Londonwide LMCs
The professional voice of London general practice

SENT BY EMAIL ONLY

Javina Sehgal
Director of Primary Care,
NHS North West London

Genevieve Small
Medical Director
NHS North West London

Vijay Tailor
Ealing Borough Medical Director
NHS North West London

9 February 2024

Dear Vijay, Genevieve, and Javina,

NWL LMCs' concerns re the NWL ICB proposed Same Day Access Service

As you are aware, the ICB introduced the principle of a Same Day Access model being incorporated into the NWL Single Offer as late as in January 2024, to go live from April 2024. We have been clear that we believe this to have been an unrealistic and inappropriate timescale to assimilate proposals which will have far-reaching impact on individual GP practices, their day to day running and their contractual delivery of care to their patients. We have also been clear from the outset that this proposal should sit outside the single offer, and not to be conflated with other enhanced services relating to clinical care. We have been engaging with LMC members and CDs regarding their views of the proposals, and we are writing to share concerns and questions raised.

We recognise the ICB's commitment to investing recurrent funds to support this model. We, of course, welcome additional investment in general practices to support their workload and access to patients. However, as we have repeatedly stated in meetings with the ICB, Londonwide LMCs, representing LMCs and GPs within North West London and across the Capital, have ongoing reservations about the specific one size fits all target operating model and the speed of the rollout.

We also believe that it is vital that any rollout should be based on evaluation and experience of pilot sites. Speaking as a GP in a practice within one of the ten pilot sites, we have only commenced providing care in a same-day access hub within a limited manner controlled by individual practices and not in the way that is specified in the access enhanced service. Given we are still finding our feet, there's been no opportunity for feedback of our experience nor evaluation of our work. It would therefore be inappropriate to draw upon pilots that are themselves not yet delivering the model, nor having been evaluated, as a basis for widescale rollout. Further, feedback from lead clinical directors has been mixed, with many expressing this is still work in progress, and most expressing that they would not want their individual models to be used as a precedent for prescriptive rollout to other areas. Indeed, each pilot varies in their delivery model which has been developed through local self-determination, and therefore they do not constitute as single target operating model.

We understand that this model has been driven by recommendations in 'The Fuller Stocktake' which recognises the need to address same day access requirements, but it does not mandate this model as the necessary solution to this issue. Indeed, it specifically states;

> *'A personalised care approach means 'what matters to me, not what's the matter with me'.*

In the appendix below, we detail the concerns for which we seek clarification and assurance. In summary, GPs across NWL have raised significant issues around:

1. **Patient safety**
    a. Clinical triage
    b. Limits of clinical competency
    c. Unsafe clinical supervision arrangements
    d. Meeting the needs of unregistered patients
2. **Clinical quality and effectiveness of care**
    a. Impact of loss of personalised care and continuity of care
    b. Widening health inequalities
    c. Driving up demand for clinical advice and care for self-limiting conditions
3. **Logistic concerns**
    a. IT functionality
    b. Estates
4. **Patient experience and public consultation**
    a. Patient experience
    b. Public engagement and consultation
5. **Impact on staff and retention**
    a. Impact of implementing change
    b. Staff experience
6. **Perception of 'enforcement' despite immense concern**
    a. Inflexible contracting approach
    b. Appropriate use of funds

All GPs are invested in optimising the patient experience of accessing care. While we support funding to enable improvements to patient access, it is also important to be clear that the ultimate limiting factor of timely patient access is a gross mismatch between demand and capacity. We need to recognise that, as a system, we are offering more appointments than ever in the context of one of the lowest GP to patient ratios in the country.

A shift of this magnitude in the way of working requires a safe, effective model of care to meet patient need, and a change management process over time. It is clear from feedback we have received that there is immense concern regarding this model, with unrest heightened by: the proposed timescales; the desire to mandate this as part of the single offer which is being seen as

an enforcement; the lack of outcomes, as yet, from a reliable, valid, comprehensive, fair and ethically conducted evaluation.

Given that the most serious concerns relate to personalised patient care, quality and safety, **please can you kindly let us know who has clinical accountability within the ICB for this model so that we can escalate any outstanding concerns appropriately.**

It would also be extremely helpful if you could kindly share, with practices, the contact details for the senior clinician responsible for this programme within KPMG to aid them in making the best use of the KPMG support that has been commissioned.

We look forward to your responses by 12 February which may allow us to allay some of the concerns in preparation for your meeting with PCN CDs on the 14 February.

