service. Comparing the EPCS appointment figures in the first 6 months of launch and the most recent 6 months (July – December 2016), 21 out of 43 practices in Southwark have experienced more than 100% increases in EPCS appointments. This suggests that buy-in to EPCS has increased since its launch.

Source(s): Interviews with stakeholders, IHL and QHS data on EPCS utilisation, finance and workforce, patient and staff surveys on EPCS feedback.
Operation findings – total capacity

Available appointments at EPCS have been flexible over time, with the number of slots adapting to trends in bookings.

Both hubs experienced increases in available appointment over time. IHL launched with high capacity (to ensure sufficient capacity as the Lister walk-in centre on the same site was decommissioned at that time) and subsequently scaled back. QHS adopted a phased launch, with relatively low available appointments initially and gradually increasing it as demand rises.

Evaluation

- Initially, IHL opened with a high level of capacity at 3,600 available slots in the month of launch. When it was observed that the hub was seeing fewer referrals than anticipated, the flexible design of the EPCS allowed capacity to be scaled back to meet demand.
- Since inception, average monthly utilisation (percentage of available appointments that are booked) has increased over time from c. 26% and 73% for IHL and 37% to 65% for QHS (although certain days and times are much higher, as set out on the next slides). The number of appointments available has also been flexed month-on-month, with utilisation as a percentage of available appointments growing over time. This reflects increases in the number of booked appointments while allowing some spare capacity to respond to fluctuations in the need for additional capacity in the system.

*I*Data on appointments by staff mix was not included in the QHS dataset because these are recorded at session level rather than appointment level. From April – December 2016, there were 79% GP sessions, 21% nurse led sessions

Source(s): EPCS data
Operation findings – planned capacity

At IHL, available appointments were initially scaled back but have since been scaled up, QHS implemented a phased capacity roll out

<table>
<thead>
<tr>
<th>Available appointments vs planned availability (November 2014 – December 2016 for IHL; April 2015 – December 2016 for QHS)</th>
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<tbody>
<tr>
<td><strong>Available appointments vs planned availability</strong>&lt;br&gt;<strong>(November 2014 – December 2016 for IHL; April 2015 – December 2016 for QHS)</strong></td>
</tr>
<tr>
<td><strong>Note:</strong> data on contracted available capacity for IHL is not available before April 2015.</td>
</tr>
<tr>
<td>QHS’ modelled monthly available appointments, estimated to gradually increased to 100%</td>
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<tr>
<td>IHL available appointments</td>
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• Initially, in the first 2 months of launch, IHL started with full capacity as it was located on the site of a decommissioned WiC and commissioners wanted to ensure appropriate capacity during this transition. As a response to demand it has scaled back its capacity from 100%.

• Building on the lessons learnt from the South, QHS introduced service capacity in a phased manner.

• The dotted lines are the contracted available appointments for IHL and the modelled available appointments for QHS. Both hubs started with below 100% capacity (after IHL scaling back) and this gradually increased over time. However, current provision was still below contracted and modelled levels at December 2016.

• Both IHL and QHS gradually increased their provision of available appointments.

Evaluation

• As at December 2016, the EPCS was not operating at its full ‘contracted’ capacity levels, nor were appointments fully utilised based on the levels of available appointments offered. Introduction of routine appointments could increase patient referrals, however, it is important this does not have unintended consequences in terms of overall demand management. This was a point emphasised by Federation and CCG staff, that the goal of the EPCS is not simply to let practices refer patients when demand is high, but to ensure that a flexible, high quality service is available to patients. From patient and staff surveys, a main pull factor of the EPCS is the high quality service provided. It is important that this standard is kept as the service progresses and utilisation increases.

• However, it is noted that the most important thing is to ensure that the “right patients are referred”, not just to pursue increased capacity and buy-in. From interviews with practices, nursing services and medical tests (such as blood tests, X-rays and ultrasound) were mentioned for expansion. Also, more ‘discrete’ services, such as sexual health, were also mentioned by practices. In response to the changing demand, both IHL and QHS are planning to provide routine appointments and specialise clinics in the EPCS. A routine pilot has already been launched in IHL and QHS has provided a dressing clinic since April 2016.

"QHS negotiated with CCG and opened only 4-8 initially in weekdays, then gradually 8-8, 7 days a week." CCG representative

"Currently, EPCS is running at below full capacity, the staff level is scaled to match this figure“ GP surgery staff member

"There is a need to change the thinking from "using the EPCS because there is extra capacity” to “how to make the EPCS a service that fits the type of patients it is intended to serve for practices”. Local Practice Manager

"QHS is well positioned in getting the right patients to come, not just as a demand/pressure management tool." Federation staff member

Source(s): Interviews with stakeholders, IHL and QHS data on EPCS utilisation, prescription, finance and workforce, patient and staff surveys on EPCS feedback
**Operation findings – referrals by time**

Based on IHL data, EPCS use is the highest in the morning across all days, with low activity on weekend evenings and early mornings.

**Evaluation**

- In IHL in 2016, there are a very high number of referrals in core practice hours (8am to 6:30pm). In general, non-core referrals are lower, with Sunday lower than other days. Booked appointments peak between 9am and 11am and generally drop after this time. Referrals on Monday are consistently high, even in the evenings. Peak EPCS referrals occurs on Monday 9:00am (430 referrals).

