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Dear Regional Heads of Primary Care

RE: GP Access; expectations in respect of extended and core hours

Please find appended a slightly revised version of the guidance that was issued by email on 27th November. The difference lies in some of the regulatory references and now has numbered paragraphs for ease of reference

I am also issuing again in this format at the request of colleagues who wanted confirmation that this represents the national NHS England guidance to commissioners

In response to a number of queries I should like to take this opportunity to reinforce that this NHS England guidance has been drafted to assist commissioners in coming to a *judgement* about whether a practices' access arrangements meet the reasonable needs of its patients. There is no single test or set of rules that can be applied to all practices so commissioners should take into consideration each of the points in the attached and review each practice individually, prioritising those practices that close regularly for longer periods and where subsidiary data (e.g. patient complaints, A&E demand etc.) may suggest that alternative arrangements are failing to adequately meet patient needs.

Best wishes

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Appendix A:

GP access; expectations in respect of extended and core hours- National standards and guidance for commissioners

Context and Background:

1. The General Medical Services (GMS) and Personal Medical Services (PMS) Regulations require general practice contractors to provide essential and additional services at such times within core hours, "as are appropriate to meet the reasonable needs of patients," and require the contractor to have in place arrangements for its patients to access those services throughout core hours in case of emergency. Core hours for GMS practices are 8:00 – 18:30, Monday – Friday, excluding weekends and bank holidays. PMS terms are applied in the same manner following national negotiation and the definition 'core hours' is in the contract and in the underpinning regulations. Schedule 2 of the PMS contract allows local commissioners the flexibility to agree alternative opening hours 'normal hours' and this should be specified in the contract where they have been agreed

2. Opening hours for APMS practices are set out in their contract largely mirror GMS opening hours or longer.

3. The Public Accounts Committee (PAC) report into GP access held in March 2017 set out a number of recommendations. One was to ensure that no practice that was closed weekly for half a day should be in receipt of additional funds to provide 'extended hours' i.e. outside 'core hours' and secondly that patients should know what they can 'reasonably' expect of their GP practice during core hours

4. This Guidance has been drafted to help commissioners to work with their providers of general practice in respect of the services that they offer to patients during 'core hours' as well as the conditions that should govern the commissioning of extended hours

5. Specifically it considers the issues surrounding the subcontracting of services during core hours

Core Hours:

6. The wording of the GMS contract permits practices to subcontract their services during core hours with the approval of the commissioner. As there is no limitation within the contract to the number of hours that can be subcontracted, commissioner approval is central in determining what is acceptable or unacceptable.

7. There are a number of reasons why a practice may opt to close their surgery for a short period of time including practical operational considerations e.g. for team training or reviewing the quality of services. The contract however does not support a closure during core hours without alternative arrangements being in place to provide services as described in paragraph 1.

8. Practice closures according to the practice E-Declaration (as at December 16/17) indicated that 53% of practices reported that their reception closed for 30 minutes, on at

least one day a week and 25% of practices closed for 30min every day during the week. This could be a short closure for lunch, opening at 08:30 instead of 08:00, or perhaps closing at 18:00 instead of 18:30. At the other end of the spectrum one in seven GP practices close for a half day every week.

9. There has never been a national standard or definition of what constitutes 'appropriate to meet the reasonable needs of patients' and as a result there have been multiple historical interpretations and arrangements in place for practices that close during core hours, some of which have been in place for many years and dating back to days when commercial/retail outlets closed routinely

10. The regulations says the following in terms of subcontracting;

GMS (Schedule 3, Part 5, Sub contracting)

44. (1) Subject to sub-paragraph (2), the contractor must not sub-contract any of its rights or duties under the contract in relation to clinical matters to any person unless-

(a) In all cases, including those duties relating to out of hours services to which paragraph 45 applies, it has taken reasonable steps to satisfy itself that-

(i) It is reasonable in all the circumstances to do so, and
(ii) The person to whom any of those rights or duties is sub-contracted is qualified and competent to provide the service; and

(b) Except in cases to which paragraph 45 applies, the contractor has given notice in writing to the board of its intention to sub contract as soon as reasonably practicable before the date on which the proposed sub-contract is intended to come into effect

(2) Sub-paragraph (1)(b) does not apply to a contract for services with a health care professional for the provision by that professional personally of clinical services

(3) A notice given under sub-paragraph (1)(b) must include-

(a) the name and address of the proposed sub-contractor;
(b) the duration of the proposed sub-contract
(c) the services to be covered by the proposed sub-contract; and
(d) the address of any premises to be used for the provision of services under the proposed sub-contract

Furthermore

(5) The contractor must not proceed with a sub-contract or, if the sub-contract has already taken effect, the contractor must take steps to terminate it, where—

(a) (a) the Board gives notice in writing of its objection to the sub-contract on the grounds that the sub-contract would—

(i) put the safety of the contractor's patients at serious risk, or

(ii) put the Board at risk of material financial loss, and notice is given by the Board before the end of the period of 28 days beginning with the date on which the Board received a notice from the contractor under sub-paragraph (1)(b); or

(b) the sub-contractor would be unable to meet the contractor's obligations under the contract.

