**LMC Discussion 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.

**The Proposal**

NHSE has therefore come forward with an outline proposal, “Improved Access” ( the LMC prefers this term to “Extended Access” to avoid confusion with “Extended Hours”) that they believe is workable, and very wisely they have left most of the detail up to local negotiation. NHSE have selected a number of CCGs to pilot this from 1st April 2017, giving these CCGs just four months to set up viable schemes. The most important thing to note is that this 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.

The CCG has wisely taken the basic structure of the national requirement and sought to adapt it 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. In theory it appears the requirement remains to provide 7 day eight to eight services, in practice that seems to be adaptable according to locally determined need.

During the pilot phase practices can continue to provide Extended Hours on the current £1.90 per patient basis 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

**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 it may well be best to operate it out of just four or five Hubs. Experience in Wessex suggests that patients who want out of hours appointments are prepared to travel, and almost by definition this group will be independently mobile. 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 from hosting the service should offset some of the costs of premises, and running Improved Access clinics close to day time provision increases the likelihood that the service can provide genuine extra capacity rather than just re-arrange 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 very limited specification we have seen simply says that a “proportion” of appointments must be pre-bookable and given that growing proportion of practices triage all 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. Spread over for Hubs that means about 70 hours a week each, and if there were three or four clinicians working in parallel in each hub that makes about 20 hours of opening for each. 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 means four or so openings for each Hub each week. It may be more practical to run the shorter weekday sessions more locally, in essence by expanding existing Extended Hours provision. It is already possible for practices to offer Extended Access collaboratively, though the extra indemnity costs may make this unattractive, but the benefits of sharing work in cost control, improved resilience and work management are considerable if this can be resolved.

**Communications**

The first requirement for this proposal to be acceptable is that seamless, secure and simple communication can be established. With all but two Somerset practices now using EMIS Web, nearly all practice based clinicians will be familiar with the same clinical system, and networking EMIS users in a locality should be a relatively simple task. Clearly there will need to be a single appointment booking system, and perhaps some notification to practices that a patient has consulted remotely. Practices will expect this to be paperless.

**Finance**

The CCG has been given £1.50 per patient (about £840,000) for the next few month 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.

It is not yet clear how Improved Access will fit with the Primary Care Improvement Scheme, and to what extent the resources that come with it will contribute to the funding of PCIS. This is obviously a matter that the LMC will wish to explore in detail with the CCG, but the funding arrangements will need to be reasonable for practices to stay within PCIS.

**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 over the winter, 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.
* 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 record sharing via OneDomain will support new models of working at larger scale during the day, as well as out of hours. In particular, this should give us an opportunity to explore the indemnity or insurance cover options.
* If practice clusters are prepared to take on subcontracts for the provision of a service it may be possible to generate a modest profit.
* 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.

**Conclusion**

The CCG has been given a challenging task to introduce Improved Access from 1st March 2017 and there is a risk that the timescale is just too short for practices to be able to contribute. There are benefits for practices in participation, but realising these will be critically dependent on the availability of enough clinicians prepared to work additional hours or the recruitment of new staff. It is unlikely many localities will have the clinical leadership or management capacity spare to develop a new service from the ground up during the busiest time of the year without considerable support. Funding, and how this relates to the Primary Care Improvement Scheme, will be a major factor in practices’ decisions on participation. Prioritisation of this work in the long list of tasks that they need to undertake will be a matter for individual practices.

The LMC anticipates that in most of the county schemes will initially need to be driven by the CCG, perhaps procured through SPH, and building on the good ideas and enthusiasm of local clinicians. It will need to be flexed according to specific local needs and service capacity. Ultimately the LMC hopes that they will be owned and controlled by GP provider localities.