- A major user of Sunday EPCS appointments is SELDOC, which takes up more than half of all Sunday appointments. As SELDOC is an out-of-hours service, a higher utilisation on weekends is expected. However, there may be scope for practices to refer patients to EPCS for routine appointments on weekends and early mornings in the future, as well as for Sunday appointments for patients who are telephone managed on a Friday that don’t need to be seen on the same-day or next-day.

- While overall Sunday use is low, there appears to be a mid-morning spike in referrals, based on IHL data. In periods of low activity, staffing may already be at the minimum levels for providing consistent 8-8 service, limiting the ability to scale back.

- Looking at written responses from the snapshot EPCS patient survey, it is suggested that some patients welcome non-core hours primary care availability. However, other patients in the EPCS patient survey also note that they are not used to seeing a GP on Sundays. From case studies, clinicians report that working adults find being able to see a GP in the evening helpful.
**Operation findings – referrals by practice**

**Variation in EPCS utilisation among practices is high**

<table>
<thead>
<tr>
<th>QHS EPCS average booked appointments per 1,000 patients (April 2015 – December 2016)</th>
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</thead>
<tbody>
<tr>
<td>St James’ Church Surgery*</td>
</tr>
<tr>
<td>Grange Road Practice</td>
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<tr>
<td>Surrey Docks Health Centre</td>
</tr>
<tr>
<td>Bermondsey Spa Medical Practice</td>
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<tr>
<td>Silverlock Medical Centre</td>
</tr>
<tr>
<td>Albion Street Group Practice</td>
</tr>
<tr>
<td>Princess Street Group Practice</td>
</tr>
<tr>
<td>Park Medical Centre</td>
</tr>
<tr>
<td>Manor Place Surgery</td>
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<tr>
<td>Bermondsey and Lansdowne Medical Centre</td>
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<tr>
<td>New Mill Street Surgery</td>
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<tr>
<td>Avicenna Health Centre</td>
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<tr>
<td>Villa Street Medical Centre</td>
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<tr>
<td>Penrose Surgery</td>
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<tr>
<td>Trafalgar Surgery</td>
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<tr>
<td>Sir John Kirk Close Surgery</td>
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<tr>
<td>Old Kent Road Surgery</td>
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<tr>
<td>The Surgery (East Street)</td>
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<tr>
<td>Aylesbury Medical Centre</td>
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<tr>
<td>Falmouth Road Group Practice</td>
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<tr>
<td>Blackfriars Medical Practice</td>
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<tr>
<td>Borough Medical Centre (Dr Misra)</td>
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<tr>
<td>Maddock Way Surgery</td>
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<td>Borough Medical Centre (Dr Sharma)</td>
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<tr>
<th>IHL EPCS average booked appointments per 1,000 patients (November 2014 – December 2016)</th>
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<tr>
<td>Hurley Group Practice - Lister Primary Care Centre</td>
</tr>
<tr>
<td>The Gardens Surgery</td>
</tr>
<tr>
<td>Camberwell Green Practice</td>
</tr>
<tr>
<td>Forest Hill Group Practice</td>
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<tr>
<td>Queens Road Phs Practice</td>
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<tr>
<td>St Giles Surgery, Drs Roseman &amp; Vasant</td>
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<tr>
<td>Sternhall Lane Surgery</td>
</tr>
<tr>
<td>The Dulwich Medical Centre</td>
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<tr>
<td>Acorn and Gaumont Surgery</td>
</tr>
<tr>
<td>Concordia Parkside Medical Centre</td>
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<tr>
<td>Dr Arumugaraasah</td>
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<tr>
<td>Hambleden Clinic</td>
</tr>
<tr>
<td>Elm Lodge Surgery</td>
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<tr>
<td>Dr Hossain</td>
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<tr>
<td>The Nunhead Surgery</td>
</tr>
<tr>
<td>DMC Chadwick Road</td>
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<tr>
<td>The Lordship Lane Surgery</td>
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<tr>
<td>306 Medical Centre</td>
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<tr>
<td>St Giles Surgery, Drs Virji &amp; Begley</td>
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<tr>
<td>Concordia Melbourne Grove Medical Practice</td>
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</table>

**Evaluation**

- Wide variation is found in EPCS utilisation among different practices.
- There are some practices that book significantly fewer patients into EPCS, as such there is variation in patient access opportunities. Reasons for the differences in rates are discussed later in this section. While there is no single clear reason for this, contributing factors could include the way that practices explain the service and patient perceptions of accessibility.
- From interviews, clinicians noted that as patients try the EPCS, they generally like the experience and would not mind being referred there again: in patient satisfaction surveys and friends and family test survey results collected consistently by both hubs, over 90% of patients have a high satisfaction rate or would recommend the service to friends and family.

*Note: St James’ Church Surgery is an outlier because the clinic has been closed since 11 July 2016 and of all its services have been transferred to QHS EPCS centre at Bermondsey Spa under caretaking arrangements. Source: EPCS data, Southwark CCG website: http://www.southwarkccg.nhs.uk/news-and-publications/news/Pages/Important-information-for-patients-of-St-James-Church-Surgery.aspx*
Operation findings – referrals by demographics

Most EPCS referrals are for children and working-age individuals

EPCS visits by gender IHL and QHS: booked appointments

Southwark demographic distribution compared to the distribution of EPCS referrals (as a % of total population/referrals)

Evaluation

- Currently, many EPCS patients are young children. This is partly because the service has focused on same-day and next-day issues. The demographic distribution of the Lister walk-in Centre was similar (c. 20% compared to under 7% in the general population).
- Anecdotally, there is demand for routine out-of-hours appointments for working age individuals. Out-of-hours routine appointments in the EPCS were not the focus initially, but more recently both hubs have started introducing routine appointments.
- Future service development plans could be targeted towards these demographic groups to maximise impact. For example, sexual health, contraception, travel vaccinations and young person clinics/paediatrics services.