Kind regards,

Chaand Nagpaul
Chair
NWL LMCs Strategic Leadership Network (SLN)
Chair
Harrow LMC

Hannah Theodorou
Medical Director
NWL LMCs

Jamie Wright
Director Primary Care
NWL LMCs

Asiya Yunus
Medical Director
NWL LMCs

cc NWL LMCs
NWL CDs
NWL GPs and Practices

Londonwide LMCs
The professional voice of London general practice

Appendix

Concerns about the Same Day Access model proposed for North West London

Londonwide LMCs, representing LMCs and GPs within North West London (NWL) and across the Capital, recognise that this is an evolving discussion, however there is a degree of urgency to address these issues due to your proposed timeframes. We would therefore appreciate a quick response. Please note that our summary below is not exhaustive and we continue to receive feedback from practitioners in the area.

Patient safety concerns

1. **Clinical triage**

Clinical triage and care navigation are very different processes that have been conflated in this model. Clinical triage makes patient safety a priority by ensuring that patients with urgent needs receive correct and timely treatment to reduce the risk of death or morbidity. This includes recognising:

- Serious conditions that may present similarly to benign conditions,
- Exacerbations of chronic illness and serious impacts of seemingly minor illness on other conditions,
- Factors that may alter the presentation of symptoms and signs of severe illness, particularly when there are limitations to immune competency,
- Features of severe or life-threatening injuries,
- Features of serious illnesses that require an immediate response,
- Conditions associated with social, cultural and lifestyle factors that influence the incidence, severity, and presentation of acute illnesses,
- Multi-factorial problems associated with patients who live alone and/ or with multiple co-morbidities.

Evidence shows that the best clinical outcomes are achieved if triage is performed by the most senior clinician, with prior knowledge of the patient where possible.

Senior clinician triage reduces total patient contacts, ensuring patients are seen by the right person and in the most appropriate timeframe, and is key to meeting patient expectation.

In the model that you, NWL ICB, want practices to implement, triage is referred to as a "back-office function" throughout the document, carried out by a care navigator. While there are existing AI tools and some standardised clinical pathways and population health management tools to support triage functions, evaluation of their outputs and use is still emerging.

On behalf of all GPs in NWL, please can the ICB clarify where the clinical triage function sits in this model.

2. Limits of clinical competency

Concerns have been raised that this model will require staff employed through the Additional Roles Reimbursement Scheme (ARRS) to work outside their remit or capabilities.

Please can you share the modelling and safeguards that reassure that this is not the case?

3. Unsafe clinical supervision arrangements

The medicolegal risk and responsibility of this overarching role is not detailed within the documentation. The suggestion that a single GP should hold the clinical responsibility for over 100 patient encounters in a day is well outside the safe workload limits outlined in the BMA's safe working guidance.

Please can you provide a description of the level of supervision that the ICB feels is required and the modelling which shows that adequate accommodation for this has been made in your model?

4. Meeting the needs of unregistered patients

Does this access model support access for unregistered patients, and are there special considerations for the operating model for those who are unregistered?

Clinical quality and effectiveness of care concerns

5. Impact of loss of personalised care and continuity of care

Personalised care and continuity of care are two of the core tenets of high quality, effective general practice.

The evidence-based benefits of continuity of care include better health outcomes, more cost-effective care and higher patient and staff satisfaction. The benefits of personalised care include improved access to care, improved health outcomes, better self-care, reduced costs and increased satisfaction of both patients and staff.

Please can you explain why you want practices to implement a model which reduces, rather than increases, these core tenets of care?

6. Widening health inequalities

There are immense concerns that this model will increase health inequalities through several different mechanisms, including:

1) The model amplifies the digital barriers currently experienced by those with greatest need, including some patients with physical or learning disabilities or language barriers, and risks priority of access to be given to those who have access to, and are able to engage with, digital technologies.

2) The model also does not seem to allow for flexibility for specialist practice populations such as homeless practices, where patients' trust is built through regular contact with their registered practice or more complex nuances are missed when patients are seen by other providers.

3) The model requires staff to prioritise working to meet the needs of patients without complex needs at the expense of supporting those patients with greater and more complex heath needs.

4) Practices understand the social, cultural and environment dimensions of providing care to their local populations and flex their delivery of care accordingly. One size will never fit all.

Please can you share the health inequalities impact assessment for the model you want practices to put in place?

7. Driving up demand for clinical advice and care for self-limiting conditions

This model is not a hub, with additional staff, that supports practices and patients by providing additional capacity for those whom practices have triaged as appropriate for at-scale services, ensuring that the finite expert workforce resource at practice level can be dedicated to those who will benefit from it the most.

