Somerset GP999 Scheme:
Summary Activity Report for Quarter 4 – 2018/19 (Jan, Feb, Mar)

Summary Activity Data for Q4 for Taunton & Yeovil Cars (ALL ACTIVITY DURING REPORTING PERIOD):

	Jan 2019	Feb 2019	Mar 2019	Q4 Total
Number of Cases	213	188	222	**623**
Community Treatment (%)	151 (70.9%)	134 (71.3%)	171 (77.0%)	**456 (73.2%)**
ED Attendance (%)	29 (13.6%)	24 (12.8%)	23 (10.4%)	**76 (12.2%)**
Admission Direct to Speciality (%)	33 (15.5%)	30 (16.0%)	28 (12.6%)	**91 (14.6%)**
Admission to Community Hospital/Hospice (%)	0 (0%)	0 (0%)	0 (0%)	**0 (0%)**

Summary Data on Admission Avoidance for Q4 (ALL ACTIVITY DURING REPORTING PERIOD):

Outcome*	Jan 2019	Feb 2019	March 2018	Q4 Total
ED attendance prevented	181	154	193	**528**
Short Stay admission prevented	80	85	95	**260**
Long Stay admission prevented	13	4	11	**28**

*Estimates are based on a 'best clinical judgment prediction' by the attending GP and/or the clinical lead upon review of case notes & incident details. It is likely that admissions (short and long) are underestimated, as a proportion of the prevented ED attendances may well have resulted additionally resulted in an admission. Cases where an admission (long or short) are prevented usually also prevent an ED attendance unless otherwise stated, and direct admissions usually also prevent an ED attendance. A variety of data sources are used to compile these estimate, including clinical records, CAD, ePCR etc and it represents a 'best judgment'.

Activity Breakdown by Shift Type (Q4)*

	Jan 2019	Feb 2019	Mar 2019	Q4 Total
Number of Cases (Total) **Dayshift (10am-7pm)** **Twilight Shift (7pm-12)**	**= 213** **179** **34**	**= 188** **155** **33**	**= 222** **201** **21**	**= 623** **535** **88**
Community Treatment (%) **Dayshift (10am-7pm)** **Twilight Shift (7pm-12)**	151 (70.9%) 125 (69.8%) 26 (76.5%)	134 (71.3%) 105 (67.7%) 29 (87.9%)	171 (77.0%) 154 (76.6%) 17 (81.0%)	**456 (73.2%)** **384 (71.7%)** **72 (81.8%)**
ED Attendance (%) **Dayshift (10am-7pm)** **Twilight Shift (7pm-12)**	29 (13.6%) 23 (12.8%) 6 (17.6%)	24 (12.8%) 22 (14.2%) 2 (6.1%)	23 (10.4%) 22 (10.9%) 1 (4.8%)	**76 (12.2%)** **67 (12.5%)** **9 (10.2%)**
Admission Direct to Speciality (%) **Dayshift (10am-7pm)** **Twilight Shift (7pm-12)**	33 (15.5%) 31 (17.3%) 2 (5.9%)	30 (16.0%) 28 (18.1%) 2 (6.1%)	28 (12.6%) 25 (12.4%) 3 (14.3%)	**91 (14.6%)** **84 (15.7%)** **7 (8.0%)**

Admission Avoidance Breakdown by Shift Type (Q4) §

Outcome*	Jan 2019	Feb 2019	March 2018	Q4 Total
ED attendance prevented (tot) **Dayshift (10am-7pm)** **Twilight Shift (7pm-12)**	181 **152** **28**	154 **125** **29**	193 **175** **18**	**528** **452** **75**
Short Stay admission prevented (tot) **Dayshift (10am-7pm)** **Twilight Shift (7pm-12)**	80 **67** **13**	85 **67** **18**	95 **84** **11**	**260** **218** **42**
Long Stay admission prevented (tot) **Dayshift (10am-7pm)** **Twilight Shift (7pm-12)**	13 **10** **3**	4 **3** **1**	11 **11** **0**	**28** **24** **4**

§Explanatory Notes for Breakdown by Shift Type

1. Due to the additional winter uplift finding, it was decided – following submission of a proposal to Somerset CCG – to make use of this funding by extending the availability on key days of the Somerset GP999 service.