Paragraph 45 relates to sub-contracting of out of hours services.

PMS (Schedule 2, Part 5, Sub-Contracting)

43. (1) The contractor must not sub-contract any of its rights or duties under the agreement in relation to clinical matters to any person unless it has taken reasonable steps to satisfy itself that-

(a) it is reasonable in all the circumstances to do so;
(b) the person to whom any of those rights or duties is sub-contracted is qualified and competent to provide the service; and
(c) the person holds adequate insurance in accordance with regulation 83

(2) Where the contractor sub-contracts any of its rights or duties under the agreement in relation to clinical matters, it must-

(a) inform the board of the sub-contract as soon as reasonable practicable; and
(b) provide the board with such information in relation to the sub-contract as the board may reasonably request

Services that should be available during core hours (including in subcontracted arrangements):

11. Some practices have established a sub-contracted arrangement using local providers (a mix of OOHs providers or from practices that group together such as within a federation). Some of these arrangements will have developed to improve system resilience and would be recognised as a development towards 'at scale' working, underpinning primary care transformation and delivery of the GP forward view. What is not acceptable however is where arrangements are little more than a signposting service directing patients to urgent care providers

12. Subcontracting arrangements will need to be assessed to ensure that the arrangements in place are considered adequate contractually and there are a number of suggestions below to guide commissioners in making that assessment

13. CCG initiated training events are designed to support an overall system wide benefit and should be supported, recognising that these are rarely more frequent than monthly/6 weekly. Consideration should be given however to how these are delivered so as to limit the impact on access to GP services e.g. agreeing practice representation over a practice closure

14. Where subcontracting arrangements exist, the requirements may differ between GMS and PMS contracts. The regulations state that GMS contractors have to give notice (in writing) {to the commissioner} regarding sub-contracting arrangements and the board

has the right to object to any such arrangements whereas under PMS arrangements, the contractor need only inform the board {commissioner} of the sub-contracting arrangement. That said in the standard PMS contract there is a term that requires PMS contract holders to seek approval before sub- contracting which aligns it with the GMS contract.

15. The services listed below have been distilled following engagement with patient groups and patient representatives so whilst not explicit in the contract these represent in broad terms the types of services that we expect will form the basis of discussions with practices;

- Ability to attend a pre-bookable appointment (face to face)
- Ability to book / cancel appointments
- Ability to collect/order a prescription
- Access urgent appointments / advice as clinically necessary
- Home visit (where clinically necessary)
- Ring for telephone advice
- Ability to be referred to other services where clinically urgent. (including for example suspected cancer)
- Ability to access urgent diagnostics and take action in relation to urgent results

16. Subcontracted arrangements approved by the commissioner should consider the views of local patients.

- We expect practices to consult patients (through the PPG[1]) about both the need for the closure so that they understand the context and the proposed subcontracted arrangements and commissioner approval should take account of their views.
- Patients should know in advance of the closure and not arrive at the practice to find it closed.
- During core hours a patient needs to be able to speak to a receptionist or clinician over the phone not given an answering machine message i.e. either at the sub contracted practice or the patients responsible practice.
- Patients should not have to redial another number as this could cause a delay which might jeopardise patient safety
- If telephone calls are diverted to a sub-contractor the responder should treat these patients as they would their own registered patients.
- The sub-contractor must be able to have access to the patient's clinical record (not just the summary care record) again in the interests of patient safety.
- Where practices close for training purposes, these dates should alternate so it is not the same day each time.
- Any alternative service should be local or easily accessible by public transport so that there is no need for excessive travel on the part of the patient (and/or their carer). This especially important for elderly or fragile patients

17. Commissioners will need to be assured that there is no duplication of payments for example provision of 7 day access. All subcontracted arrangements must be resourced by the practice(s) wishing to sub-contract essential services during core hours.

[1] Commissioners should make sure that the PPG has reasonable representation of the patient population, or, if not, should engage with patients of the practice through a different medium to gain an understanding of the support or concerns of the patient population

18. Evaluation of local arrangements where subcontracting of core services is a key feature should include:

- Patient feedback (Family & friends test / GP Patient Survey / patient complaints)
- Triangulation with other activity data e.g A&E / admission activity etc).