Source(s): Interviews with stakeholders, IHL and QHS data on EPCS utilisation, prescription, finance and workforce, patient and staff surveys on EPCS feedback
Operation findings – case-mix

Prescription data suggests that EPCS is being used as intended (for ‘one off’ cases), however further case mix data is needed to test this finding.

- Across Southwark, EPCS generally prescribes medicine related to more acute medical problems (such as infections, skin, and respiratory system) as compared to the typical practice.
- This could reflect case mix of the EPCS with acute cases referred to the EPCS, and prescribing for chronic conditions, such as cardiovascular diseases, remaining within the practice.
- Prescriptions are only a rough proxy for case mix. For instance, chronically ill patients could go to the EPCS with a UTI.
- In QHS between 1st April and 30th June 2015, 997 patients attended an appointment at the EPCS and 569 (57%) of these received a prescription for at least one medication. A total of 857 items were prescribed resulting in an average of 0.86 items for every appointment, or 1.5 items for every person that required medication.*

QHS prescription audit information

- From the QHS audit, prescribing at the EPCS appears in line with national, local and service guidelines. Courses are generally short and only 1 prescription out of 857 prescribed items was considered excessive.
- Prescribing appears in line with NICE (short courses of benzodiazepine and ‘z’ drugs), local antibiotic guidelines (very low numbers of cephalosporin and/or quinolone prescribed) and service guidelines (low numbers of repeat medications).
- Recommendations include reissue and distribution of prescribing guidelines to all GPs providing a service at the EPCS to emphasise shortest length of treatment course, plus re-audit of prescribing at the EPCS in the future.

*Note: Data on practice prescribing compared to appointments was limited and a comparison against general prescribing rates was not possible.
Source(s): EPCS prescription data, England prescription data, QHS prescription audit.
Operation findings – access

Patient Survey results suggest that location, while important, is not as big a factor for patients as staff may perceive

Summary

- The EPCS snapshot staff survey suggests that staff perceive location as the most important reason patients don’t use EPCS hubs (54% of 43 respondents thought changing location would make patients more likely to use it).
- However, responses to the snapshot patient survey* indicated that, for patients who did not use EPCS, this was mostly because they were able to get an appointment at their local practice (57%) or they did not need an appointment (38%). None said that they had declined the EPCS appointment.
- Snapshot patient survey results suggest that, while some patients would prefer a different location (24% of those that used EPCS in survey results) this was not the biggest factor for why patients don’t use EPCS. Further testing would be needed to understand this results further.
- Overall, due to the limited sample targeted focus groups, a survey of patients referred to the EPCS could clarify the position further.

Patient question: What was the reason behind this (for respondents who heard of the EPCS and answered “no” for “have you ever used the EPCS”)?

- I was able to get an appointment at my practice: 56.8%
- I was offered an appointment, but declined: 0.0%
- I was not offered an appointment but needed one (e.g. had to visit A&E instead): 5.4%
- I didn’t need an appointment: 37.8%

Source: EPCS snapshot patient survey, 39 of 279 respondents answered this question. 24 respondents had used the service.

Patient question: Are there any aspects of the Extended Primary Care Service you would change to improve the service (select all that apply)?

- Location: 53.5%
- Services offered: 30.2%
- Capacity to undertake telephone management: 11.6%
- Nothing: 11.6%
- Other (free text): 25.6%

Source: EPCS snapshot staff survey, 43 of 48 respondents answered this question. 24 respondents had used the service

Staff question: Is there anything about the EPCS you would change to make your patients more likely to use it?

“Location is a big issue and a predictor for whether the patient is willing to go to the EPCS centre”
- GP Surgery

Staff question: Is there anything about the EPCS you would change to make your patients more likely to use it?

- Location: 53.5%
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Source: EPCS snapshot staff survey, 43 of 48 respondents answered this question. 24 respondents had used the service.

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- Overall, due to the limited sample targeted focus groups, a survey of patients referred to the EPCS could clarify the position further.

Source(s): Interviews with stakeholders, snapshot EPCS snapshot patient survey and EPCS snapshot staff survey

*All references to patient survey relate to the snapshot patient survey outlined in the sources section (slide 18).
Operation findings – patient satisfaction
When patients use the service, responses are positive

Monthly contract monitoring reports show consistently high satisfaction with EPCS hubs

Patient satisfaction and FFS survey results in 2016 (from contract monitoring)

<table>
<thead>
<tr>
<th>Month</th>
<th>QHS</th>
<th>IHL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-16</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>Feb-16</td>
<td>100%</td>
<td>96%</td>
</tr>
<tr>
<td>Mar-16</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Apr-16</td>
<td>100%</td>
<td>94%</td>
</tr>
<tr>
<td>May-16</td>
<td>100%</td>
<td>93%</td>
</tr>
<tr>
<td>Jun-16</td>
<td>100%</td>
<td>92%</td>
</tr>
<tr>
<td>Jul-16</td>
<td>100%</td>
<td>91%</td>
</tr>
<tr>
<td>Aug-16</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>Sep-16</td>
<td>100%</td>
<td>89%</td>
</tr>
<tr>
<td>Oct-16</td>
<td>100%</td>
<td>88%</td>
</tr>
<tr>
<td>Nov-16</td>
<td>100%</td>
<td>87%</td>
</tr>
</tbody>
</table>

QHS reports friends and family test (FFT) responses every month, and consistently over 90% of people report they are “likely” or “very likely” to recommend the EPCS, with over 1200 respondents from Jan. to Nov. 2016.