2. Funding allowed for an additional approximately 16 hours per week of GP clinical time, during the winter 'uplift' period of January to March 2019.

3. On the basis of known service activity and frontline crew feedback, it was decided to deploy these hours as an additional 'twilight' shift on Fridays, Saturdays, Mondays and Tuesdays, extending the GP availability until midnight. As the service was running at 7 days out of Taunton, this location was chosen for the uplift hours.

4. To enable staffing of these shifts and to make shift length and times practical, it was decided to split the day into a 10am-7pm shift, and a 7pm-12pm shift. This allowed for a 30 minute 'handover/changeover' period between 7pm and 7:30pm.

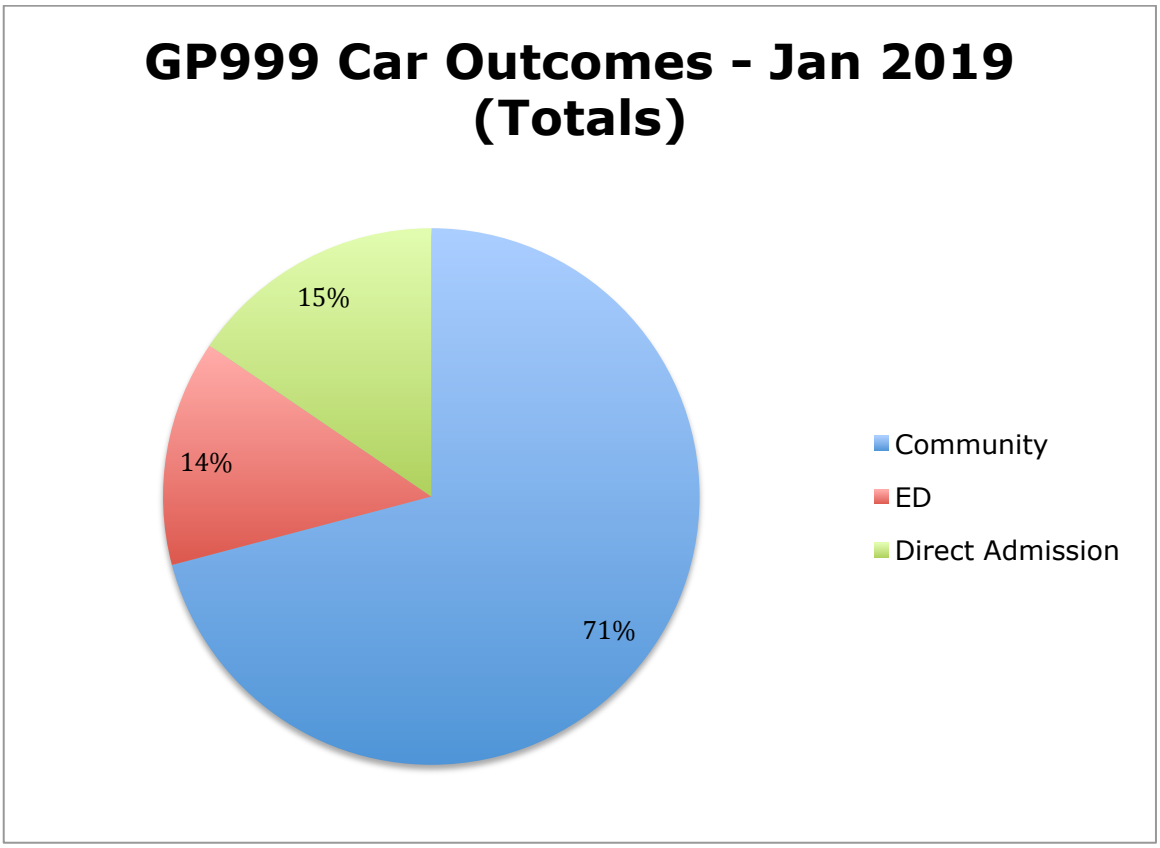
5. As such, it should be noted that data breakdown is shown in the format of these two shift periods, (although winter 'uplift' funding only technically supported the additional period of 8pm-12midnight, as core funding covered up until 8pm).

