Enhanced Access

How organisations ensure a smooth transition

livi

See a GP by video

Introduction

The delayed transfer of enhanced access services to primary care networks (PCNs) until October 2022 provided welcome breathing room for providers grappling with unprecedented demand.

Now, as we approach the autumn, GP practices, PCNs and commissioners are collaborating to develop Enhanced Access Plans detailing how services will be delivered.

In the run up to service commencement and as plans continue apace, it's a good time to take a look at some of the ways organisations can ensure a smooth transition both pre- and post-transfer of services.

This Livi report covers:

- How CCGs and PCNs can adapt between now and October
- Potential models for enhanced access
- Next steps and Enhanced Access Plans

How CCGs and PCNs can adapt

Upon announcement of the second transfer delay, NHS England tasked commissioners with making necessary arrangements to extend existing services between now and the autumn.

This was to provide more time for PCNs to 'explore how to best unlock synergies with in-hours services at a practice level, as well as consider options for collaborative working at a larger scale outside of individual PCN footprints,' NHSE explained.

For PCNs that can 'demonstrate readiness', the transition of services can be initiated earlier than the deadline. Despite these transitions being out of sync with the October roll-out, the early transition to these 'ready' PCNs will provide valuable insight to the rest of the industry in how to make the conversion as seamless as possible.

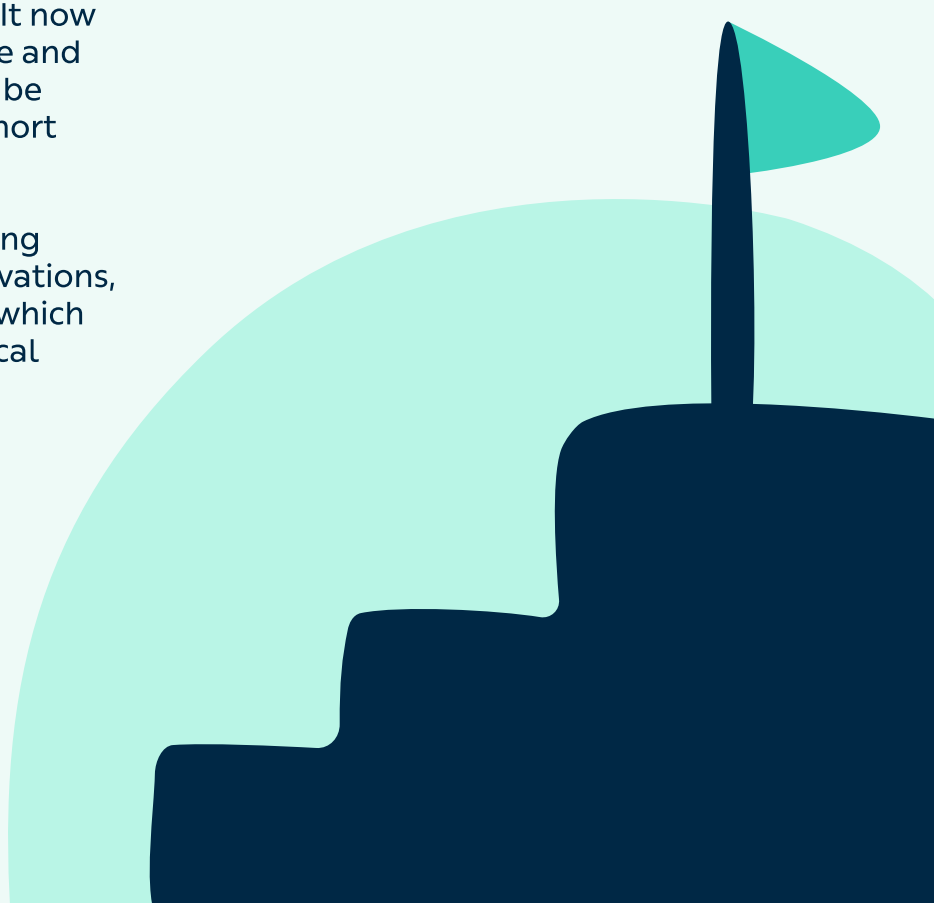
The key challenges that lie ahead for commissioners and PCNs

In the interim period, CCGs must now continue management of current arrangements for a further six months.

For traditional services that have struggled with less capacity during the pandemic and vaccination drive, the delay presents a new challenge. It now raises operational, administrative and planning implications that must be adapted to within the NHS in a short period of time.

These implications include pushing back potentially supportive innovations, service additions and upgrades, which are very much required at this local level.