IHL’s most recent contract monitoring report also report a similar figure of general satisfaction of 94%, with 85% satisfaction with receptionists and 68% satisfaction on access (almost 1500 patients responded from Jan. to Nov. 2016).

Patient feedback from the snapshot survey

Overall, there have been positive responses to the service, though some individuals have expressed concerns. Some example comments from the EPCS snapshot patient survey are set out below:

“My practice has mentioned the extended service if they cannot offer me an appointment. Most of the time I have been able to get an appointment at the GP.”

“I was feeling very unwell on a Friday but decided to wait it out. On Saturday I was in a lot of pain so I called the out-of-hours service at my GP Practice. They had a GP call me back. I was then booked into the Lister that same-day and was seen by a GP and was diagnosed and treated. Excellent service!”

But:

“The problem is when you have been with a doctor a long time you build trust, this is not there with a strange doctor.”

The two sites are highly inconvenient to access from my home or from my work. Why can we not simply have extended hours at existing practices?”

The EPCS snapshot patient survey is consistent with the results reported consistently by the hubs

Patient question: Overall, how would you rate your experience of the Extended Primary Care Service? (21 responded to this question)

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very poor</td>
<td>0.0%</td>
</tr>
<tr>
<td>Poor</td>
<td>0.0%</td>
</tr>
<tr>
<td>Good</td>
<td>38.1%</td>
</tr>
<tr>
<td>Very good</td>
<td>61.9%</td>
</tr>
</tbody>
</table>

Source: EPCS snapshot patient survey, 21 of 279 respondents answered this question. 24 respondents had used the service

Summary

• Those who visit the EPCS have very positive experiences, evidenced through the snapshot patient survey to assess EPCS performance and patient awareness, friends and family tests (part of the contractual indicators for the EPCS), and IHL’s contract monitoring feedback. This suggests that the EPCS is a good service and adds value for patients.

Source(s): Interviews with stakeholders, IHL and QHS data on EPCS utilisation, prescription, finance and workforce, patient and staff surveys on EPCS feedback
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Access

1. Focus on developing consistent buy-in to EPCS across practices through the use of incentives, transparency and advocacy

To generate a higher level of practice ‘buy in’ and referrals across all practices in the absence of contractual agreements between CCGs and practices, a number of areas could be explored:

- **Incentives.** Are there any areas where federations can provide non-monetary incentives for cooperation (e.g. access to support or training and development)? What contractual levers could be implemented, e.g. between CCGs and practices?
- **Transparency.** For example, are there ways to show practices how their referral levels compare to their peers in more compelling ways?
- **Advocacy.** For example, by estimating how much ‘capacity’ and time practices save per referral; publicise good patient and practice reviews of EPCS; publicise the benefits for practice staff of having close links with the hub.

2. Explore if the pooled telephone management system should be started again

A pooled telephone management system/ other digital technology or support could help practices who are not able to offer efficient telephone management even with support in redesigning their ways of working. While centralised management was attempted before, it was at a time when the EPCS process was relatively new and uptake was lower. Now that the hubs are established, it may be worth drawing on learnings from the initial centralised system and undertaking a new pilot. It is important to note that telephone management will not have same rates as SELDOC in relation to the number of calls that do not require a face-to-face appointment following telephone advice as there is no option to refer patients back to the practice. recent telephone management experiences and audits within QHS and IHL should be fed into this exploration.

3. Share best practice and promote cooperation across practices on telephone management

For some practices, telephone management implementation continues to be a challenge, with practices needing to change the way they work on a day-to-day basis. For some practices, it might be helpful to develop ‘best practice’ case studies to help provide models for practices or have ‘buddies’ in addition to the hands-on support provided.
Recommendations

Extending the primary care offering

4. Explore the possibility of allowing Federations to refer to either hub

There is inconclusive evidence around the drivers of low EPCS utilisation by some practices. Patient familiarity with transport links to hubs could affect utilisation, although again this is uncertain. Federations could explore the possibility of cross-site working, however this would require agreement from commissioners and depend on factors including the financial implications of cross-hub referrals. The data sharing relationship would also need to be resolved, and would require further consideration.

5. Offer new types of appointment in a targeted way

Given the number of unused appointments, exploring highly targeted routine offerings may increase use. For instance, Southwark has a high proportion of relatively young people (working age and children). Targeted weekend offerings such as women’s health appointments and vaccines have already been included in service improvement plans, and dressing clinics, travel clinics, and GP routine appointments have started to be offered. High Type 2 diabetes prevalence might indicate that e.g. diabetes clinics – such as the service in Cumbria’s Workington model – could also provide value for Southwark’s population. Once specific services are agreed, targeted marketing to the patient segment may create a ‘push’ where patients ask their GP about these services. There may also be scope to expand the ways that people can access existing types of appointments, for example online appointments as set out by the General Practice Access Fund (GPAF).