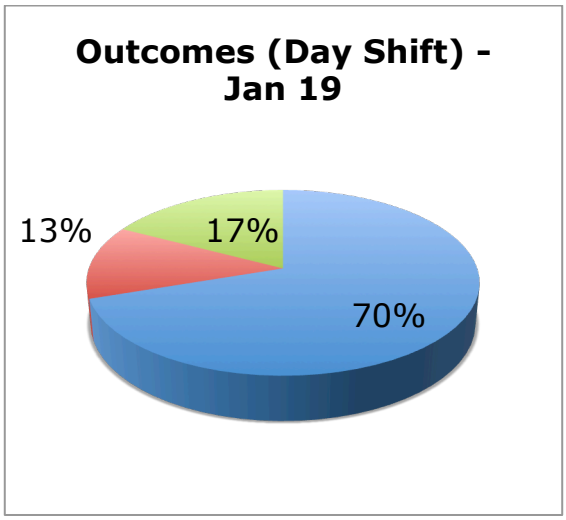
6. This slight caveat should be noted when interpreting the data split by shift type – and particularly when making comparisons with previous quarters - as figures reported for 'daytime' shifts actually represent a shift period that is 1-hour shorter than in previous quarters, for the reasons explained above.

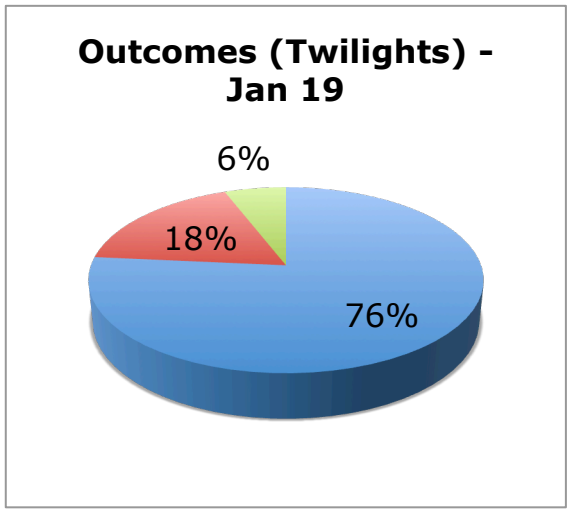
Summary Estimates Since GP999 Scheme Inception

