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The professional voice of London general practice

Analysis of the ICB response to concerns raised by practices in NWL about the proposal for their single access programme

A. Patient safety concerns

1. Clinical triage

The concern raised

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 comorbidities.

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 proposed model, 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. As such, senior clinician triage is still necessary.

The question posed to allay concern

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

ICB response

The letter states:

> *During triage it is essential that decision making is clearly clinically supervised and patients are reviewed by the most appropriate clinician.*
>
> *PCNs [primary care networks] will need to ensure that the clinical workforce skill mix has the appropriate competencies and that supervision capacity is identified as integral to the model.*

Further information about where the clinical triage function sits is given in the principles document:

> ***Principle 1:***
>
> *Ability to triage same day demand at scale ie. PCN or borough-level function.*
>
> ***Principle 2:***
>
> *- Care navigators can process incoming queries, collate information and*
>
> *support the senior clinical decision maker around who is best to deal with the*
>
> *presentation.*
>
> *- Allocation and filtering should aim to the support the patient interacting with right person depending on the presenting condition.*

Analysis

Has the question been answered?

Yes

The ICB are very clear that the triage function sits at PCN or borough level.

Have concerns been allayed?

No

There continues to be conflation of care navigation and clinical triage, and it is unclear what "filtering and allocation" involves and therefore how it will aim to support the patient interacting with the right person, as stated in the document, or within the right timeframe.

Practices may take some comfort from the autonomy and flexibilities described in the letter. The ICB acknowledge that "work to date may have given the impression that this is an inflexible top-down delivery of a plan"', and that the ICB intention is to support networks of practices "in considering ways of managing this demand in a model of care which works for their individual populations and circumstances".

This implies that practices will be able to add clinical triage provision into their revisions to the model proposed by the ICB. However, this will obviously have workforce and resource implications for practices.

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Actions for LMCs

1. LMCs will continue to highlight this concern to the ICB.

Further considerations for practices include

1. Despite the clinical triage role not being clear in the ICB proposals to date, practices need to give serious consideration to how clinical triage is carried out safely and who is qualified and competent to undertake this role. Whilst it seems reasonable that care navigators *"can process incoming queries, collate information and support the senior clinical decision maker",* this is not clinical triage. Careful consideration needs to be given to who will be making the clinical triage decisions, and who will be carrying responsibility for those decisions.

2. Practices need to consider whether moving this function away from the practice and the registered list to triaging at PCN or borough level is the most appropriate and effective scale for their population, or whether this is more effectively delivered by clinicians at the practice level who may know more information about the patients, their condition, and the context.

3. Practices also need to consider whether moving this function away from practices would be acceptable to their patients - see section C: Patient experience and public consultation.

2. Limits of clinical competency

The concern raised

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.

The question posed to allay concern

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

ICB response

The letter states:

> *As part of the workforce mapping, PCNs will need to ensure that the clinical workforce skill mix has the appropriate competencies and that supervision capacity is identified as integral to the model. We are not prescribing the way that ARRS teams will work but highlighting how some of our wave one sites have utilised the various skill sets of these team members to support new ways of working.*

Additional information in the principles doc:

> ***Principle 2:***
>
> *Skill mix will be determined by the PCN and depends on the scale of the model.*
>
> *- Models could use ARRS roles, but must include senior clinical decision makers who will be responsible for patient safety and on the day clinical governance.*
>
> *- ARRS roles cover a range of different disciplines, the principle is not prescriptive but suggests that care navigators will support the clinician in patient direction and some clinical ARRS team members may benefit from spending time supporting the at scale working.*
>
> *- Care navigators can process incoming queries, collate information and support the senior clinical decision maker around who is best to deal with the presentation.*
>
> *- Administrative and non-clinical queries can be managed by other team members.*
>
> *- Clinical presentations can be allocated for delivery within the access centre, at the GP practice or referred / signposted to other primary care providers such as community pharmacists (including CPCS and Pharmacy First), dentists, ophthalmologists.*
>
> *- Allocation and filtering should aim to the support the patient interacting with right person depending on the presenting condition.*
>
> *- Staffing model will not be prescriptive around what should be – should be determined by the PCN.*
>
> *- As models develop it may be useful to consider a competency-based framework approach rather than qualifications for triage component. This recognises the diverse and impressive skill set that many of our workforce have and that working in new ways requires support, training and supervision*

Analysis

Has the question been answered?

