

**LMC Position Paper on the Improved Access Scheme**

**Background**

The Conservative Manifesto for the 2015 election included a number of pledges to increase access to general practice. A Conservative government would “ensure that you can see a GP seven days a week by 2020” and that “everyone over 75 will get a same day appointment if they need one.” Later on it indicates that by 2020 they wanted people to be able to see a GP “7 days a week from 8am to 8pm” and that they would “restore your right to access a specific named GP”, though no time limit for this is mentioned.

With such an unambiguous commitment it is probably inevitable that the Department of Health should now be instructing NHS England to deliver. However, senior leadership at NHSE is well aware of the very fragile state of general practice across much of England and understands that the manifesto pledge simply cannot be honoured as it stands - indeed, to try and do so in the current climate would very likely cause primary care to implode.

NHSE has therefore come forward with an outline scheme, “Improved Access” (IA) that they believe is workable, and very wisely they have left most of the detail up to local negotiation. NHSE selected a number of CCGs to pilot this from 1st April 2017, giving them just four months to set up viable schemes. The most important thing to note is that this is a CCG obligation, and not one that is laid directly on practices. GPs and practices can, therefore, simply decline to take part if they so wish.

Although almost everyone would agree that it would be much better to spend the extra money on bolstering the OOH service and better integrating existing unscheduled care services, the NHS has to make the best of a bad job and collectively we need to see if the scheme can be adapted to meet some of the wicked problems with which we are already struggling: notably how to maintain continuity of care for patients with complex long term conditions, and how to make the GP working day tolerable again. Presumably DH strategists see this as one step on the road to a full 7-day 8-8 service, but the LMC view is that IA will look very different in a rural county than in the urban environment for which it was planned, and that makes it possible for the scheme in Somerset to be genuinely useful. There is a risk that this is the thin end of a wedge, but with the whole configuration on NHS services now so uncertain that risk cannot readily be quantified.

**The Proposal**

The specification for IA is very simple – just one page it the NHS Operational and Planning Guidance for 2017- 19 (Appendix 1). In essence it requires the CCG to commission access to “GP services” in the evening and at weekends and it requires a mixture of pre-bookable and on the day appointments. Every weekday evening from 18.30 to 20.00 must be covered, and the weekend requirement is for “services on Saturday and Sunday…to meet local need”. The CCG preference is that the service should be provided by Somerset practices – indeed, to do anything else would make a nonsense of the principle that the scheme is about extending routine access. It is important to note that it is not an extension of full GMS, or even “GMS-lite”, but rather about increasing the hours during which patients can access *limited* GP services. It is also not a replacement for, or a supplement to, the Out of Hours service, though forming sensible links with OOH would obviously be helpful for everyone. The expectation is that practices will form clusters or localities of 30,000+ patients to deliver IA.

To meet the expectation that at least some progress will have been made by 1st April the CCG has taken the basic structure of the national requirement and suggested that this should be merged with the existing Extended Hours DES (EH). Most federations and localities only need to make relatively modest changes in their number of hours they collectively provide under EH arrangements to meet the terms of the IA scheme.

During the pilot phase practices can continue to provide Extended Hours on the current £1.90 per patient basis (IA is commissioned by the CCG and EH by NHSE) but we anticipate that ultimately the two schemes will merge. Meantime, it would be sensible to use the added flexibility that having both offers to develop a model that will meet the national requirements and provide secondary benefits for Somerset practices and the wider health economy.

**Consultations**

As we are unable to staff GP services for five days, let alone seven and out of hours, the outline specification talks about access to GP *services* and not GP *appointments.* That means that the clinicians concerned may be nurses, pharmacists, ECPs, Nurse Practitioners, Health Care Assistants -or any other person who sees patients in general practice - and not just doctors. Furthermore, consultations do not need to be face to face. They could equally be by phone, Skype, or online. The initial requirement is for 30 minutes of consultation time per 1000 patients per week, rising to 45 minutes in due course. Access can be made more flexible by using online systems such as WebGP which can lead a patient through a series of questions leading to different dispositions, can also collect those that need a GP consultation into phone “clinics” at times convenient to both the patient and the service. There is no stipulation that appointments “on the day” can be made during IA time. Providers simply need to have some available during the working day and once these have been taken, you will not have to offer more. At the weekends the requirement could presumably be met by offering some online or telephone slots rather than opening telephone lines, though equally you could have a phone line open until all the appointments are taken and then put on an answering message.