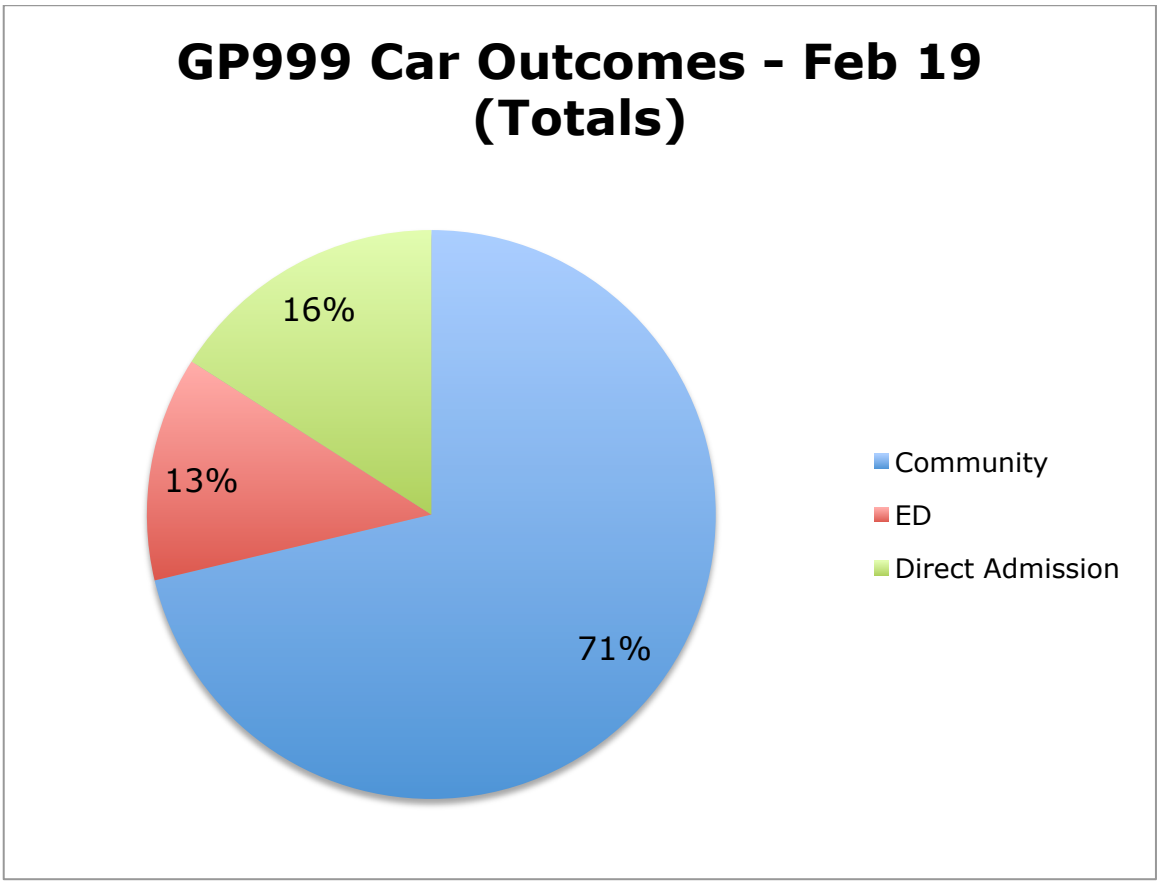
	Cumulative Estimates Since Scheme Start
Number of Clinical Cases	3,368
Community Treatment (%)	2,467 (73.2%)
ED Attendance (%)	383 (11.4%)
Admission Direct to Speciality (%)	428 (15.4%)
Admission to Community Hospital/Hospice (%)	14 (<1%)

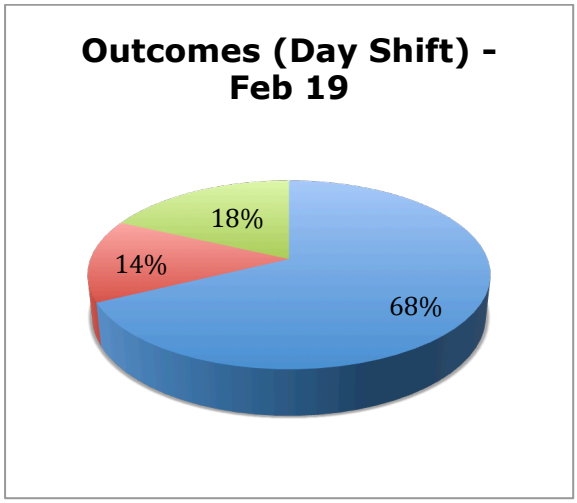
Graphical Summary of Car Outcomes by Month (Q4)

