Developing a Minor Illness Clinic

Introduction

I work in a busy, city centre, university practice serving a young and ethnically diverse student population, as well as the local, multi-cultural community. We currently have almost 18,000 patients registered with us. 60% of these are university students: a lot of whom are living away from home for the first time and are sometimes in need of reassurance and guidance on managing minor illnesses. It seems appropriate for the surgery to consider developing a Minor Illness Clinic (MIC) in order to accommodate these patients, in addition to the local population.

The practice currently has 7 General Practitioners (GPs), 3 part-time GPs (Locums), 2 nurse practitioners, a mental health nurse, a health care assistant (HCA) and a phlebotomist. There are also numerous other therapists, midwives and health visitors attached to the surgery. They lost a salaried GP six months ago and a partner resigned last month, so they are two doctors short at present, and have been struggling to recruit any further GPs as replacements.

There is a huge demand for appointments every day. Many are patients requesting same day appointments for acute minor illnesses. Marsh (1995) suggested the increase for such appointments may be due to heightened anxiety of parents about their children, remoteness of older experienced family members, particularly relevant for our students, and less tolerance of minor health problems in general. More relevant today than ever, as everyone expects 24/7 service and is unaccustomed to having to wait long for anything.

My role

According to Woollard (2006), there were 1,000 GP vacancies in the UK as far back as 1997, with recruitment being particularly difficult in urban areas. Health Education England (HEE) established an independent Primary Care Workforce Commission in 2014. They called for rapid implementation of the 10-point plan launched by the RCGP, BMA, NHS England and HEE. The Commission's report, *The future of primary care: creating teams for tomorrow*, called for broadening the skill mix of GP practices. The government promised 10,000 more GPs, but have yet to deliver this. Consequently, primary care services are having to rethink their approach to patient care and as Evans (2016) points out, skill mix in primary care is not a new concept and Paramedics can work as part of a multidisciplinary team to help practices manage their workload.

I have been employed to try and take some of the pressure off the on-call doctors and to try and ease the workload of the other GPs and nurses. As a Paramedic, I am used to working autonomously, seeing patients at their home address, seeing patients of all ages and ethnic backgrounds and having to triage patients appropriately. Having undergone further minor illness training and sitting in with the doctors and nurses at the surgery, I have been tasked to start developing a Minor Illness Clinic at the surgery. This assignment will detail the protocols for establishing such a clinic and take into account all views of the stakeholders involved, the problems encountered and how I am managing to implement the new service.

Why Paramedic-led?

I have asked why the nurse practitioners do not run a minor illness clinic and am surprised the surgery chose to employ a Paramedic rather than an additional nurse practitioner who

can prescribe. However, having raised the question, my employer explained that the nurses at the surgery were not comfortable with telephone triaging, they do not see patients under 16 years of age and are happy with their regular routine clinics and established roles. There used to be three nurses at the practice, but having only two now means they are very busy keeping up with demand for contraception services, immunisations, travel vaccinations and chronic illness clinics. They still see a small number of patients with minor illnesses most days, but prefer their more traditional roles. Consequently, they are pleased for me to take responsibility for establishing a minor illness clinic.

The Minor Illness Clinic at the surgery will therefore be Paramedic-led and will be reliant upon input and assistance from the doctors on-call. The doctor on-call will be required to write or sign any prescriptions needed, may be asked to see patients who are not suffering a minor illness, will still have to deal with the telephone triage list of patients and, occasionally, have to go on home visits.

Getting Started

When I joined the practice, I had a clear vision of what I would like the MIC to be and deal with, but many staff were not so clear about what a Paramedic can or cannot do. There was uncertainty amongst the reception team as to what is suitable for the MIC and what is not. The Practice Nurses were initially wary of my employment and I think they felt vulnerable that their jobs were at risk. The HCA and the phlebotomist had similar concerns. Some of the doctors had unrealistic aspirations and expected me to make referrals, write letters to consultants and be able to prescribe. There has been a need for much re-education and reassurance. Good communication skills, an open-mind, flexibility and perseverance have all been, and will continue to be, essential. As Fisher & Ury (2011) point out, successful negotiation requires being both firm *and* open.

Nevertheless, I have been very well supported by all the doctors and nurses at the practice. Having a Paramedic at the surgery is a new initiative and is a developing role. There appears to be very little literature relating to Paramedic-led minor illness clinics, so I have researched developing a minor illness clinic in general and have used nurse-led clinics as a model and starting point. According to Roberts (2015), Professor Martin Roland, who led the GP workforce commission, even dared to recommend that Paramedics could “substitute for GPs” in some cases. Having a Paramedic in GP practices is a new concept and I am very proud to be championing the way forward and hope to be of use to the practice by making a success of the MIC.

The Stakeholders’ views

Hatchett’s article in the Nursing Times (2008) sets out 10 essential steps to setting up a nurse-led clinic. This was a useful model to follow. I am fortunate in that I didn’t really need to build a detailed business case, his first step, as this is what I was, in part, employed to do. Medicine management and considering the views of pharmacists and dispensers was not particularly relevant either, as I cannot prescribe, so to begin with, I set about completing a SWOT analysis. This is a strategic planning method to identify strengths, weaknesses, opportunities and threats involved when setting up a new venture (see Appendix 1). In my opinion, there were far more positives (strengths and opportunities), but I needed to ask the other stakeholders for their opinions and ideas.