No

The ICB has not provided workforce modelling for this model and the letter implies that undertaking modelling would be a responsibility for the network of practices as part of the design phase.

Safeguards to ensure that staff are able to operate within the remits of role competency are not addressed in the letter. The only clinical safeguard seems to be the supervising GP: *"senior clinical decision makers who will be responsible for patient safety and on the day clinical governance",* and that *"supervisory capacity is identified as integral to the model".* See concern 3 below.

Regarding understanding competencies of new roles, the ICB state that "*it may be useful to consider a competency-based framework approach rather than qualifications for triage component".* The ICB does not clarify who would have responsibility and clinical accountability for devising, assuring, and applying such a framework.

Have concerns been allayed?

No

Actions for LMCs

1. LMCs will continue to highlight this concern to the ICB.

Further considerations for practices include

1. Practices may want to carefully consider the patient need that is likely to be diverted to the access centre, and the consequent capability and capacities required to deliver this model of care.
2. Taking into account current understanding of remits of roles and responsibilities, practices should consider whether this workforce is both available, and can be diverted from delivery services to patients within the practice.

3. Unsafe clinical supervision arrangements

The concern raised

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.

The question posed to allay concern

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?

ICB response

The letter states:

> *As part of the workforce mapping, PCNs will need to ensure that the clinical workforce skill mix has the appropriate competencies and that supervision capacity is identified as integral to the model.*

Principle 2:

Models could use ARRS roles, but must include senior clinical decision makers who will be responsible for patient safety and on the day clinical governance.

Analysis

Has the question been answered?

No

Have concerns been allayed?

There are ongoing national concerns about the lack of clarity for the supervisory role of the GP with regard to additional roles, which unlike supervision of GP trainees, is not part of a training programme with a defined end point. The uncertainty is heightened for the supervisory role of clinicians for whom there is not a legal requirement to have certain qualifications or experience (or meet an alternative condition or requirement) in order to undertake certain professional activities. There is also national debate regarding the cost effectiveness of new roles brought in who are unable to practice autonomously without GP supervision, when the time required to provide a comfortable level of supervision is taken into consideration.

Actions for LMCs

1. LMCs will continue to highlight this concern to the ICB.

Further considerations for practices include

1. Practice should consider what level of supervision is deemed to be appropriate to ensure patient safety at all times and to ensure that the supervising clinician feels safe in delivering their supervisory role.
2. Practice should consider the GP capacity required to undertake this supervisory role, how this GP capacity will be met and the effectiveness of this model.

4. Meeting the needs of unregistered patients

The question posed to allay concern

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

ICB response

The letter states:

> *Unregistered patients should be encouraged to register with a local practice when they access urgent care at UTCs and A&Es and work is already underway with these providers to proactively signpost to local GP practices.*

Analysis

Has the question been answered?

Partially.

By implication, it is not unreasonable to assume that this access model does not support access for unregistered patients

Have concerns been allayed?

No

Actions for LMCs

1. LMCs will continue to highlight the systemic barriers experienced by practices that lead to unsuccessful registration attempts with GPs in London, and will explore with the ICB the impact of their proposed model on unregistered patients who try to access same-day care

Further considerations for practices include

1. Practices should consider how they will support unregistered people to register and have access to same day care.

B. Clinical quality and effectiveness of care concerns

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

The concern raised

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.

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The question posed to allay concerns

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

ICB response

The letter states:

> *We absolutely acknowledge the benefits of continuity of care. The intention behind this model is to support individual practices to focus on providing continuity for those patients where continuity is essential to better health and social outcomes. The purpose of this programme is to help liberate GP practices from managing low acuity reactive and episodic same day consultations and so enable them to see more of the patient cohort where continuity really adds value. We are currently exploring the utilisation of WSIC as a risk stratification tool within the GP IT system to ensure these patients are flagged as requiring continuity. As part of the 9 key principles we are committed to looking at tools that support this identification.*

The letter also states:

> *The 10 PCN early adopters in phase 1 have already started work on how to support GP practices continue to deliver complex care for patients whilst managing simpler patient queries and conditions differently. This has enabled some places to extend the time length for 2 some GP appointments.*

There is further information in the principles document and attached letter:

> ***Principle 7:***
>
> *Ability to book appoints with patient's home' practice for those with complex needs.*
>
> *- It is down to the ICB to ensure that there is an appropriate risk stratification tool.*
>
> *- ICB is looking to enable the appropriate connectivity / interoperability to support this.*
>
> *- PCNs/Borough will need to identify which patients would benefit from continuity within the practice.*

Analysis

Has the question been answered?