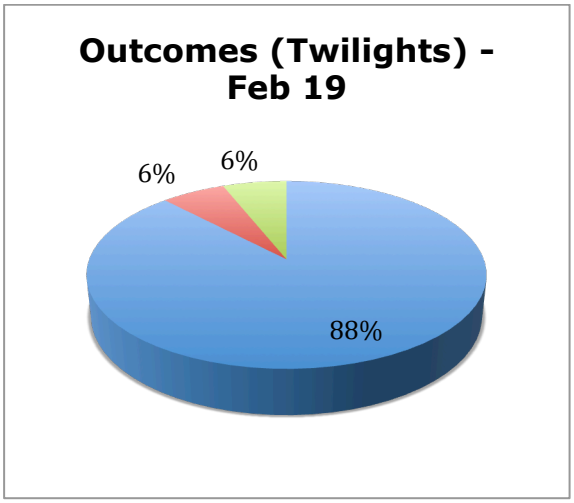


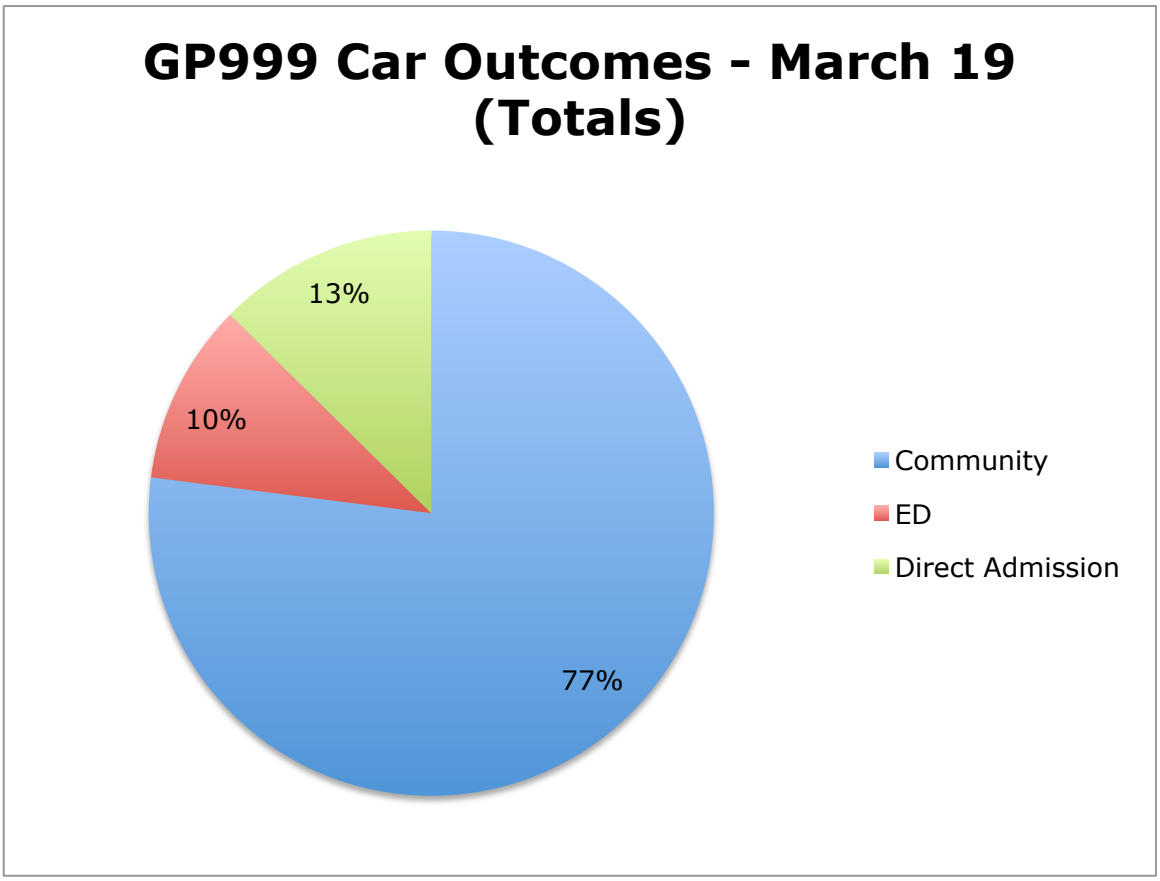


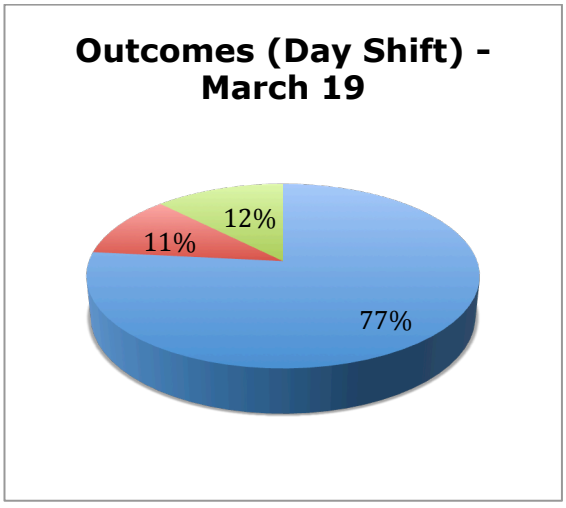


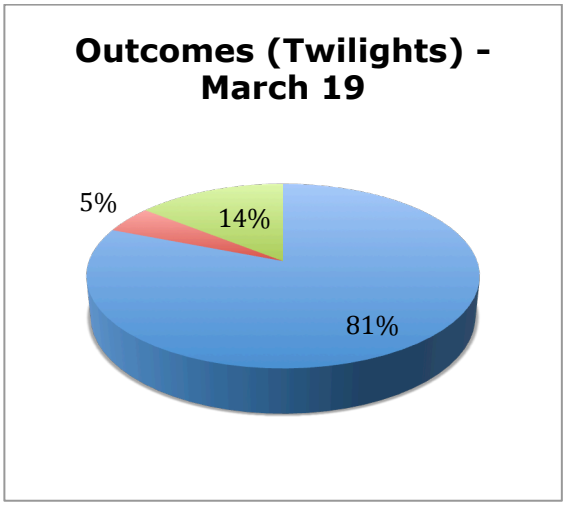

GP999 Car Outcomes - Feb 19 (Totals)
16%
13%
71%
Community
ED
Direct Admission


Outcomes (Day Shift) - Feb 19
18%
14%
68%

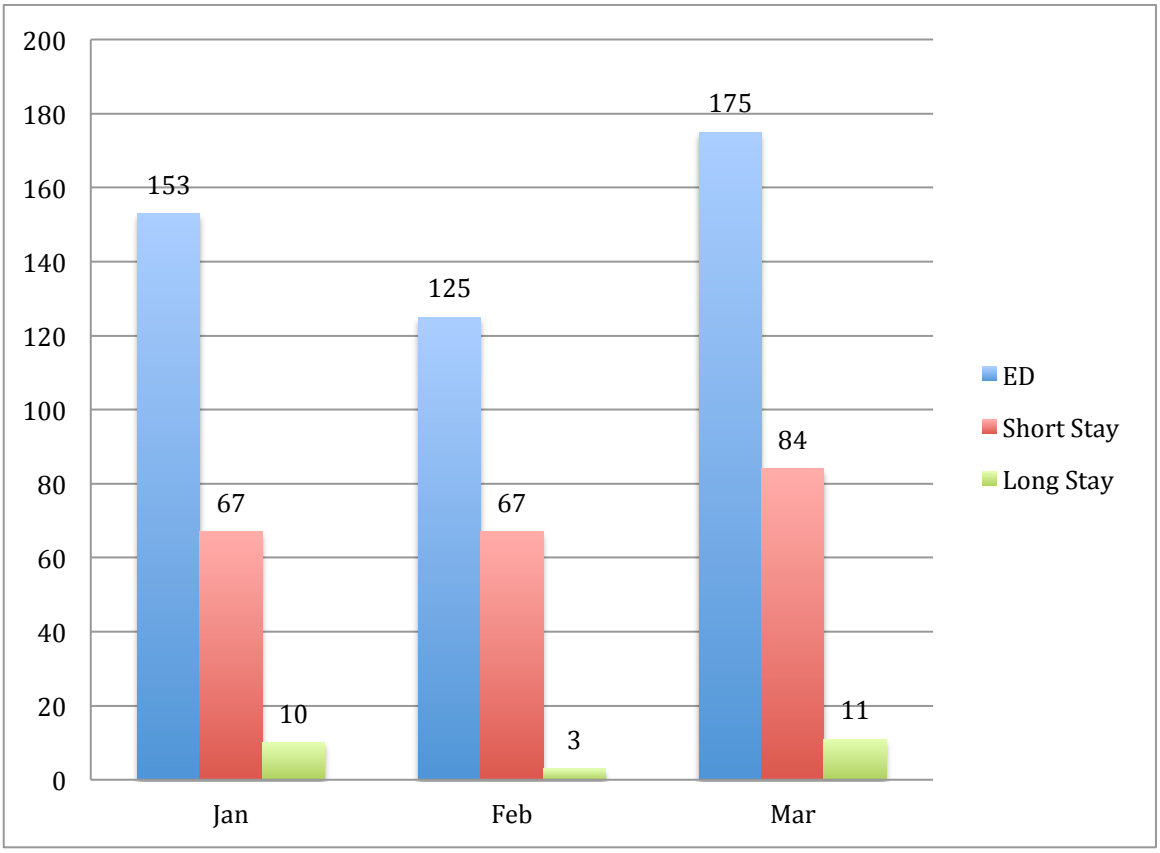

Outcomes (Twilights) - Feb 19
6%
6%
88%


GP999 Car Outcomes - March 19 (Totals)
13%
10%
77%
Community
ED
Direct Admission


Outcomes (Day Shift) - March 19
12%
11%
77%


Outcomes (Twilights) - March 19
5%
14%
81%

Graphical Summary of Admissions Avoided by Month (Q4)



Sub-analysis of patients referred and/or conveyed to ED (Q4):