**Location**

There is no requirement for the service to be organised at a practice level, and this would not be a widely attractive option in the current climate. The LMC and the CCG agree that organising at Federation level or higher is the most realistic option, and that ultimately it may well be best to operate it out of a limited number of Hubs. Experience elsewhere suggests that patients who want urgent out of hours appointments are prepared to travel, but those seeking routine appointments prefer to be seen in their own practice, so if a Federation rotates opening times around the practices the majority of patients seen in each location will be registered at that practice. Interestingly the scheme does not restrict appointments to GMS work, so it should be possible to offer services such as HGV medicals which patients really do want to have out of working hours. There is also no prohibition against parallel working, so a small team of clinicians could work the same hours, supported by a minimal number of administrative staff, perhaps just a single receptionist. Given the short timescale hubs will need to be established in existing NHS premises, which could be community hospitals or other clinic space if practices will do not wish to host the new service. On the other hand, income to practices from hosting the service should offset some of the costs of daytime running, and providing Improved Access clinics in close association with day time provision increases the likelihood that the service can provide genuine extra capacity rather than just re-arranging current work.

**Scope of Service**

Demand for GP services falls into three broad categories. A small proportion is urgent care for serious or life threatening conditions. It is increasingly clear that this requires dedicated capacity and the old “duty doctor does it all” model for daytime care must not be carried forward into Improved Access time. This work should remain with the OOH provider for the foreseeable future.

A growing percentage of primary care work is the management of long term conditions, which increasingly requires specialist nurses, access to equipment, and the availability of routine laboratory services. A substantial majority of this work should continue to be provided in-hours as relatively few of the patents concerned will be in full time work with no flexibility and therefore not able to attend an in-hours appointment

The remainder is the traditional mix of GP consultations: acute minor illness, semi-acute presentations, general health concerns and so on. This is the part of the workload that is most transferable - in some places much of it is already seen in Walk-in centres – and which patients might reasonably expect the new service to provide. There will be considerable overlap between Improved Access and patients calling 111, attending an MIU or consulting a pharmacist and clearly planning must anticipate growing links between all of these services.

The “proportion” of appointments must be pre-bookable is not specified and given that growing number of practices triage appointment requests, a mixed model with some appointments pre-booked by practices and some available for booking on the day seems appropriate. Access to the appointments will need to be controlled to ensure that the pre-booked slots are fairly taken up in proportion to list size, and also to prevent “on the day” appointments being seen as a handy place into which 111, OOH, SWAST or Trust EDs might dump urgent work.

The LMC believes that the new service should ultimately have a role in the continuing care of patients with complex conditions and admission avoidance, though it may not be necessary or appropriate for a clinician working in Improved Access to consult such a patient him or herself. Quite how this will work remains to be decided, but having an experienced GP to the full patient record to contribute to decision making is probably the key element. As with Extended Hours, there is no requirement for Improved Access providers to undertake home visits.

**Hours**

All this taken together suggests that for the county about 280 hours of clinician time will be required. Demand for *routine* care at weekends appears to be rather different to that for urgent care, with Saturday mornings, Sunday late afternoon/early evening and midweek evenings being more popular. Depending on what shift patterns are most attractive to staff – long enough to be worth turning out for, but short enough not to ruin the weekend- that probably one practice/hub opening in each locality each weekday evening and weekend day.

**Finance**

The CCG has been given £1.50 per patient (about £840,000) for the next few months for set up costs and thereafter recurrent funding of £6 pp per year (about £3,360,000) to run the service. If the service is operating 280 hours a week for 52 weeks that equates to initial finding each hour at roughly £230, reducing to £154 when the opening hours are extended. This needs to cover admin and operating costs (maybe 10%), premises, communications, software and consumables, training and clinical governance and, last but far from least, additional indemnity. The amount left for clinical staffing is therefore likely to be adequate, but not extravagant. Practices will be paid individually through PCIS for participation but obviously a costs reconciliation and balancing cross payment arrangement amongst the practices in each scheme will be required. We strongly urge practices to do their own individual and collective cost and benefit calculations before making a final decision on participation.

**PCIS**

The early adoption of Improved Access will have a significant effect on the attractiveness of PCIS. For practices facing large losses due to PMS or MPIG clawbacks the final decision will probably be unchanged, but for others the balance of work against income will not look so favourable, especially if they are undertaking a high volume of unfunded work that is rolled up into PCIS. Because full payment for IA will not be made until schemes are up and running, practices are likely to lose some potential income because of the unrealistic timetable of the scheme, though at the time of writing the CCG has a agreed to pay the full amount if schemes are running by the end of April 2017. Because PCIS is partly funded by recycled PMS premium money the LMC will be seeking an assurance from the CCG that any PCIS money not paid out is re-used in primary care.