Partially

The ICB believe that this model will increase capacity at practice level to dedicate to those who will benefit from continuity of care the most, and their correspondence states that this has been realised in some of the pilots, but without explanation of the detail behind this.

Have concerns been allayed?

More information is required about the how the pilots have achieved this and whether their methodology and outcomes are transferable to other networks of practices. If this is the case, concerns could be allayed.

Whilst there is a rationing argument that finite practice time should be dedicated to those who benefit most from continuity of care, at last year's Conference of England LMCs, GPs voted against any move to separate planned and unplanned care in general practice because of the deleterious impact on patient care. GPs highlighted the complexity of patient presentations and expressed concerns about the ability of new risk stratification tools to identify, reliably and accurately, those who would not benefit from continuity of care.

It is unclear whether the funding enables further people to be employed.

In their letter of 31/1/24 the ICB state funding will be '*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*'.

This implies that the funding cannot be used to employ staff, although we are seeking greater clarity on this point. The ICB have informed us that this funding is recurrent for 4 years, so would not accommodate the funding of permanent positions, even if employing workforce were permitted.

If networks of practices decide that they would need to employ additional staff, thereby ensuring that staff could remain offering continuity of care to the more complex patients at practice level, there are no guarantees that the workforce is available within the ICB area which has one of the highest number of patients per GPs and PNs.

Further actions for LMCS

1. To understand more how the pilot sites have managed to increase capacity in practices despite providing workforce to the access centre.
2. Understand whether the methodology and outcomes achieved by the pilots are transferable to all networks of practices
3. To seek clarity from the ICB about the use of funding.

6. Widening health inequalities

The concern raised

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

- 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.
- 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.
- 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.
- 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.

The question posed to allay concern

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

ICB response

The letter states:

> *We believe that delivery of enhanced services including the access programme through the single offer acts to give a consistent expectation of service delivery across NW London, reducing the post code lottery that had previously existed. The programme is still in its infancy and as it progresses we will be undertaking the appropriate EQIA and QIA which we will be happy to share with you.*

Analysis

Has the question been answered?

No

No health inequalities assessment has been carried out/ shared as yet.

Have concerns been allayed?

No

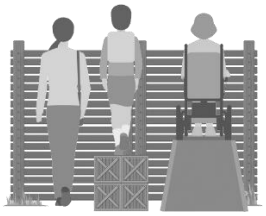
There appears to be conflation of equality of service provision with equality of access and outcomes.

Practices have considerable experience of modifying the delivery model of their services to meet the needs of their communities, and the GMS contract promotes practice autonomy in order to provide equity of service provision to patients. Practices understand their local communities, flexing services to meet need in the context of the local social, cultural and environment dimensions, and often employing members of the local communities.

The ICB explicitly aim to give a consistent service offer across NWL. Equality of service delivery does not result in equality of outcomes.

Equality of service offer with inequality of outcomes.

Equality means each individual or group of people is given the same resources or opportunities. Equality is not enough without an understanding that people aren't always on equal footing. In fact, equal treatment can often perpetuate inequality.



Equity of service offer with equality of outcomes.

Equity acknowledges that there are differences between people and what they need to succeed. Equity recognises that each person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome.

And yet, the law is clear that ICBS must have regard to reduce inequalities **with respect to outcomes**.

Health and Care Act 2022 14Z35 Duties as to reducing inequalities:

> *Each integrated care board must, in the exercise of its functions, have regard to the need to—*
>
> > *(a)reduce inequalities between persons with respect to their ability to access health services, and*
> >
> > *(b)reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services (including the outcomes described in section 14Z34(3)).*

Further actions for LMCs

1. To continue to highlight the role that practice-level care has in delivering equitable services, and the impact of aiming for equality of service offer on quality of patient outcomes.