Once again in this quarter, a top-level analysis of the data shows very similar reasons for ED conveyance, and does not indicate any particular patterns or clinically appropriate alternatives. This is in keeping with previous months.

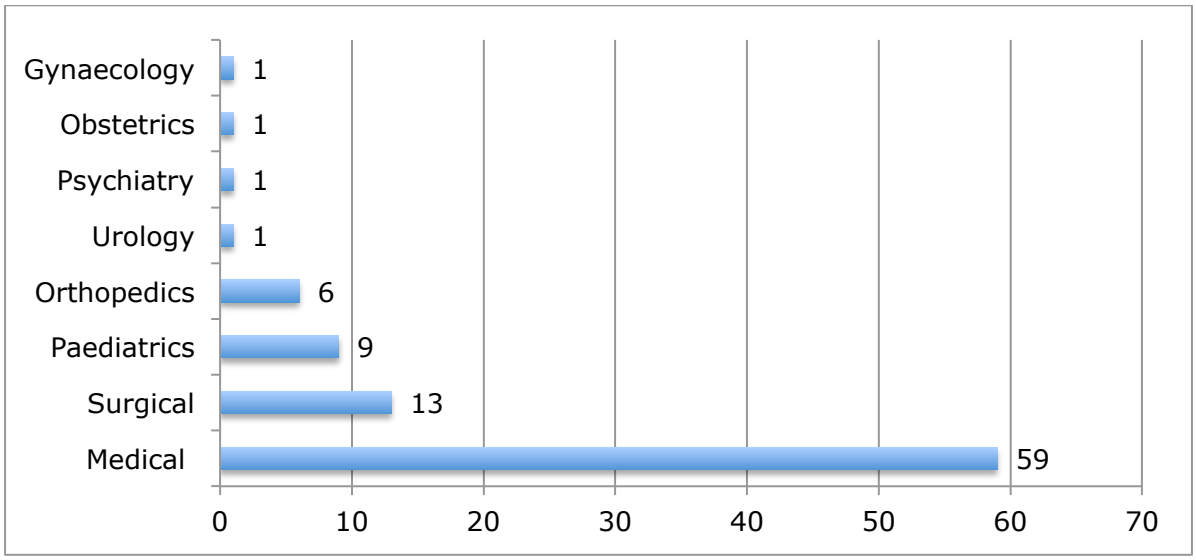
REASON FOR ED TRANSFER
Acute Coronary Syndrome (ACS) – unsuitable AMU
Abdominal pain – cause unknown (unclear medical/surgical)
Bowel Obstruction requiring ED input
?Meningitis
Acute severe asthma
Pyrexia of unknown origin
Urosepsis requiring stabilization in ED
Low GCS ?cause
Acute Stroke
Severe dehydration
Head injury (Observation required)
Head injury (CT required due anticoagulants)
Fracture / Dislocation of Knee
Multiple Stabbing
?Acute intracranial bleed / SAH
Accelerated hypertension with vomiting
Neutropoenic sepsis
Acute Coronary Syndrome (ACS) – unsuitable AMU
RTC multiple traumatic injuries
Diverticular sepsis
RTC multiple injuries (HEMS conveyed)
Traumatic back pain ?fracture
Stridor / acute airway compromise
Acute stroke
Facial abscess / tracking cellulitis
Acute Coronary Syndrome (ACS) – unstable AMU
Choking episode with aspiration
Foreign body airway compromise
Acute Coronary Syndrome (ACS) – unsuitable AMU
Acute severe asthma
Acute Stoke
Acute Coronary Syndrome (ACS) – unsuitable AMU
Acute severe asthma
Acute Stroke
Acute Stroke
RTC with neck pain
Sepsis requiring stabilisation
Overdose