6. Explore ways of ensuring telephone management does not exclude particular patient groups, in particular those whose first language is not English or those who are hearing impaired

Because same and next-day appointments through EPCS are booked via telephone management, they may not be as accessible to non-English speakers or those who are hearing impaired. While there was an Equalities Impact Assessment on the service model before the service was commissioned, alternative options such as text and email might be explored, to ensure that differential systems do not exacerbate inequalities in access. For example, there should be a way to accommodate those patients who have highlighted a preference for email communication.
**Recommendations**

**Metrics and data to improve the service**

7. Develop a consistent way of collecting improved metrics across the two hubs

To enable further understanding of the services, there is a need to **standardise data collection from across practices and between the two EPCS hubs** to strengthen comparative analysis. While data collection tools by themselves have not been successful, it may be helpful to gather **feedback on potential tools** from stakeholders to make a more tailored (and easier to complete) format. There could then be **dedicated support** to roll out the tool. An optimal solution would go beyond static templates to involve **collecting more real time data**. Some metrics that could be collected are e.g. how many **EPCS referrals required a practice follow up** appointment and whether patients were **referred appropriately**, and these could be integrated into the EMIS system.

8. Keep abreast of national developments to better collect outcomes data from practices

One of EPCS’ main objectives is to increase access to primary care. In order to assess the impact that the service is having on patients and practices, metrics such as waiting time for appointments could be collected from practices. At present, there is no consistent measure of this type of data, although there is national work to pilot a measure of waiting time based on third available appointment. Federations should keep up to date with developments in measuring access, and seek to implement data collection of good metrics for access. It will be critical to work with practices on the best and easiest way to collect these types of measures, and be realistic about what can be achieved.

9. Collect additional data to understand the main drivers of patient utilisation of EPCS

This evaluation included a snap-shot survey of c. 300 patients across the patch to understand EPCS use. However, only a fraction of the sample had been offered EPCS appointments (and none declined). This provided a relatively limited sample for drawing strong conclusions on the main drivers of patient utilisation of EPCS. Ways to collect further data on this could therefore be explored. For example, it might be possible for the duty GPs to integrate a **standard set of wording** into patient notes as part of telephone management, or it could be **added to practice systems** as an ‘outcome’ of the call. To get a more representative picture of why patients might not use EPCS, targeted focus groups or surveys to those that were offered EPCS could be conducted.
Recommendations

Sustainability

10. Explore what works in terms of attracting a stable complement of staff to minimise use of locums in the context of a challenging national workforce environment.

In terms of GP recruitment, initiatives that fit with career preferences of GPs (e.g. GP “portfolio” contracts) should be continued. In addition, flexible salaried working, the possibility of continued on-the-job learning with a strong Federation can be emphasised. Nurses will be in greater need once targeted routine services roll out fully, and joint recruitment with practices will be critical in helping find the right staff.

11. Work with non-practice referral in pathways to redirect to EPCS (SELDOC, A&E, 111) in order to maximise the system-wide impact.

To make sure EPCS is used in the best way, further advocacy and exploration of, for example, contractual levers, could be undertaken with existing non-practice referrers. For instance, this could include making sure that all A&E staff are aware of EPCS. Also, referrals are still going to SELDOC treatment centres, even though all of these should be referred to EPCS. This could be investigated. Traditionally, the South site had more UEC referrals, with more SELDOC referrals and being on the same site as the old WiC.

12. Explore further alignment between EMIS systems to make EPCS a true extension of general practice rather than being a referral system.

Historically, EPCS hub clinicians did not have Read/Write access on EMIS, which could lead to duplication of effort. Currently, both Federations have purchased functionality to enable Read/Write access on patient records, and QHS has piloted this. This allows for synchronous effort and will help enable a wider set of services (e.g. diabetic clinics). However, it is important to note that efforts may be needed to encourage practice acceptance of other clinicians being able to write on their notes, in what is truly an extension of primary care rather than a referral system.

13. Keep flexibility to adjust the number of slots by time, day and season of appointments.

To maximise sustainability, it may be worth further adapting and continually reviewing patterns in utilisation to provide the right level of service. For example, if Sunday has low utilisation, sessions could be further reduced, and then increased when utilisation is close to 90% to provide sufficient head room for unexpected activity. Now that there is historic data on EPCS use, this could be fed in to update the EPCS session capacity model. This will need to be combined with data on routine referrals as these increase. Targeted work to get the right routine/urgent mix in sessions will be helpful as utilisation increases, and noting that at some times (Sunday afternoons) there is already only the minimum service provision to ensure 8-8 seven day service (i.e. one GP).
Recommendations
Learning for future expansion

14. Explore a way of developing a stronger awareness of EPCS

When EPCS was launched, it was not marketed directly to patients because the EPCS could only be accessed following referral from general practice. Whilst this is still an important principle, a focused communication campaign (with a consistent message) would be necessary to increase patient recognition of EPCS as a trusted extension of their general practice and GP out-of-hours.

15. What we would do differently next time: consider phased expansion to help smaller practices adjust

In the future, a phased expansion (rather than a longer pre-launch timeframe) may be used to maximise momentum whilst giving practices the time they need to adapt their ways of working. However, this is not always possible (e.g. IHL needed to go live 100% from day one because the Lister WiC was decommissioned).