Further considerations for practices include:

Practices should consider the health inequalities impact of implementing the at-scale model and principles on health outcomes of their populations and ability to access services, and whether this model and the principles are in the best interest of those with the greatest need. Please do share your views of the impact on your population with us to support further discussions with the ICB.

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

The concern raised

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, without providing additional workforce capacity. 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.

The question posed to allay concern

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?

ICB response

The letter states:

> *This model is about exploring how to use existing resources in a more efficient way across a wider landscape to enable the workforce to be used efficiently to meet the current demand. At the same time there is the London deliberative enquiry which is poses questions to the public including how best to use the resources we have as a community to keep people well.*

Analysis

Has the question been answered?

No

Have concerns been allayed?

No

The relationship between the London deliberative event and public engagement on this particular model is unclear. The principles for the ICB access model, with their associated trade-offs such as continuity of care, have already been determined by the ICB and yet deliberative event is still in the design phase. This seemingly pre-empts the outcome of the public deliberation exercise.

Further actions for LMCs

1. To understand how the deliberative event has informed the proposed contract variation for April 2024.
2. To continue to highlight this risk, seeking reassurances or mitigations, from the ICB.

Further considerations for practices include:

1. Practices may wish to consider how they would monitor impact on demand should the implement this model.

C. Patient experience and public consultation

8. Public engagement and consultation

The question posed to help allay concern

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?

ICB response

The letter states:

> *As per the beginning of this letter all the insight and engagement work with residents across NW London has highlighted access to general practice as an issue. Underpinning this programme, we built in a range of engagement activities. In addition, we are working as part of the London Deliberative enquiry and reaching to our patient groups and Healthwatch to support these conversations*

Analysis

Has the question been answered?

Partially

The ICB have informed us that public engagement has taken place, but outcomes of public engagement and consultation have not been shared.

Have concerns been allayed?

No. We await detail of the outcomes of public engagement and consultation.

Access is a problem. The number of patients per full time equivalent GP is untenable and the impact on access, quality of care and safety of care is a matter of grave concern to patients and GPs alike. GPs experience immense morale injury at not being able to deliver the care they want, and have trained, to deliver. There simply are not enough GPs: GPs continue to reduce their number of working sessions; leave London to practice elsewhere; or leave the profession altogether. Primarily because of untenable working conditions.

NWL has one the greatest number of registered patients per full-time equivalent (FTE) GP in the country. Furthermore, whilst general practice staffing numbers appear to be slightly recovering in other areas of the country, numbers continue to fall in London.

NWL ICB, general practice staffing, staff FTE per 100,000 patients

Staff Group	**NWL**	**England**
GPs	37	44
Nurses	13	27
Direct Patient Care	19	27
Admin/non-clinical	83	120

NHS England Digital, General Practice Workforce, 31 January 2024

However, the question refers to engagement about the model that the ICB is putting in place as the solution for challenges in NWL.

In their letter, the ICB mention the deliberative event that will be taking place across London. The relationship between the London deliberative event and public engagement on this particular model is unclear. The principles for the ICB access model, with their associated trade-offs such as continuity of care, have already been determined by the ICB and yet deliberative event is still in the design phase. This seemingly pre-empts the outcome of the public deliberation exercise.

It is also unclear:

- Which patient group and HW views have been sought to date,
- how these have influenced the principles and the model, and
- whether alternative solutions to the access problems were offered or discussed.

Further concerns:

1. **The ICB's assumption that high volumes of interactions that our population make with general practice do not need continuity, and whether this assumption has been tested through engagement and consultation with the public**

The ICB state that "high volumes of interactions that our population make with general practice do not need this level of continuity" of care, and the ICB model is based on this assumption. To date, modelling that supports this assertion has not been shared, neither have the outcomes of public engagement that demonstrate that the public agree.

The assertion that high volumes of interactions with our populations and general practice do not need continuity of care was strongly refuted in a debate between hundreds of GPs across England, each representing GPs in their local area. GPs voted to reject a proposal to separate on-the-day care from planned general practice care on the grounds of safe effective care and patient experience. GPs highlighted the complexity of the undifferentiated illnesses that our patients experience, in which frequently the diagnosis, and whether this is minor or an emergency, is not clear at the outset. There is a complex and extremely complex interplay between different conditions, mental and physical health, and other key factors in providing holistic care such as significant events in the patient's life, the wellbeing of loved ones particularly family members, and the wider determinants of wellbeing such as housing and loneliness. Furthermore, GPs have highlighted that building continuity of care over time, through seeing patients with minor conditions, sets the foundations for a trusted doctor:patient relationship that is beneficial if/when a patient experiences a more significant illness or life event.