Extended Hours:

19. The commissioning of extended hours is governed by a directed enhanced service (DES), details of which can be found here.

20. These are **additional** hours (average 3 hours per practice) usually provided during the week or on a Saturday morning, as distinct from any other CCG funded access initiative.

21. The intention behind the DES is to pay additional funds to practices for providing additional hours of service i.e. additional to core hours. Therefore the policy intention is to only pay practices the DES funding on that basis.

22. Following negotiations with the GPC an amendment has been made to the extended hours DES directions such that as of the 1st October 2017, a practice can only qualify for the DES if;

- The contractor's practice is not closed for half a day on a weekly basis unless by written prior agreement of the board and
- Requirement that patients must be able to access essential services during core hours from the contractors practice or from any person who is sub-contracted during core hours

23. In responding to the DES changes, some practices (supported by CCGs) have established a sub contractual arrangement using local providers similarly to the sub contracted arrangements that have been established to meet the core hour's requirement. Whilst these arrangements support the principles of 'at scale' working, they do not reflect the policy intention which underpinned the negotiations regarding the Extended Hours DES.

24. Whilst the revised directions give a degree of flexibility i.e. 'with prior agreement of the board,'; use of this flexibility is considered highly exceptional requiring commissioner (NHS England or delegated CCG COO) plus NHS England regional director support and finally sign off by the National Director.

25. Any subcontracted arrangements should also ensure that the overall appointment capacity delivered by the sub-contracted arrangements increases patients' ability to seek advice or appointments to see a clinician across those practices involved (in the host provider and also sub-contractor), with in addition, where commissioned, extended access capacity being maintained as well.

Required Commissioner Action:

26. Commissioners should first consider the 16/17 GP contract electronic declaration (e-dec), the bi-annual access collection and any local intelligence in identifying those practices that are closed routinely during core hours. [NB e-dec data from 17/18 should be available by end December 2017]

27. Commissioners will be expected to prioritise conversations with those practices that are closed for the longest periods with a particular focus on;

- Those practices that are intending to remain closed for half a day weekly and who continue to claim DES funding (see para 24 on process to be adopted for approval). Commissioners will be expected to reclaim any DES related funding post 1st October 2017
- Those that plan to surrender the extended hours DES funding and continue to close for half a day weekly as this would result in both reduced access and a poorer service for those patients.
- Those practices with ½ day closing arrangements whose GPPS data is a negative outlier in terms of accessibility against the CCG average
- Those practices that declare a period of closure where a significantly higher number of patients attend A&E compared to a CCG average suggesting the patients' needs are not truly being met.

28. Practices should be given the opportunity to substantiate with evidence that they are meeting their reasonable needs during a routine closure and this should include how they have engaged patients and worked with their PPG to properly consider the impact of any sub contracted arrangement, in particular on the elderly, less mobile or patients with protected characteristics.

29. Commissioners are asked to form a judgment on the 'test' of meeting reasonable need using as a guide;

- The services describe in sections 15 and 16
- The evidence provided by the practice including patient views and opinions
- The impact on the rest of the health system e.g. the contribution of a practice closure may be having on secondary or community care provision

30. Commissioners should also consider what benefits will be realised by choosing a subcontracted model over being open during the full core hours period

31. Where a CCG has full delegated powers, all practices operating a subcontracting arrangement to allow closure during core hours, should be approved by the Primary Care Commissioning Committee.

32. The change to some historical arrangements will take time to effect and commissioners should consider the support that practices may require in addressing the new requirements including agreeing an appropriate pace of any change e.g. appropriate alternative arrangements negotiated or an amendment to terms and conditions of employed staff. It is expected however that the necessary arrangements will be put in place by April 2018

Contractual Measures/Next Steps:

33. After assessment of the arrangements in place during core hours has been completed and where there is a dispute between the commissioner and the practice either on the services available or the subcontracted arrangements in place/proposed then commissioners may need to consider contractual action

34. Practices who decide to withdraw from the extended hours DES and therefore the provision of extended hours, should be reminded of their responsibilities to inform patients and ensure sufficient notice/minimum disruption

35. For practices that are found to be in breach of contract, remedial notices will be required to agree a reasonable and proportionate pace of change and ongoing dialogue between the commissioner/practice on progress

36. Failure to respond would result in a Breach notice

Reporting:

37. Commissioners will be required to report progress on this requirement via the Primary Care Activity Report between November 2017 and April 2018 including what if any contractual action has been taken