16. What we would do differently next time: focus on culture change and developmental support recognising that changing the way practices work takes time

One of the biggest implementation challenges expressed in interviews with Federations and practices was the need to change the way the practice worked on a day-to-day basis rather than the technical challenges to telephone management. In the future, these ‘soft’ changes should be specifically tested at an early stage to see if a high level of support may be needed. If this is a challenge, it might be appropriate to develop ‘best practice’ case studies to help provide models for practices or have ‘buddies’ in addition to the hands-on support provided.
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Case studies - Introduction

Introduction

Due to the challenges collating general practice appointment data it was decided a more in-depth look at a few practices would provide useful insight into the use of the EPCS. The practices range in size and distance from the hub sites.

This section contains the summary findings from the four case-study GP practices. The case studies included two practices from North Southwark and three from South Southwark:

- Albion Street Group
- Villa Street Medical Centre
- Camberwell Green Surgery
- Lordship Lane Surgery
- The Gardens Surgery

The case studies focus on the experiences of practices with the EPCS more generally and provide data with respect to practice utilisation and appointment referrals to the EPCS over the period in which EPCS has been used. The case studies also highlight the practices’ experience with the telephone management process and their views on proposals such as the centralisation of the management system.

The data and findings from the case studies have also been used as part of the evaluation findings within the respective phases.
Case studies – Key themes

**Key themes**

- **Variation.** There was varying usage across practices, with some practices engaging more with the service than others. Reasons cited by practices in terms of utilisation differences included telephone management adoption, distance to the EPCS hub, and internal capacity to manage patients.

- **Initial difficulties.** Some practices experienced initial difficulties with using EPCS, which were resolved overtime. In particular, there were difficulties around telephone management.

- **Relief.** EPCS provided relief for practices during busy periods, and in some cases its use was concentrated to these periods. However, as there is limited comparable data on e.g. patient waiting times in practices, it is difficult to quantify this.

- **Engagement.** Patients at the selected practices were in some cases hesitant with using the EPCS. Location and accessibility (such as parking and public transport access) was cited as a factor.

- **Practice persuasion.** Practice persuasion is needed to “sell” the EPCS to patients. Usually, the feedback is that while there is initial reluctance, patients have good experiences at the EPCS and are happy to visit the centre again.

**List-size normalised appointments per month booked at an EPCS hub (per 1,000 patients), November 2016 snapshot**

<table>
<thead>
<tr>
<th>Practice</th>
<th>EPCS appointments per 1000 list size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albion Street Group Practice</td>
<td>12</td>
</tr>
<tr>
<td>The Gardens Surgery</td>
<td>22</td>
</tr>
<tr>
<td>Camberwell Green Practice</td>
<td>34</td>
</tr>
<tr>
<td>Villa Street Medical Centre</td>
<td>4</td>
</tr>
<tr>
<td>Lordship Lane Surgery</td>
<td>2</td>
</tr>
</tbody>
</table>

Source(s): EPCS data on practice level utilisation
### Case study 1 – Albion Street Group Practice (1/2)

#### Overview

The practice refers patients to the EPCS and has had telephone management in place prior to the EPCS being launched with all patients contacting the practice with urgent needs speaking to a clinician.

- 13,700 patients
- 9 GPs, 6 Nurses
- 1-2 weeks waiting time for routine appointments

#### Overall experience with the EPCS according to practice representatives

<table>
<thead>
<tr>
<th>Access</th>
<th>Lessened the pressure during periods of high demand. Also, the EPCS is one of the tools the practice uses to ensure patients with acute needs are seen on the day (either in practice or EPCS).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Limited effect on improving access in normal times as patients generally had little problem in accessing the practice before its introduction</td>
</tr>
<tr>
<td>Engagement</td>
<td>Staff interacted frequently with the EPCS</td>
</tr>
<tr>
<td></td>
<td>Patients are generally satisfied when using the services</td>
</tr>
<tr>
<td>Other</td>
<td>There were initial operational issues with the system, e.g. at the start, staff had difficulty operating the booking system. However, there seems to be no inherent barrier with using the EPCS and IT and telephone management systems have since ran smoothly</td>
</tr>
<tr>
<td></td>
<td>The ability for EPCS staff to access patient medical records has been beneficial</td>
</tr>
</tbody>
</table>

"On one occasion, we had four doctors sick, and there was considerable demand on the existing workforce. The extra capacity EPCS offered came in very handy to the practice in making sure patients were seen."

**Practice representative**

Source(s): Discussions with representatives of Lordship Lane Surgery, NHS England data 2015. Clinicians data refer to total headcount in the practice, data from March 2016. Waiting time estimates are anecdotal – provided by practice clinicians
Case study 1 – Albion Street Group Practice (2/2)

Summary data (2016)

<table>
<thead>
<tr>
<th>Experience with telephone management</th>
</tr>
</thead>
<tbody>
<tr>
<td>• As an early adopter of telephone management, the practice finds telephone management is important because of the value added for GPs.</td>
</tr>
<tr>
<td>• The practice has used telephone management differently to others as it normally has two GPs operating the service, one in the morning and one in the evening, and the receptionist transfers calls to the duty doctor only if deemed necessary.</td>
</tr>
<tr>
<td>• Following telephone consultation, the GP will either book the patient an appointment at the practice or refer the patient to the EPCS. EPCS is most helpful during times of high demand. During busy hours, nurse practitioners or clinicians do actively use the EPCS.</td>
</tr>
<tr>
<td>• Positive experience with the EPCS. There seems to be no inherent barrier for using the EPCS. IT and telephone management systems ran smoothly. Picking up the service was relatively quick.</td>
</tr>
<tr>
<td>• The practice welcomes expansion of services, including flu clinics, smear tests and immunisations.</td>
</tr>
</tbody>
</table>

* ‘Allocation’ refers to the number of appointments that practice would use if appointments spread evenly based on list size.
### Overview

The practice has recently set up a telephone management system, although it had previously introduced changes to the appointment system. Given this, demand pressure was significantly reduced prior to EPCS and therefore the system has had little discernible impact according to practice representatives.