2. **The public engagement and consultation in determining, and public acceptability of each of the mandatory principles of the ICB model**

Some of the principles, on which the access model must be based, will have significant implications and trade-offs for the patient, and it is unclear whether these have been determined collaboratively with patient groups. These principles are likely to change the characteristics of general practice.

The European Society of General Practice/Family Medicine provides a comprehensive definition of general practice. It describes six core competencies and twelve characteristics. This model is likely to impact on these core characteristics of effective, quality general practice, such as the doctor:patient relationship and longitudinal continuity, centred on the patient and context, and holistic care. ***See annex on World Organization of Family Doctors (WONCA) core competencies.***

3. **Unknown whether other solutions have been explored with the public**

WONCA highlight that international evidence indicates that health systems based on effective primary care with highly-trained generalist physicians (family doctors) practising in the community, provide both more cost effective and more clinically effective care than those with a low primary care orientation.

There is an access problem because there are no longer enough GPs to meet the demand of the local population. This is a problem nationwide but disproportionately a problem in NWL.

Yet, across NWL, GPs report that they have a significant number of wasted appointments addressing the workload of, and patient queries about issues relating to, other providers. GPs

also report that they waste a significant amount of time navigating system failings such as IT and care pathway failings.

4.

In Winter 2023 we conducted our most recent Londonwide LMCs workforce survey and asked practices to share their concerns about safe patient care:

- An increasing number of practices say that their ability to deliver safe patient care is being impacted by workload shift from other workers. 77% compared to 72% last wave.
- And 90% of those practices say that they are unable to absorb that additional workload. When asked how frequently the staff team express concerns about meeting patient demand safely, 87% of practices reported that patient safety concerns resulting from workload shift were raised at least quarterly; with three in ten practices saying staff express concerns daily about safely meeting patient demand. Only 6% of practices reported an absence of reported staff safety concerns.

Reducing the significant components of GP workload that belong to other providers, and addressing the IT and other system failings that are outside of the gift of practices to resolve, will not only improve safety, GP effectiveness and quality of working lives but also liberate significant time and improve access for those who need GP practice services, without compromising continuity of care and the other core tenets of high quality general practice.

Londonwide LMCs has offered the ICB alternative ways to address these issues and increase the retention of GPs, helping to address the poor doctor:patient ratios. In December 2022, this document was disseminated to ICBs and brought to the London Primary Care Board.

We have also provided a detailed list of what can be done to prevent GPs spending their time addressing workloads of hospitals.

Further actions for LMCs

1. To clarify with the deliberative event oversight group chair regarding the relationship between public engagement with public about the NWL model and the deliberative piece of work and seek assurance that the deliberative event does not have predetermined outcomes.
2. To seek further clarity from the ICB regarding which patient group and HW views have been sought to date and how these have influenced the principles and the model.
3. To raise the further concerns with the ICB

Further considerations for practices include

1. If practices wish to engage with their communities to understand their views on the mandated principles for this model before deciding how to proceed, we will produce a resource pack to support you to do this imminently.

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9. Patient experience

The concern raised

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:

- Preference to see their own doctor,
- Preference to access care within their own practice,
- Moving care away from home,
- Difficult transport links.

The question posed to allay concern

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

ICB response

The letter states:

> *We are gathering and collating information from our early adopters and will share it as soon as we can. We have rich information and the MORI survey which speaks to some of the difficulties that some of population have accessing primary care and our aim is to support PCNs and General Practice to improve the patient experience and navigation through the system with new models.*

Analysis

Has the question been answered?

No, not as yet.

Have concerns been allayed?

We anticipate that many GPs will be relieved to have received the reassurances that the ICB is not looking to impose the blueprint 'target operating model', shared with GPs on 31/1/24, which generated a significant number of patient safety concerns.

The 9 key principles shared under cover of the ICB letter and identified as "*fundamental for the hubs to run effectively and meet patient demand".* will have a significant impact on the patient same day access journey and leave concerns about the patient flow and experience unaddressed.

