

Specification for a directed enhanced service

Access to general medical services

Introduction

1. There is increasing evidence that patients value improved access to primary care services. Many primary care providers are currently investing in various management methods to improve patient access to health professionals.
2. At present, there are different ways of rewarding or incentivising improved access in each of the four countries. This DES reflects these differences in approach and also incentivises and rewards differing levels of achievement in improving access.
3. This DES rewards practices for the period leading to achievement of, and for 2003-2006 for achieving, the national access targets. Maintenance of the relevant national access target will be rewarded through the 50 bonus points available through the quality and outcomes framework.

Improved access directed enhanced schemes

England

4. The NHS Plan in England sets out that:

“by 2004, all patients will be able to see a primary care professional within 24 hours and a GP within 48 hours”.
5. The target is aimed at providing fast access. However, this may not be with the GP or professional of the patient’s choice. The following definitions of terms used in the target provide a fuller explanation:
 - (i) **a GP.** Any general practitioner. This is not a named GP nor is it necessarily a GP at the practice with which a patient is registered. Naturally the latter is desirable wherever possible. However, in the event of a practice not being able to see a patient within the target timeframe, PCTs should agree joint working arrangements with local practices and other health service providers eg a NHS walk-in centre or a locally developed PCT walk-in clinic to ensure that patients can still be seen
 - (ii) **within 48 hours.** Within two normal working days (ie not including Saturday or Sunday) following the day when a request by a patient was made. For example, if a patient requests an appointment on Friday, he or she should be seen at a convenient time no later than Tuesday of the following week. Where a practice provides out-of-hours services, it will need to make provision for out-of-hours services, especially at weekends for emergency care, otherwise this will be a PCT responsibility
 - (iii) **a primary care professional.** Any healthcare professional who is a member of the practice or the wider primary care team, including practice nurses, allied health professionals, other healthcare staff within the practice or elsewhere eg in an NHS walk-in centre. A GP may also count where an appointment is available within the target timeframe for access to a primary care professional. It does not necessarily mean a primary health care professional working in the practice with which a patient is registered. Part of the PCT’s role will include ensuring that there is local provision for access to, for example, district nursing or health visitor services or a walk-in service or centre
 - (iv) **within 24 hours.** By the end of the following normal working day (ie not including Saturday or Sunday). For example, if a patient requests an appointment on Friday, he or she should be seen at a convenient time no later than Monday of the following week. Where a practice provides

out-of-hours services, it will need to make provision for out-of-hours services, especially at weekends for emergency care, otherwise this will be a PCT responsibility

- (v) **patients.** Patients registered with a general practitioner or practice. It will be for the PCT to make sure there is appropriate access across its locality. This will involve clarifying how the targets will be met and monitored. Likewise GPs working in partnership should share the responsibility of providing access to patients registered with the practice
- (vi) **to see.** Face-to-face personal contact. The use of alternative consultations such as telephone and e-mail can be used to reduce demand for face-to-face appointments and can be used to support delivery of the target but should also be delivered within the target. Delivery of the target will be assessed against waiting time for face-to-face contact.

Scotland

6. "Our National Health - A Plan for Action, A Plan for Change' identified that the Scottish Executive would work with the NHS and professional bodies to ensure patients in Scotland could get "access to an appropriate member of the Primary Care Team in 48 hours".
7. Access to an appropriate member of the primary care team means direct contact (which may be by telephone or face-to-face) between the patient and the professional (see below) in line with the practice's consultation arrangements where:
 - (i) professional, clinical advice is sought and given within two working days in accordance with the clinical needs of the patient; and
 - (ii) a professional, clinical opinion and/or diagnosis is required in order to determine a further course of action eg to treat, to refer or to provide professional advice.
8. **Professional** means a doctor, nurse or health visitor in the practice with which the patient is registered, who is competent to deal with the patient's clinical needs.
9. **48 hours** means two working days, where a patient requests a consultation in that time, during the normal working hours of the practice, where consultations are available as published by the practice. For example, if a consultation was requested on a Friday, it should be arranged no later than the following Tuesday. If the practice has identified a planned closure for staff training on the Monday, the consultation should be arranged no later than the Wednesday.
10. **Patients** means those (including temporary residents) who are registered with the practice.
11. The definition excludes:
 - (i) situations where the patient does not wish to be seen within 48 hours
 - (ii) situations where the patient specifies a particular professional or individual, where an appropriate, alternative professional is available within 48 hours
 - (iii) requests for emergency or urgent treatment which should be dealt with immediately or within 24 hours in accordance with the clinical need
 - (iv) pre-planned courses of elective treatment or care programmes where access arrangements are established in advance eg chronic disease management, treatment or screening programmes
 - (v) out-of-hours coverage ie outside the normal working hours of the practice
 - (vi) planned closures eg public holidays or staff training.

Wales

12. "The Future of Primary Care" – the Welsh Assembly Government's strategic plan for the development of primary care services has defined the access target for Wales as "patients will be able to access an appropriate member of the primary care team within 24 hours of requesting an appointment and much sooner in an emergency".
13. It is the intention to further develop the definition of this target in discussion with Local Health Boards and after consultation with GPC (Wales). This work will cover developing enhanced access standards for primary care which take account of, amongst other factors:
 - (i) access to chronic disease management services in primary care
 - (ii) access to a range of services including therapy and counselling services at a primary care level
 - (iii) the involvement of NHS Direct as the first point of contact for primary care advice and information, and information on access to emergency services
 - (iv) engagement with patient groups to discuss the most appropriate access systems in emergency and non-emergency situations
 - (v) working with Local Health Boards and primary care practices to pilot and evaluate advanced access in primary care.