**Potential Benefits**

The health gain and cost benefit of providing extended routine access to primary care are arguable, but these are perhaps not questions that we can usefully consider here. Given that it is a national imperative, are there secondary benefits that could be realised?

* The availability of additional appointment slots does give practices some capacity to shift some demand away from the normal working week, and if the system is able to accommodate some “semi-urgent” demand that may allow practices better to manage demand peaks, especially on Friday afternoon and Monday mornings. This may be particularly valuable as the workforce position tightens, and practices face the possibility of sudden clinical staffing crises.
* The additional capacity could contribute towards the provision of a properly integrated evening and weekend service involving OOH, Trust EDs, MIUs, Community Pharmacy and others. There is no requirement that only GMS services are provided, so we assume that patients wanting HGV medicals and the like can be booked into these slots.
* Patients with complex long-term conditions should have better continuity of care meaning unscheduled interventions will be needed less often.
* The scheme also gives localities a chance to start to develop wider sharing arrangements, and certainly the introduction of EMIS record sharing and more general sharing of information under OneDomain will support new models of working at larger scale during the day, as well as out of hours.
* Participation should generate a modest profit to offset income loss from PMS premium and GMS MPIG clawbacks.
* The scheme should help the development of a skill-mix and access model (including, for example, web consultations) that can also be used in-hours. It may also identify new staff able to contribute to the day time workforce as well Improved Access as well as creating a helpful context for shared same day services.

**Constraints and Questions**

***Indemity***

As the arrangements for indemnity cover have become ever more complex and expensive, the need for reform of the system is becoming pressing. Attempts to procure system rather than individual cover are proceeding, but will not offer a solution in time.

Currently Somerset practices are split roughly 50-50 between those that have a practice policy, and those that allow GPs to choose their own indemnifier. The latter arrangement causes all sorts of problems, and the LMC encourages practices to have a group policy. Conversations with the MDOs suggest that if a locality was prepared to move *en bloc* to one provider, extending cover to include IA would not be significantly more expensive than existing policies. The MPS, for example, has said that they now regard 18.30 to 20.00 as normal working hours and that if clinicians have access to the full GP record that does not count as an “Out of Hours” consultation. This may mean that participating GPs just need to make sure that they are covered for the total number of sessions that they work rather than needing to pay an Out of Hours supplement. It is also easier to get non-medical clinicians covered in a collaborative scheme.

***Workforce***

Adapting the existing EH DES means that few additional GP hours will be needed, and in many places the amount of face to face GP time required may actually reduce. This, of course, depends on the capacity of locality providers to redeploy current staff into Improved Access time and to recruit additional clinicians. Given that existing out of hours services are not able to recruit and retain enough GPs IA needs to be made predominantly non-medical, but even so IA schemes may further aggravate the problems of other services. However, as the DH has chosen not to instruct NHSE to commission this as an integrated service here is not much we can do about that.

***Equity of Access***

For all sorts of reasons patients of some practices may use IA appointments more than those of others. If practices take it in turn to open this will tend to even out, but it would be wise to establish a recharge arrangement under which practices using the appointments disproportionately (say 10 or 20% above benchmark for its weighted population) pay a greater proportion of the running costs for that quarter.

***IT***

Networking EMIS practices in localities using remote access is apparently relatively straightforward and inexpensive. The CCG has offed to help fund this. It is also possible to set up a shared appointment book within EMIS, but not in Front Desk. Seamless incoming telephone access may require some ingenuity, but simple answering machine messages or call transfers offer a technically simple interim solution.

***Employment***

For various reasons staff are – at least initially - likely to be best employed by aparticipating practice and not the federation or practice cluster. Agreements will need to be reached on how staff time is deployed, shared & costed. The LMC Practice Support Unit may be able to provide some documentary help with this.

***Premises***

If all practices are opening their premises *pro rata* according to size each could be responsible for their own costs. If a small number of hubs are chosen the basis for costing opening should be agreed in advance.

***Management***

Will the participating practices form a collaborative arrangement for managing the service, second an existing manager to do this, or buy in additional management time? Is there a need for a formal oversight group made up of authorised practice representatives? Will the group allow some practices to join without participating in service provision, simply handing over the £6 per patient to the collaborative provider?