There are the potential implications for patients accessing same day care, based on the information that has been provided:

Principle 1: Ability to triage same day demand at scale ie. PCN or borough-level function

A person who feels that they need to be seen on the same day will no longer contact their practice for an appointment with their doctor or practice staff member. They will be diverted, along with all people wishing to access same day care to a central access hub that covers a network of practices, usually across a population of 30,000 – 100,000 people. In northwest London, the practices per PCN vary from 3 in Harrow East PCN, to 15 in Acton PCN. The concerns relating to ensuring safe clinical triage patients in this model has already been covered.

Principle 2. Staffed by multidisciplinary extended primary care team

If a same day appointment is deemed to be necessary, the patient will be seen by staff who are working across the network of practices. If patients are not considered to be complex, it is unlikely they will be seen by a doctor; it is likely that they will be seen by other healthcare professionals whom they probably will not know or, if other services best meet the need that has been determined at triage, will be sign posted elsewhere in the community.

Principle 3. Ability to manage low complexity patients both face to face and remotely

For patients who are allocated to an appointment, they may have to travel to a physical premises operating across all the practices in the network, to any one of the practices in the network, or not be allocated to a face-to-face appointment but have a remote consultation.

There has not been estates planning to accompany this model, nor ring fenced funding for estates, and the letter states that the model introduced will need to *"consider what is already in place and any constraining factors that each area has, such as estates. It may be that at scale provision for a PCN can only work at a virtual level"*.

This implies that across some networks of practices the staff providing appointments as part of the access hub may not be able to see patients face to face. The ICB does not suggest what should happen if the patient would prefer to be seen face to face or needs a face-to-face clinical assessment to determine diagnosis, severity of the condition and appropriate management. Presumably, the patient will initially be diverted to the at-scale service for a remote consultation with a health care professional who, if they felt a face-to-face assessment were required, would have to divert the patients back to their practice.

Principle 7 Ability to book appoints with patient's home' practice for those with complex needs

The ICB state that it is *"down to the ICB to ensure that there is an appropriate risk stratification tool and the ICB is looking to enable the appropriate connectivity / interoperability to support this".*

The model is based on the assumption that patients can be categorised into complex and non-complex, using a digital tool, with the complex requiring continuity of care in the practice and the non-complex not benefiting from continuity of care.

This assumption is not widely accepted, and the concerns that patients who would benefit from seeing their doctor could get classified as not complex and not offered this remain unaddressed.

The ICB also state that "*networks of practice /Borough will need to identify which patients would benefit from continuity within the practices".* It is not clear who would undertake this role across the whole borough, and many GPs feel that continuity of care benefits nearly all patients to a greater or lesser extent. GPs have expressed concern at the erosion of continuity of care due to the ever-increasing number of patients per GP and the intensity, complexity, and volume of workload on each day that has resulted in GPs dropping to part time, although still working full time hours, to safeguard their health and the wellbeing of their families.

Principles 6 and 8

6. Ability to order diagnostic tests and issue prescriptions

8. Referral to other primary, acute, mental health and community care services as needed

The ICB has not yet provided information about the functionality and processes that enable staff working in the hub to undertake all of these essential functions. The ICB have said that this is work in progress, but there is currently no time frame provided for this.

If these referral processes are not in place when a patient who is deemed to need a same-day appointment is seen by a hub member of staff (face to face or possibly virtually), it's not clear what should happen if they require any investigation, treatment, or referral. Presumably, the patient will be referred back to the practice where a GP will need to re-assess the patients before they can safely take responsibility for the management plan and treatment; resulting in wasted appointments for the patient and duplication.

Impact on patients who need scheduled pro-active care

The ICB does not make an additional staffing provision for this model and implies that staff will be relocated from the practice to the hub. There is finite workforce capacity and if staff are re-deployed to meeting same-day demand, it's not unreasonable to assume that there will be an impact on patients accessing other practice services. For example, many practice pharmacist and advanced nurse practitioners play a vital role in supporting people to manage their long-term conditions and remain well, but these staff members have been suggested by the ICB as key members to staff the hub.