Northern Ireland

14. A decision has yet to be taken on the most appropriate access target for Northern Ireland, and this will be announced in due course.

Process

15. At the beginning of each year the practice will discuss and submit to the PCO its intentions regarding participation in this DES.
16. In England, where PCTs and practices already have an agreed arrangement under the former Primary Care Access Fund (which now forms part of PCTs' three year unified budget allocations) they may wish to roll that arrangement forward as their DES.
17. Elsewhere, and in England where such an agreement does not exist, practices will need to agree a plan for implementation with the PCO which would cover:
 - (i) profiling the demand for fact-to-face appointments within the practice
 - (ii) identifying and implementing approaches to shaping demand within the practice in order to use face-to-face consultation more effectively
 - (iii) matching the capacity of the practice to the demand for face-to-face appointments on a daily basis and reducing any backlog of appointments as required
 - (iv) collecting data on a monthly basis to demonstrate improvement (eg third available appointment measure for GPs and nurses within the practice)
 - (v) if appropriate, supporting the active participation of practice staff at local collaborative events for example through locum backfill for at least one GP
 - (vi) developing contingency plans to deal with such issues as staff sickness, holidays etc.

18. Practices will need to be able to demonstrate to the PCT that they are achieving the required level of access as assessed by a random audit of the next available appointment. Throughout the year the PCO will monitor achievement by a random sampling. Patient surveys or questionnaires may also be used.

Funding

19. Funding streams are as follows and will be paid in two instalments: 50 per cent at the start of the year as an implementation payment and 50 per cent at the end of the year as a reward payment, once the practice has demonstrated that it has reached the access standard. If the standard is achieved the practice will also receive 50 bonus points through the quality and outcomes framework.

England

20. The suggested benchmark price for the DES for 2003-2006 is £5,000 for a practice of average size. Funding will flow from the enhanced service floor within PCOs' allocations.
21. In England, during 2003/04 incentive payments agreed in 2002/03 covering 2003/04 as part of the Primary Care Access fund will continue for those who have demonstrated sustained achievement of the NHS Plan access targets either through practising Advanced Access or other means.

Scotland

22. The report of the Primary Care Modernisation Group – Making the Connections (March 2002); and guidance issued to NHS Scotland on the use of the primary care modernisation funding announced in August 2001 identified improving access to primary care services, together with developing and improving chronic disease management, organisational support, and developing services for key groups, as priorities for the programme of investment and reform.
23. The allocation in 2003/04 is £12,000,000. In addition £7.6m is available to fund the Scottish Primary Care Collaborative over the next 3 years. This funding will be used to support the rollout of the "Advanced Access" approach (with the support of the National Primary Care Development Team) to 400 practices during this period.

Wales

24. Funding for this DES for 2003/04 will be £5,000 and will come from enhanced services and through the 50 bonus points in the Quality and Outcomes Framework.

Northern Ireland

25. Once implemented, access will be funded from the resources available for enhanced services and through the 50 bonus points in the Quality and Outcomes Framework.

Monitoring arrangements

England

26. A monthly Primary Care Access Survey is carried out a part of the Department of Health's Local Delivery Plan (LDP) return. In addition, the level of funding being allocated to enhanced services by PCTs will be monitored by Strategic Health Authorities to ensure that they are meeting, if not exceeding, the enhanced services funding floor.
27. Monitoring arrangements for the quality payments attached to access will be introduced alongside the rest of the quality framework.

Scotland

28. In order to meet the 48 hour access target local NHS systems must demonstrate that practices have in place one (or more) of the following:

- (i) Open access
- (ii) 'Advanced Access' (or equivalent) to provide same day appointments
- (iii) Practice Accreditation, Training Practice Accreditation or QPA where the access criteria have been achieved
- (iv) Telephone (or email) access to a member of the primary care team for professional advice
- (v) Doctor/nurse triage
- (vi) Arrangements for patients to be seen within 48 hours or sooner where there is a clinical need

29. Evidence in support of this should be on the basis of:

- (i) identification, within practices or more widely in local health systems, of the systems and processes to support the criteria listed above; and/or
- (ii) quantitative measurement of the time for a consultation from the point of request; or prospectively available appointments at a given point in time.

30. NHS Boards will be required to provide progress reports to the Scottish Executive.

Wales

31. Local Health Boards will work with practices to support them in achievement of this standard and monitor its delivery. Progress will be reported via the Saff process. Further guidance on monitoring arrangements will be given to LHBs following consultation with GPC (Wales).

Northern Ireland

32. Monitoring arrangements in Northern Ireland will be determined in due course.

Pricing

33. In 2003//04 the payment be £5,000 per annum per average practice. This payment rewards practices for the period leading to achievement of, and for 2003-2006 for achieving, the national access targets. Maintenance of the relevant national access target will be rewarded through the 50 bonus points available through the quality and outcomes framework. This figure will be uprated by 3.225 per cent in 2004/05 and again in 2005/06.