It is therefore crucial that commissioners consider the impact of rolling on existing contracts on a monthly basis, in place of initiating new (albeit short-term) contracting models. This can ensure delivery of innovations that increase efficiency and lower administrative burden on practices.



Immediate action and long-term solutions

In the short term, commissioners can approach suppliers for contracts to cover the gap created by the delay in transition.

This can include – but is not mutually exclusive to – lighter versions of new models that can be implemented with minimum impact, while delivering some of the benefits of longer-term, more substantial alternatives. Short-term or non-procured contracts can allow quick and immediate support, as well as the chance to use local budgets creatively to meet immediate demand.

Using digital healthcare is an effective solution for providers to extend healthcare access to their populations. Digital solutions can strengthen in-hours access plus offer access out-of-hours, while also providing a more efficient way to deliver care compared to alternatives such as locum GPs for out-of-hours appointments, which can cost up to 40% more.

Additional capacity is added with no additional physical space required, and the administrative element can be carried out by the digital healthcare provider. Over-the-phone appointment booking queues are also removed, easing daily strains on GP practices.

These services can be onboarded quickly in the meantime, to ensure CCGs smoothly manage the next 6 months while also helping them manage the transition to their PCNs in October.

Potential models for enhanced access

As we begin to look ahead to that transition, the question will be, what models work well?

Recent examples shared from within the NHS Confederation network point to potential directions as PCNs look to plot their journey ahead.

Some GP federations are already running forms of extended or enhanced access, employing a variety of approaches to deliver services. Service models already feature close, consistent working alongside PCNs to offer appointments in evenings and weekends.

Here we take a look at two approaches.

Model 1

The Covid-19 vaccination effort provided an opportunity for this GP federation to begin to utilise principles of extended access under the direction of their PCN.

The federation has been running a range of services on top of extended access, including care homes and frailty, already demonstrating maturity, prior to formal transition in the autumn. A not-for-profit ethos is prevalent, with any surplus reinvested in primary care across the region.

Avoiding duplication

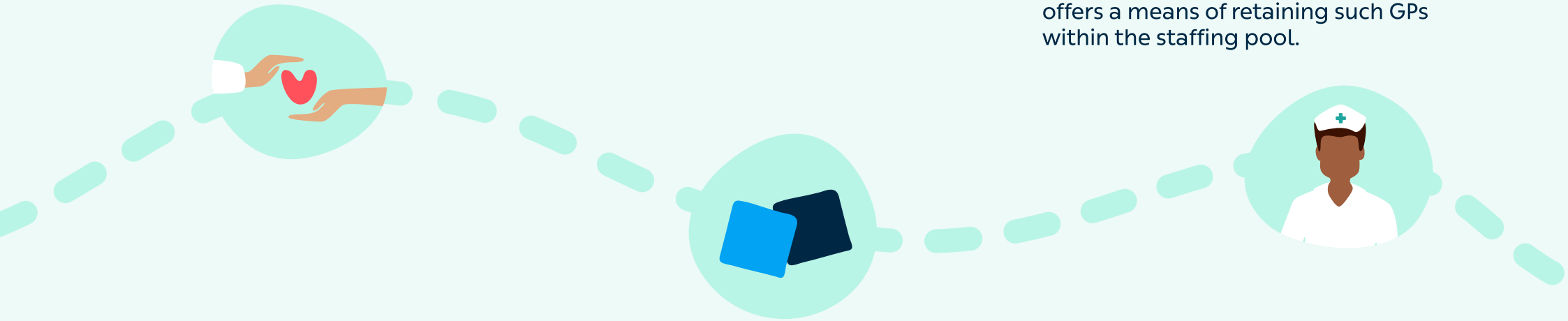
The organisation has worked to avoid duplication of infrastructure by collaborating closely with their PCN. In terms of what that infrastructure looks like, the federation provides back-office functions, including operational, finance, recruitment and additional roles reimbursement scheme (ARRS) support.

Cost sharing agreements have been established and clinical directors from the PCN make up part of the federation board, helping to shape the future of primary care in the locality.

Utilising an experienced workforce

The service is delivered by a large number of long-term, local GPs from practices in the locality, including both salaried GPs and GP partners. GPs deliver evening and weekend cover once a week at a time convenient for them and may choose to offer sessions on days when they are already in practice.

Additionally, the service utilises GPs who have ongoing family commitments. For these GPs, it provides regular sessional work and a means to continue to receive appraisal and validation. While at a system level, the service offers a means of retaining such GPs within the staffing pool.



Putting the right management and IT in place

To manage the day-to-day running of the service, the federation employs a large number of back-office staff. This team manages all HR staff requirements as well as ensuring all regulatory requirements are met. From clinical and prescribing audits through to audits of estates, policy checks and processes.