The ICB state: *"The 10 PCN early adopters in phase 1 have already started work on how to support GP practices continue to deliver complex care for patients whilst managing simpler patient queries and conditions differently. This has enabled some places to extend the time length for 2 some GP appointments".* Also "*This specification aims to encourage that activity into a more collective resource which enables more time to be given to those patients that do need that one-to-one relationship that they value".*

Further actions for LMCs

1. To reach out to the pilot sites to understand the models that they have implemented and how they have managed to increase capacity and outcomes for both same day and scheduled care without changes to their workforce.

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D. Logistic concerns

10. IT functionality & IG compliance

The question posed to allay concerns

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

ICB response

The letter states:

> *There are a number of key enablers to make this programme a success which includes integration of IT functionality and IG compliance, which are currently in 5 development. We are working within NW London ICB to address many of these issues.*

This question is also addressed in the principles document*:*

> *Principles*
>
> *6. Ability to order diagnostic tests and issue prescriptions - ICB needs to provide the functionality to do this. Discussions have commenced.*
>
> *7. Ability to book appoints with patient's home practice for those with complex needs - It is down to the ICB to ensure that there is an appropriate risk stratification tool - ICB is looking to enable the appropriate connectivity / interoperability to support this. - PCNs/Borough will need to identify which patients would benefit from continuity within the practice.*
>
> *8. Referral to other primary, acute, mental health and community care services as needed - Community services referrals take place via email. SystmOne hubs could make referral, EMIS – need EMIS community/or task back to practice. - Two-week wait referrals – eRS functionality is now in place for the hub to make a referral, i.e. doesn't have to be the registered GP, but do still need to work through the process. - ICB discussion around C2C referrals for primary care clinicians in the hub to refer to mental health and acute. - Conversations with community and mental health services planned*

Analysis

Has the question been answered?

Yes. The ICB is working towards having these enablers in place.

Have concerns been allayed?

No

The response raises further questions about the time frames for implementation of these key enablers for safe effective care.

Further actions for LMCs

1. To continue to work with the ICB to address the concerns. Although the ICB has offered reassurance about their time frames for implementation, practices who wish to delivery this model will need to know when these enablers will be in place in order to plan services.

Further considerations for practices include

1. Practice would need to consider this uncertainty in their planning processes if they choose to accept the contract variation.

11. Estates

The concern raised

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.

The questions posed to allay concerns

1. **Please can the ICB outline funding sources available to support the use of independent premises or existing PCN sites?**
2. **Please can the ICB share the estates plan that identifies any impact on delivery of core services within practices, and mitigates any issues identified?**
3. **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?**

ICB response

The letter states:

> *The funding for the NW London access programme is to support PCNs to develop, implement and build sustainability into the model. This is not prescriptive of any one particular estate model or hub. It may be that the solution for an individual PCN will exist in the virtual space*.

Estate is also mentioned in the principles document:

> *Principle*
>
> *This is not dependent on a single physical hub, it could be in one place (practice), or dispersed across practices and utilising existing resources to support care pathways. - Based on connectivity and integration*.

Analysis

Have the questions been answered?

Partially

There is clarity that any funding required for premises required to deliver this model will come out of the contract funding for the access service line.

Questions 2 and 3 remain unanswered.

Have concerns been allayed?

The concerns about impacts on existing core services remain unaddressed

Further actions for LMCs:

1. LMCs will continue to highlight these concerns to the ICB. Please do share any impact assessments that would help us to represent you effectively.

Further considerations for practices include

1. Practices may wish to consider how this model will impact on the use of estates and the delivery of both same-day care and scheduled care.

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E. Impact on staff and retention

12. Impact of implementing change

The question posed to allay concern

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

ICB response

The letter states:

> *Steps and time frames*
>
> *We are in the final stages of developing our first draft of key deliverables that PCNs can work towards over the course of 2024/25 and the subsequent year. We are keen to share this with you and discuss your feedback.*

Analysis

Has the question been answered?

Change management process planning has not been shared.

Clinicians and management colleagues will have to divert time away from direct patient care to undertake the complex processes of design, prepare to implement, implement, monitor and review. This change management is particularly complex because there will need to be process standardisation across practices in the network, all of whom have patients of different demographics, needs and priorities and consequently different standard operating procedures.

It does not seem from the response that this has been considered nor assessed.