Staff input

I developed a brief survey (see Appendix 2) for staff at the practice to complete, so they could feel involved and have an opportunity to put forward their views. Two thirds of staff responded to the survey. The results were overwhelmingly positive. All staff who returned the survey were in favour of having a MIC at the surgery. A quarter were concerned that I could not prescribe. Two doctors were concerned that a strict booking criteria was needed and that there would inevitably be delays at times, when the on-call doctor was unavailable. One staff member was concerned about cover during annual leave.

Further comments included that it was a great idea! The general consensus was that it would be useful and rather than see it as a hindrance, as I was anticipating, the reception staff were most encouraging and saw it as helping them offer more appointments and choice to patients.

The partners and GPs all seemed to be in favour of having a Paramedic at the surgery, helping deal with the on-call list and being able to do urgent blood tests, ECGs and act as a chaperone, as well as going out on home visits, but some were sceptical about how a MIC would work. However, after having observed most of the doctors work and assisted them with their on-call surgeries, I soon got to know how the different doctors worked and was able to explain to them what I felt comfortable dealing with, any anxieties I had and what I felt I may be able to do in the future, with more training, support and experience. The doctors are all under such pressure, they appreciate any help I can offer and have been very patient answering questions and explaining procedures and techniques. They were keen for me to start seeing patients independently and trust me to ask for their help and opinion, or input, when needed.

The two nurse practitioners, HCA and phlebotomist were all unaware of what I was able to deal with and were unsure why I had been employed at first. There appeared to be a little anxiety and fear that their own jobs and positions were in jeopardy initially, but once I was able to explain the partners' rationale for my for employment, I was able to put their minds at rest. They now see me not as a threat, but as an additional member of the surgery team with my own, unique skills to offer. Having observed their practice and been observed by them, I was able to get to know them and allay any fears. I feel I have now been accepted as part of the team.

The reception and administrative staff have been most welcoming and appreciative of my being at the surgery. I was concerned they would be frustrated at having to ask so many questions of the patient before being able to ascertain if they were suitable to be seen by a Paramedic. On the contrary, they welcome an added member of staff who they can call upon to ask for help dealing with patients and allowing for extra appointments to become available.

Piloting the Minor Illness Clinic

This gave me the confidence to trial a new MIC at the surgery. Due to one of the partners resigning, a room had become available. This room has now provisionally become the MIC room - with computer, printer, desk, chairs and a couch. I acquired all the necessary kit and equipment and was an instant message away from the on-call doctor.

In consultation with the partners and practice managers, the reception staff were given a list of minor ailments and illnesses that I would see and were also given a list of problems that were not appropriate for me to deal with. In cases where they were unsure, I was

happy to discuss this with them and, at times, I asked them to remove patients from my list who had ailments I felt were inappropriate. Patients who called wanting same day appointments for such acute minor illnesses were offered a 20-minute appointment between 09:00-16:00 to see a Paramedic. Such appointments have been offered for the last two weeks.

Evaluation

After two weeks of trialling a MIC, I have audited the number of patients and cases seen (see Appendix 3). Over the two weeks, I saw 126 patients and dealt with 93 independently. 33 patients were referred to the on-call GP: 20 of those patients needed a prescription, the other 13 patients I required assistance with, because they were not suffering from a minor illness, had ongoing problems or needed referring for blood tests and x-rays.

This accounts to only 16% of patients needing a prescription. The majority of patients I could deal with independently as they frequently only required advice on self care, reassurance or needed advice on which over the counter remedy to use. Some patients were not suffering from a minor illness and were just desperate to have an appointment and be seen by somebody. These patients have been re-educated, but only time will tell if they have understood the concept of the MIC.

The second week, patients were asked to complete a short survey after they had been seen (see Appendix 2). Out of 63 patients seen only 28 patients completed the survey. The results were, nonetheless, hugely satisfying as they were all positive. 26 out of 28 had been informed they would be seen by a Paramedic. 27 would be happy to be seen by a Paramedic again, the remaining patient wasn't sure. 25 were VERY HAPPY with the service they had received and 3 were HAPPY.

Conclusion

The surgery has so far been unable to recruit any new doctors, as partners or salaried GPs. Patient demand for GP appointments far outstrips the capacity of the practice and the nurses are working to their full capacity. As a result, I was employed to help manage the workload. The setting up of a Minor Illness Clinic at the surgery has been very exciting and has proved to be a huge success so far. I have been able to deal with almost three quarters of the patients independently and as I become more experienced and patients are more aware of what I can deal with, this may increase further. The fact that I cannot prescribe has not been as much of a problem as first envisaged.

We will continue to develop the clinic and with good communication between myself, staff and patients, any problems will hopefully be resolved. The reception staff are getting more accustomed of what is appropriate for me to see and what is not. The on-call doctors are developing their own strategies for dealing with helping me and coping with the telephone triage list and other patients. The patients are being introduced to this new clinic and are being advised what can be dealt with in the clinic and how it works. We will be developing a patient information leaflet and publicising the MIC from next month to help with this. The nurses have seen that it is not a threat to their positions or roles and the doctors are happy to be seeing less minor illnesses and more serious cases. Overall, more appointments are being offered and more patients are being seen. It is a win win situation!

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