In terms of IT, data sharing agreements have been established to protect against any instance of a potential data breach, and the federation has implemented strong processes to safeguard against such breaches occurring.

The federation is also responsible for managing all matters relating to the service including complaints, staff sickness, clinical letters and referrals. While the latter is followed up by the patient's own practice.

Currently, decision making around sites and opening hours is made by the GP federation and CCG.

In the future, due to the solid relationship already in place with the PCN, the service will be able to make changes quickly and flexibly depending on needs of the population, and adjust appointments offered based on both utilisation and feedback.

Model 2

This GP federation was tasked by their CCG to deliver an extended access service some years ago and has been working across a city-wide footprint as a delivery partner for multiple PCNs.

The adopted service model allows patients to be seen almost anywhere within the region, facilitated by information sharing across PCN sites. This groundwork, put in place prior to Covid-19 laid the foundations for the area's vaccination response.

Today, the service delivers extended access and extended hours contracts. Patients are seen by a range of healthcare professionals through the service, reflecting the multi-disciplinary makeup of traditional general practice.

Similar to the previous model, any profit is reinvested in primary care in the region. While the federation board also includes clinical directors from PCNs alongside practice partners.

Utilising local hubs

The service is delivered at a number of dedicated hub locations.

These hubs are used for PCN services during the day and extended access at night. This removes the need for a host practice and offers a great deal of control. Patients can be seen anywhere after the working day and a dedicated operational team is onsite weekdays and weekends.

Working at scale

By putting the right infrastructure in place, the regions' PCNs have been able to work at scale across the entire locality. The federation has collaborated closely with local clinical directors and PCN practices, adopting a flexible approach to provide support where it's needed, depending on local need.

This infrastructure has been helped by all member practices in the patch employing the same clinical system. This means appointments can be booked via a patient's own GP practice during the week, or through 111 at weekends. Pre-bookable appointments are available up to one week in advance with the remaining released on the day.

A multi-disciplinary clinical team

The service utilises a sessional workforce including GPs, practice nurses, advance nurse practitioners and healthcare assistants.

Shifts are scheduled using rota software, and pay rates are aligned to other urgent care providers to ensure a stable and resilient workforce across the system. A robust audit and clinical governance cycle is also in place to support a learning culture.

Over time, the service has developed a bank of regular sessional GPs and good relationships with surrounding urgent care providers.

Looking to the future, there are plans to integrate new services such as mental health within the extended access service, supported by ARRS. While data and insights will continue to inform service delivery.

Consistent themes

Looking at both approaches points to some consistent themes. Both models employ highly experienced clinical and non-clinical staff, and have robust infrastructure and governance frameworks in place to facilitate at-scale working.

Furthermore, close collaboration between PCNs and GP federations now is laying the groundwork for how enhanced access services will be delivered in the future. This is seeing all areas of primary care beginning to work as one, to exist and serve each other.

This 'working as one' can lead to less duplication in both infrastructure and process as we have seen. Workforce management and scheduling can be done once, as opposed to separately each time across individual PCNs.

Investment in tools and technology can be streamlined and use of estates optimised. What this points to is an opportunity to do things differently over a large footprint, for systems to operate in a more agile and flexible way.

That flexibility at a workforce level offers GPs some choice as to when they will work and supplement their existing portfolios. While patients are able to see a GP where and when it suits them after work.

Meanwhile, both approaches are using data and digital tools to facilitate workforce planning over a large footprint based on surge, and offer a blend of digital and face-to-face appointments to meet demand.

To ensure success, it's clear that close collaboration between GP practices, federations and PCNs is key. Mapping out how all parties will work together across large footprints and populations will rely on strong relationships. Clearly much has been accomplished already on that journey during the COVID-19 pandemic.

Indeed, PCNs should look to the successes of their vaccination programmes and build on them, working closely with their CCG to decide what their service will look like.

Next steps and Enhanced Access Plans

The finer details of that service will be mapped out in Enhanced Access Plans. As specified in updates to both the GP contract for 2022/23 and Network Contract DES, PCNs are required to work collaboratively with commissioners to produce these plans.

Published in March, both documents provide further information as to the scope of enhanced access for PCNs.

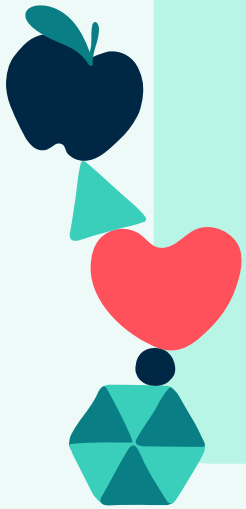
That scope specifies that a PCN must provide services between the hours of 6.30pm and 8pm Mondays to Fridays, and between 9am and 5pm on Saturdays. A visual timeline is included here including key dates for plan development.