7,000 patients

8 GPs, 2 Nurse

### Overall experience with the EPCS according to practice representatives

<table>
<thead>
<tr>
<th>Access</th>
<th>There has been no significant change in consultation volume and patient waiting times before and after EPCS. However, it is of note that Villa Street has moved to 15 minute appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EPCS can help free up availability for people unable to visit during regular hours, but this tends to be on rare occasions</td>
</tr>
<tr>
<td></td>
<td>Some patients find it difficult to access the service due to the location of the EPCS centre</td>
</tr>
</tbody>
</table>

| Engagement | The frequency of use of the EPCS is high |
|            | Clinicians select which patients they feel are appropriate to use, and are likely to accept going to, the EPCS |

| Other | Practices need support in routine appointments, however it is important to not disrupt the hiring of nurses in Southwark |

"From a clinician’s perspective, there are questions about the continuity of care with the EPCS. For example, a practice GPs would need to carry out tests, signed off by the EPCS duty clinician, that they would not have issued themselves. This is less a concern for SELDOC, in the sense that if the patient is going call SELDOC, he is not planning to see his/her GP anyway."

Practice representative

Summary data (2016)

EPCS appointments from Villa Street Medical Centre (January 2016 – December 2016)

- Compared to other practices, utilisation at Villa Street is significantly lower, ranging between 10-40% through 2016.
- Utilisation increased from 18% to 25% between October 2015 and 2016.

Changing the appointment system

- Before the changes, patients made either walk-in or telephone bookings, with patients booking appointments up to six weeks in advance.
- After the changes, patients were encouraged to book 1-2 days in advance, telephone management was conducted during the morning only and walk-in appointments were not accepted.
- The effect of this change was positive with improvements to patient experience and fewer ‘Did Not Attends’. In addition, the practice has made efforts to educate patients on how to appropriately use the new appointment system.

Views on potential options

Clinicians think it would be interesting to test the effectiveness of EPCS by looking at EPCS follow-ups and whether patient issues are resolved after the EPCS visit.

Source(s): Discussions with representatives of the Albion Street Surgery, EPCS Monthly Reports.
## Case study 3 – Camberwell Green Surgery (1/2)

### Overview

| | The practice, one of the largest in Southwark in terms of patients, is a relatively high user of the EPCS. Clinicians make frequent use of the system and note that it is easy to use. They also note that it helps ensure that more urgent patients are seen on-the-day as doctors have the ability to select which patients they see that day through the telephone management system. |
| | 11,500 patients |
| | 7 GPs, 4 Nurses |

### Overall experience with the EPCS according to practice representatives

| Access | The system has helped guarantee that urgent cases are seen on-the-day |
| | It has enabled an increase in appointments for both routine and non-routine patients at the practice |
| | Opening hours and the location of the EPCS has improved access |

| Engagement | Patients were at first reluctant to visit the EPCS because they would rather see their registered GP. Younger patients are more inclined to use the services than older patients and patients with young children. |
| | Clinicians are engaging well with the EPCS, using it frequently and trying to build patient trust in it |

| Other | There were difficulties in referring non-English speaking patients to the EPCS |
| | Access to patient records was very helpful and patients understood that information would only be shared with the EPCS with their consent |

"EPCS has helped guarantee that people who need to be seen are seen on-the-day. This is due to the fact we now have the ability to select which patients we see on the day, through the management system."

Case study 3 – Camberwell Green Surgery (2/2)

Summary data

EPCS appointments from Camberwell Green Surgery (January 2016 – December 2016)

- Initially there were few patients referred to the EPCS from the practice.
- This steadily increased throughout 2015. This significant increase is due to changes to the appointment system described below.
- Note: There is no practice appointment allocation for IHL practices.

Experience with telephone management

- Prior to April 2016, the practice had a walk-in clinic with patients arriving between 8am and 10am guaranteed a same-day appointment.
- According to representatives this did encourage use of the EPCS system as they could easily get an appointment at clinic.
- In April 2016, telephone management was introduced. Patients called in between 8am-10am and GPs would decide whether to refer to EPCS or to see the patient at the clinic.
- The practice noted that the telephone management system improved the management of patient flow, but GPs found it difficult to manage the volume of calls (c. 175 per day).

Views on potential options

The practice welcomes a centralised telephone management system if it can help take the pressure off the practice.

Representatives noted that there may however be logistical and political issues with operating the centralised system and IHL may therefore be needed as a facilitator.