***Clinical Care***

Federations will need to reach an internal understanding about what presentations can be managed by another practice, and which need to be referred back to the normal GP. Although shared records access is the key, Clinician to clinician messaging will be important. Ordering of investigations and consequent responsibility or follow up will need to be clarified as will referral pathways, especially for 2 week cancer wait patients. Lines of responsibility and management for non-medical clinicians need to be carefully defined.

***Prescribing***

Providers will probably want to discourage the supply of non-urgent prescriptions (there is nothing to say that these have to be supplied during IA time) and will also want to have at least a general agreement about formulary choices, use of antibiotics, and a few other matters. In rural areas dispensing may prove a complication, but the number of patients using IA will be small, and the number of medications that need to be prescribed will be modest, so the loss of dispensary scripts should be modest.

***Monitoring***

NHSE have yet to produce guidance on monitoring and reporting but providers will probably want to keep their own records for financial monitoring purposes and to look at the clinical demand pattern for future planning.

**Conclusion**

* The CCG has been given a challenging task to introduce Improved Access from 1st April 2017. For many practices, participation is effectively mandated by the need to offset the loss of core income and it should be possible to generate at least some profit from taking part.
* There are personal benefits for GPs in taking part if IA can be provided predominantly by non-medical clinicians rather than directly by the doctors as this will free some GP time: for example, a supervising GP could be doing admin tasks whilst being available to the other clinicians if needed.
* We do not think that any of the constraints are so serious as to prevent federations and localities developing viable schemes, but the LMC expects there is to be an evolutionary process that becomes more productive overtime. For example, providers may start off with GP heavy provision transferred straight from current EH contract, but move steadily to a less medical model.
* Although the CCG has in mind a clear progression from shared provision to urgent care hubs and thence to participation in an Accountable Provider, the LMC view is that we should proceed one step at a time with no presumptions about the eventual shape of the service. However, it is likely that progressively closer working will lead to further benefits over time.
* Practices should undertake a full costs analysis on the whole of the scheme and the benefits or otherwise of PCIS before making a final decision.

**Appendix 1**

**Extract from NHS Operational Planning and Contracting Guidance 2017-19**

**1.3.1 Improved access**

As outlined in the investment section, NHS England will provide additional funding, on top of existing primary medical care allocations to enable CCGs to commission and fund extra capacity to ensure that everyone has access to GP services, including sufficient routine and same day appointments at evenings and weekends to meet locally determined demand, alongside effective access to other primary care and general practice services such as urgent care services.

CCGs will be required to secure services following appropriate procurement processes.

Recurrent funding to commission additional capacity and improve patient access will increase over time. In 2017/18 CCGs with General Practice Access Fund Schemes, and a number of additional geographies identified across the country which will accelerate delivery of improving GP access, will receive recurrent funding of £6 per head of population (weighted) to commission improved access. In 18/19, this will expand to enable remaining CCGs to improve access, with £3.34 available in 2018/19 for those remaining CCGs. In 2019/20 all CCGs will receive at least £6 per head extra recurrently for those improvements in general practice.

In order to be eligible for additional recurrent funding, CCGs will need to commission and demonstrate the following:

*Timing of appointments:*

• Commission weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) – to provide an additional 1.5 hours a day;

• Commission weekend provision of access to pre-bookable and same day appointments on both

Saturdays and Sundays to meet local population needs;

• provide robust evidence, based on utilisation rates, for the proposed disposition of services throughout the week; and

• Appointments can be provided on a hub basis with practices working at scale.

*Capacity:*

• Commission a minimum additional 30 minutes consultation capacity per 1000 population, rising to

45 minutes per 1000 population.

*Measurement:*

• Ensure usage of a nationally commissioned new tool to be introduced during 2017/18 to automatically measure appointment activity by all participating practices, both in-hours and in extended hours. This will enable improvements in matching capacity to times of high demand.

*Advertising and ease of access:*

• Ensure services are advertised to patients, including notification on practice websites, notices in local urgent care services and publicity into the community, so that it is clear to patients how they can access these appointments and associated service;

• Ensure ease of access for patients including:

All practice receptionists able to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services patients should be offered a choice of evening or weekend appointments on an equal footing to core hours appointments.

*Digital:*

• Use of digital approaches to support new models of care in general practice.

*Inequalities:*

• Issues of inequalities in patients’ experience of accessing general practice identified by local evidence and actions to resolve in place.

*Effective access to wider whole system services:*

• Effective connection to other system services enabling patients to receive the right care from the right professional, including access from and to other primary care and general practice services such as urgent care services.