On or before 31 July 2022
Draft Enhanced Access Plan submitted to commissioner for agreement

1 August 2022 to 31 August 2022
Ongoing collaboration between PCNs and commissioners to determine how enhanced access will be delivered from October

31 August
CGG review of plan and agreement on final iteration with the PCN's Core Network Practices

1 October
Service commencement. PCNs required to provide Enhanced Access between the hours of 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays



Plan creation

To create well rounded plans, PCNs should detail how they have/will factor in patient preferences, capacity and demand. In considering what mix of services will be offered, appointment types and channels should be included alongside staffing and skills mix.

Commissioners reviewing plans will need to ensure they form part of an ICS approach. Thus, PCNs should consider how their service factors in at a wider system level where possible.

Arrangements under the new network contract DES also allow for a mixture of both face-to-face and remote consultations. At a system level, digital appointments can support where it's not possible for a GP to be physically present, or where service demand necessitates a need for additional capacity.

Designing the service

Factors within a specific health system will be all-important to designing the service detailed in your plan. PCNs will need to deliver access that meets specific needs of many different patient demographics in a given area.

Where working parents struggle to attend face-to-face appointments, digital solutions can assist. For patients who experience mobility difficulties or cannot travel, remote consultations can enable them to get the care they need from the comfort of their home.

Patients who have communication, language or learning difficulties, may also find digital and telephone consulting beneficial.

This can give the patient the time to formulate how to relay their symptoms to a clinician in advance, or where necessary, seek help to do so.

While for patients who feel anxiety around face-to-face communication or have mental health concerns, it provides a platform to speak about issues that they may not be comfortable talking about in person.

Long-term condition management will also need to be carefully factored in. For these patients who have complex, changing needs and may require multiple appointments, the ability of digital consultations to offer urgent medical advice can be a comfort. And digital is already enabling remote management of conditions such as COPD as seen in the increase in virtual wards over the past few years. The possibility for video conferencing to enable consultation with a multi-disciplinary care team is now possible.

In areas of deprivation, digital solutions may also extend the reach of enhanced access services. Indeed, taking just one of our services as an example, 75% of Livi users come from the 50% least privileged areas.*

*In terms of median disposable income, based on Office for National Statistics gross disposable household income.

Enabling primary care at scale

Digital technology will be a foundational pillar in enabling primary care to work at scale within the scope of enhanced access.

For teams spread out over a large footprint, digital will provide a channel for close collaboration between teams. At an operational level, digital providers can assist with and help carry the weight of administrative functions in and around consultations.

Enhanced access, by its very definition necessitates provision for same-day and urgent medical help which can be challenging to predict and plan for.

But with additional digital clinical capacity that can be deployed at speed and at scale, this becomes far less daunting. Support can flex, enabling services to plan and meet surge demand. And in underserved areas, remote resource can be targeted to provide additional capacity where needed.

For existing clinical workforces that are already stretched, that support will help to ease pressure, in a given footprint. This can delivered at a reduced cost compared to locum alternatives and create cost efficiencies within the system. Digital services can also provide vital data to inform and evolve out-of-hours service delivery as the needs of patient populations change.

How Livi can support

Livi has a proven track record of extending access in a manner that delivers faster access to high-quality care, while also reducing healthcare inequalities. We're working with NHS partners to deliver primary care at scale, seven days a week.

Patient needs are often addressed on the first call, without generating inappropriate demand or pressure elsewhere in the system.

Dr Sanjay Pawar, GP Lead of Greenview Surgery had this to say about partnering with Livi:

"One of the primary aims of the GP Extended Access Scheme was to improve the accessibility of healthcare for patients. This has been particularly important during the COVID-19 pandemic.

Working with Livi has been invaluable for bettering access, as it has allowed patients to seek healthcare in an easy, straightforward and effective way.

The quality of the service and the healthcare provided has been exemplary, further serving to support the pressures on the workloads of GP practices. Livi have always been responsive, proactive and are driven to provide an effective service.

They have been revolutionary and innovative in helping general practices and have created a foundational pathway for healthcare provision for both the public and clinicians."

Livi supports a variety of services including urgent care, extended access and routine general practice. We also support resilience work, winter pressures and help reduce the administrative burden on the practices that we partner with.

For a free consultation, email partnerships-uk@livi.co.uk.