Source(s): Discussions with representatives of the Camberwell Green Surgery, EPCS Data.
Case study 4 – Lordship Lane Surgery (1/2)

Overview

The relatively small practice has experienced a number of issues with EPCS according to representatives. They note that some patients are not prepared to visit the EPCS due to the inconvenience of its location. Representatives believe in some respects that the EPCS might have increased the pressure on the practice due to the complexity of telephone management and other operational issues encountered.

4,300 patients

3 GPs, 1 Nurse

7-10 day waiting time for routine appointments

Overview

Access

It has increased access for patients when the practice is closed or when there are no available appointments.

Waiting times have remained roughly the same.

Engagement

Patients are generally reluctant to visit the EPCS because of its location. There are differences between demographics, as younger patients are more inclined to use it than older ones.

Patients do not see the EPCS as an extension of the practices as the ‘branding’ is not consistent.

Doctors are hesitant when interacting with the EPCS as they feel guilty for ‘turning patients away’.

Other

EPCS has added to the complexity of day-to-day operations as there is an additional process in the form of telephone management.

EPCS has a limited capacity and the scope of services may not be sufficient.

"Patients want to see their usual GP and are quite reluctant to go the EPCS. I also think doctors sometimes feel a bit guilty turning the patient away by referring them to the EPCS."

Practice representative

Source(s): Discussions with representatives of Lordship Lane Surgery, NHS England data 2015. Clinicians data refer to total headcount in the practice, data from March 2016. Waiting time estimates are anecdotal – provided by practice clinicians
Case study 4 – Lordship Lane Surgery (2/2)

Summary data

EPCS appointments from Lordship Lane Surgery (January 2016 – December 2016)

- On average, referrals to the EPCS has been low.
- The practice has experienced periods of greater reliance on EPCS and periods with less reliance.

Experience with telephone management

- The practice had previously used telephone management before EPCS was introduced.
- In general, the practice finds that there are not enough clinical staff to operate a regular management system.
- There have been issues with telephone management at times, as sometimes inappropriate patients have been referred which has been highlighted by IHL clinical leads
- The practice has noted some patients have difficulty with the telephone management system due to language barriers (e.g. patients with limited English).

Views on potential options

Staff at the practice are open to new ways of working that will relieve demand; a centralised telephone management system could help to achieve this.

Fundamentally, they feel that there needs to be a better IT system integration between their practice and the EPCS.

Source(s): Discussions with representatives of the Lordship Lane Surgery, EPCS Data.
Case study 5 – Gardens Surgery (1/2)

Overview

The surgery is an active user of EPCS, with a significant peak in booked appointments in February and March 2016. EPCS referrals are based on clinical appropriateness, not based on who calls first. There is some variation in the proportion of patients that each doctor sends to the EPCS when they are duty doctor; as doctors have become more familiar with the system, there is greater acceptance of using EPCS across all GPs.

| 7,200 patients |
| 6 GPs; 3 Nurses |
| 2-3 day waiting time for routine appointments |

Overall experience with the EPCS according to practice representatives

Access

- The practice is an active user of the EPCS, especially during peak seasons.
- There is no evidence suggesting that waiting times are long in the practice.

Engagement

- Over time, patients knew more about the EPCS and expect it to be offered. They are now less resistant to going there. However, this took a long time.
- More advertising about the service to patients initially would have helped. Attendance at PPG meetings is too low to have an impact on wider awareness. Some doctors are hesitant when referring to EPCS, as they may feel they are ‘turning patients away’ by not offering an appointment at the practice.

Other

- The EPCS is also good for the patients in that they will not be turned away, and the service feedback has been positive. However, the stress on the practice has not reduced significantly because the volume of telephone appointments for ‘on the day’ concerns can be very high. The scope of EPCS could also be expanded to a wider set of services.

"Patients’ willingness to go to the EPCS depends on how it is sold to them. Patients are told that there is no capacity in the practice for him/her to be seen on the day, and that he/she could go to the EPCS."

Practice representative

Case study 5 – Gardens Surgery (2/2)

**Summary data**

EPCS appointments from the Gardens Surgery (January 2016 – December 2016)

- There is a significant peak during February to March 2016, this is potentially due to the ‘winter rush’, where the late winter in 2016 has led to a surge of patient demand to visit the practice during that period.
- Patients now expect the EPCS to be offered to them.

**Experience with telephone management**

- The patient referral system has changed since EPCS was launched (as requested by the CCG).
- Before EPCS, patients would be booked into face to face slots on a first come first served basis. When they were full, receptionists carried out informal triaging, prioritising children under 5 and very unwell patients. Under this system, people were turned away.
- Under the new system, any patient who calls and says they have a need to see or speak to a doctor on the day is offered a telephone appointment on the same day. A doctor will call them back and either manage their problem on the phone, invite them into the surgery in an appropriate appointment slot or book them into the EPCS.
- The old system did not stream patients into the most appropriate management option. Now patients who do not have to be seen face to face can be managed with a telephone appointment. Those who could be seen by other services like a pharmacist or the MECS are signposted there, those who require an appointment with their own GP are offered one and those with more minor illness can be offered an appointment at the EPCS. Patient education about options like visiting the pharmacist is also offered as part of the telephone consultation.

**Telephone mgt. training**

Staff from the practice noted that refresher courses offered after the service launch were not well attended by other practices. They had reception staff and clinicians present.

The attendance might be improved if the training was held directly after regular practice engagement meetings.

Source(s): Discussions with representatives of the Lordship Lane Surgery, EPCS Data.