The only mitigation mentioned is that '*phasing that is appropriate to each area will vary'* and that '*there is no expectation that there will be a fundamental change in the same day delivery on the 01 April 2024 and that this will be a process of transformation going forward'.*

Further actions for LMCs

1. 1. LMCs will continue to highlight these concerns to the ICB. Please do share any impact assessments that would help us to represent you effectively.

Things practices may wish to consider include:

1. Practices may wish to consider their change management plan for each practice and across the network.

2. Practices may wish to consider how they would dedicate resource to this change management process and the impact on patients if staff are diverted away from patient care to enable this.

13. Experience of staff

The concern raised

Given the NWL 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.

The question posed to allay concern

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?

ICB response

> *Experience of staff/ retention Staff experience will continue to be very important and we will monitor this going forward. NWL is a great place to work and we would really like your support in continuing to make this even better. A key tenet of this programme is to improve the working lives of our colleagues across individual practices by working more efficiently. We appreciate that many practitioners are feeling isolated and overwhelmed by the different demands on their time. This programme should help address this and we are keen to put the joy back into General Practice.*

Analysis

Has the question been answered?

No

There is an expressed desire to improve the working lives of clinicians but no detail how this model will be beneficial, and not detrimental, to this aim.

Actions for LMCs

1. LMCs to support the ICB, as requested.

Things practices may wish to consider include:

1. Practices may wish to consider the impact of introducing the model on the working lives of colleagues, especially if operating across different sites and different teams.
2. With a new same-day model, practices may wish to consider how they can ensure that colleagues:
    a. have manageable workloads,
    b. feel physically, economically, and psychologically safe,
    c. are involved in decision making
    d. are personally supported,
    e. have a sense of belonging with effective team working,
    f. feel appreciated and valued,
    g. are able to develop professionally.

F. Perception of 'enforcement' despite immense concern

14. Inflexible contracting approach

The concern raised

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.

ICB response

The letter states:

> *Single Offer ICB has taken an approach to Population Health Management by addressing health inequalities through levelling up. The single offer is a way of addressing the inequalities that exist between individual practices and PCNs and is a mechanism for ensuring full service cover no matter where patients are registered. As per the response to the Pulse article the access programme has always been part of single offer and was agreed three years ago. We have been through a comprehensive sign off process relating to all of the funding of the single offer in our internal ICB processes. As you can imagine, a funding package worth a total of £75.4 million requires a lot of scrutiny and agreement. We cannot now unpick the access aspects from the rest of the programme without calling into question the whole piece of work.*

Analysis

Have concerns been allayed?

The ICB state that they cannot separate this workstream from the single contract offer. It is not clear why they cannot do this. We are unaware of any legal barriers that would prohibit this, and we do not understand why the decision regarding the contractual model would not be entirely within the gift of the ICB. It would appear that the ICB are choosing to not disaggregate.

ICBs must ensure robust financial governance and accountability. Clearly this financial accountability must be integral to all contracts and not just a single contractual offer.

Further concerns have been raised subsequent to our original letter to the ICB regarding the pressure to meet with KPMG.

Actions for LMCs

1. To gain clarity regarding the contract variation process that the ICB is following, and the implications should a practice choose not to accept the access component of the contract variation in the context of a multi-year contract
2. To discuss with the ICB and our lawyers to understand whether engaging with KPMG before April, before deciding whether to accept the contract variation, will legally imply agreement, despite not receiving any funds to engage before April.

15. Use of funds

The concern raised

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 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.

ICB response

No additional response

ANNEX

WONCA Core competency:

i. Person-centred care
   The characteristics are:
   a. Doctor-patient relationship
   b. Centred on patient and context
   c. Promotes patient empowerment
   d. Longitudinal continuity

ii. Community orientation
   The characteristic is:
   a. Responsible for the health of the community

iii. Specific problem-solving skills
   The characteristics are:
   a. Decision making based on incidence and prevalence
   b. Early undifferentiated stages

iv. Comprehensive approach
   The characteristics are:
   a. Acute and chronic health problems
   b. Promotes health and wellbeing

v. Primary care management
   The characteristics are:
   a. Care co-ordination and advocacy
   b. First contact, open-access, all health problems

vi. Holistic modelling
   The characteristic is:
   a. Physical, psychological, social, cultural, and existential