Sepsis with reduced GCS
Unconscious post head injury
Dislocated elbow
Head injury (CT needed – anticoagulants)
Head injury (CT needed – anticoagulants)
?Hip fracture
Complex head wound, needing formal closure
Acute LVF needing resuscitation
Sepsis needing resuscitation
Catastrophic haemorrhage
Sepsis needing resuscitation
Head injury (CT needed – anticoagulants)
Pneumonia with AF and Heart Failure (unable to get medically accepted)
COPD Exacerbation needing resuscitation
Head injury (CT needed – anticoagulants)
First seizure ?cause
Abdominal pain ?cause (unclear medical/surgical)
?Wrist fracture
Fractured knee
Acute Coronary Syndrome (ACS) – unsuitable AMU
Cardiac Arrest
Cardiac Arrest due to drug overdose
Head injury (CT needed – anticoagulants)
Head injury (complex wound needing formal closure)
Respiratory compromise
Acute Coronary Syndrome (ACS) – unsuitable AMU
Peri-orbital cellulitis
Fractured femur
Febrile convulsion with sepsis
Seizure and abnormal ECG
Lower limb post-op cellulitis
Pneumonia / chest sepsis requiring resuscitation
Fall with neck injury
Severe angio-oedema
Drug overdose

It is worthy of note that significant advanced clinical interventions are delivered on many of these ED cases, including Advanced Life Support, decision-making support around destinations within the Trauma Network, and the performing of interventions not usually within Paramedic scope of practice. Isolated cases occur where patients may be suitable for other direct-admission destinations, but pathways appear inaccessible (this is usually out of hours, or during times of extreme pressure on the system). Any trends will continue to be monitored.

Sub-analysis of patients referred directly to a specialism (Q4):

The reasons for direct-specialism referrals broadly remain similar to the previous quarters of 2018/19. The GP car access a range of specialism directly, including those for which there are no formal 'admission avoidance' pathways, but for whom a clinician-to-clinician discussion enables the negotiation of a suitable direct admission for the patient. This is a significant advantage of the ready access to a senior clinical decision-maker. A top-level analysis shows very similar and stable referral patterns to previous quarters. Direct medical admissions remain the most common direct-specialism outcomes.



Rapid Response

The GP999 service has also continued to benefit from being able to refer into the Somerset Rapid Response service, which has undoubtedly supported community treatment of some more borderline patients, following clinical GP assessment and a management plan. At the time of authoring this report, data is awaited from the service regarding referral rates.

Summary for Quarter 4 (2018/19)

- Activity levels remain strong, with further quarter-on-quarter increases in overall case contacts.
- Case outcomes broadly continue to mirror the now well-established split, with only approx. 12% of all contacts resulting in an ED transfer.
- Admissions and ED attendances avoided are stable and in line with previous quarters.
- The scheme estimates over 500 ED attendances, and nearly 300 acute admissions were mitigated by the GP999 scheme this quarter.
- The additional funding provided for further value in the 'twilight' hours over the winter pressure period. Outcomes from this period were particularly strong, with even lower than average referral rates to ED (averaging just 10%). Whilst it is important to avoid over-interpreting this relatively small proportion of overall activity, it does seem that the later period of the day provides for continued significant opportunities to mitigate admissions and ED attendances.
- Informal front-line crew feedback suggests clinicians valued access to the GP999 scheme into the later evening and night, at a time where activity does rise slightly and other pathways (including ambulatory care) are often closing or no longer accepting referrals.
- The project team will look at this data against present shift hours agreed for the new contract period to ensure that shift times provide optimum support to the front line activity.
- Agreement has been received from the CCG for a further 12-months of funding for a 7-day Taunton / 2-day Yeovil service to continue.

Dr Matt Booker, Local Clinical Lead, On behalf of the Somerset GP999 Project Team
April 2019