Increasing capacity for non-complex same day care will drive up demand. There is no extra workforce capacity to meet this demand. The model moves finite and limited workforce away from patients with greater needs in practices, reducing access for those with greater needs.

In a system of finite resource and the need to balance the collective purse, rationing is a necessity. Clinical prioritisation is essential to cost effective care and getting the most value from taxpayers' money.

Please can the ICB explain how this model does not contravene the ethics of healthcare rationing, and what rationing seeks to achieve, in our NHS?

<u>Logistic concerns</u>

8. IT functionality & IG compliance

Please can you provide assurance that all IT and IG issues been addressed, for registered and unregistered patients.

9. Estates

The target operating model refers to utilising independent premises or using existing PCN sites. However, in meetings it has been expressed that the attached funding cannot be used for estates as other estates funding streams should be utilised.

Please can the ICB outline funding sources available to support the use of independent premises or existing PCN sites?

Please can the ICB share the estates plan that identifies any impact on delivery of core services within practices, and mitigates any issues identified?

Given that practices report lack of estate as a barrier to increasing capacity for core services, has there been a cost benefit analysis that shows that investing estates funding in this model is more beneficial for patients?

Patient experience and public consultation

10. Patient experience

GPs have fed back numerous concerns that this will reduce patient experience, some based on their current experiences of signposting patients to other services when grounds for patient dissatisfaction include:

1. Preference to see their own doctor,
2. Preference to access care within their own practice,
3. Moving care away from home,
4. Difficult transport links.

Please can you share the evidence from the pilots that this model improves patient experience for all groups of patients?

11. Public engagement and consultation

Given the experience described above, **please can you share the public engagement and consultation that has resulted in the creation of this model, including of groups who experience access difficulties and poorer health outcomes?**

Impact on staff and retention

12. Impact of implementing change

Please can the ICB show the planning that has been undertaken to identify the steps and timeframes required by practices, to effect the change management required to implement your model.

Please can the ICB provide the analysis of the additional workload for different members of staff implementing this change process, and the impact of pulling staff away from delivery of core services to deliver this change process.

13. Experience of staff

Given the NWL London workforce data, retention of staff is a key priority to stabilise services across the NHS.

There are many factors associated with a positive staff experience of delivering care such as: continuity of care, personalised care, working with a trusted team with good established relationships, psychological safety, appropriate workloads, suitable level of responsibility and appropriate levels of support. This model is associated with loss of continuity and personalisation, rotating staff, inappropriate levels of responsibility for staff roles and inadequate provision for support. It also reduces the capacity in practices dedicated to meeting existing patient need.

Please can the ICB show how this model will improve the experience of staff working in the hub and working in practices, and how this will support staff retention?

<u>Perception of 'enforcement' despite immense concern</u>

14. Inflexible contracting approach

Although there may be PCNs who would like to progress with the model, the 'Single Offer' contractual framework has effectively made participation in the access service mandatory for all PCNs across NWL, with a 'one size fits all' approach to the service from 1 April 2024.

If practices do not agree that the ICB model is in the best interests of their patients, the ICB has made it clear that they will not be permitted to deliver **any** of the local enhanced services to their patients. Clearly, withdrawing enhanced services from local PCN/practice delivery will have a significant impact on patient care and the stability of practices, and the rapid pace of change is also likely to be destabilising.

This approach also erodes practice self-determination in meeting its contractual obligations leading to further destabilisation of General Practice.

15. Use of funds

Practices have been informed that:

> *'Unlike other specifications within the single offer, the funding attached to this specification from April will be for PCNs/boroughs to transform the way they work. Money will not be attached to providing extra activity but, instead, will support member practices to achieve a series of gateways for engaging, developing and implementing a model.'*

Although the funding proposed has not been released to practices, there are concerns that this investment is a poor use of precious funds. Some PCNs have already made alternative

suggestions for use of investment, based on their extensive knowledge and experience (both clinical and of the people practices serve), that they feel would be far more effective at achieving the ICB's stated aims. We would be keen to explore this further with you.

Londonwide LMCs is the brand name of Londonwide Local Medical Committees Limited
Registered and office address: Tavistock House South, Tavistock Square, London WC1H 9LG. **T**. 020 7387 2034/7418
F. 020 7383 7442 **E**. info@lmc.org.uk **www.lmc.org.uk**
Registered in England No. 6391298. Londonwide Local Medical Committees Limited is registered as a Company Limited by Guarantee
Chief Executive: Dr Michelle Drage