

**BMA**

# Safe working in general practice

One approach to controlling workload and dealing with  
the resulting overspill through a locality hub model



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## Introduction

General practice is in crisis, with a marked increase in workload at a time of underinvestment and a shortage of GPs. Demand will continue to grow due to an aging population and it is essential that GPs are able to protect themselves and their patients from excessive workload and the impact it has on patient safety and quality of care.

The BMA's GPC (General Practitioners Committee) first discussed a *Campaign for Safe Working in General Practice* in February 2016. Its report, *Responsive, safe and sustainable: our urgent prescription for general practice*, published in April 2016, was an attempt by the profession's representatives to quantify the needs of the service both operationally and strategically.<sup>1</sup>

Since then the NHS in England has produced the *GP Forward View* (April 2016)<sup>2</sup> and the King's Fund has published *Understanding pressures in General Practice* (May 2016).<sup>3</sup> Both papers clearly identify workload as one of the major causes of the current crisis within general practice and recognise the need for solutions.

The GP Forward View has committed to developing locality hubs (also referred to as primary care access hubs) throughout the country in order to provide additional clinical capacity.

GPC believes that the primary purpose of the hubs should be to provide sustainable support for GPs within practices to work safely; however, as the hubs develop they would likely serve a range of other useful functions, providing a foundation for new models of care in the community and offering clear benefits for patients.

This paper has been produced to stimulate discussion, proposing a model that could be used by localities across the UK, altered and adapted to suit local conditions. It is not intended to be a complete solution to the crisis in general practice, but is a pragmatic approach to the unsustainable increase in workload. Available evidence is used to present one method for quantifying safe working levels. The paper then describes the locality hub model in more detail, outlining the concept in the context of current service pressures and policy priorities. It also raises a variety of operational considerations and highlights a small number of case studies where a hub model is already being trialled.

## Working limits for general practice

Discussions with stakeholders about actually setting limits to working days reveal a paucity of hard evidence and a hesitation particularly among GPs to tackle the problem. This reluctance comes from a fear of management control and a long-standing view that professionalism will be undermined by any central limitation of workload, even if this originates from the profession itself. These are genuinely held views and any attempt to alter GPs' working lives needs to take them into account, with wide-ranging engagement and clear clinical leadership.

The RCGP (Royal College of General Practitioners) document *Patient safety implications of general practice workload* (July 2015) correctly identified the problem, but stated that 'there is no concept of "full" in the general practice setting'.<sup>4</sup>

The current recruitment and retention issues are an opportunity for the profession to re-visit this accepted truth. Initial conversations with NHS England, commissioners and patient representatives suggest a clear recognition of the workload crisis and the need to apply a pragmatic solution that could enable a safer and more patient sensitive approach to the management of workload.

### Quantifying safe working

Quantifying safe working is complex and determining appropriate limits on workload will depend on the unique circumstances of each practice. It will need to take into account list size, patient mix and complexity and workforce among other factors. However, it is clear that rethinking how clinical consultations are managed is a necessary step in controlling GP workload.

### Lengthening appointment times

The immediate introduction of 15 minute appointments would allow improved decision making and case management, and should reduce the administrative burden outside clinic times by facilitating more activity within the appointment. As patients increasingly present with more complex conditions, longer consultation times are necessary to ensure safe and high quality patient care. Clearly clinics, patients and doctors vary in their needs and expectations, and the use of telephone triage further adds to potential variables. But, this proposal does fit with minimum expectations of the system, and therefore comes closer to defining what is actually expected from the contract with the NHS.

### Reducing the number of clinical contacts per week

It is unreasonable to expect that practices currently have the capacity to lengthen appointment times to safely care for an increasingly complex patient mix and maintain the same levels of clinical contacts per week. Practices will therefore need to look at how they can limit the number of available consultations. The thought process outlined below should provide a useful guide to limiting clinical contacts, based on known accepted parameters.<sup>i</sup>

- Minimum appointments required per week = 72/1000 patients (NHSE via McKinsey, but widely accepted)<sup>5</sup>
- Average list size per GP = 1600 approx. (2014 NHS/HSCIC figures)  
Therefore required appointments per GP per week = 115
- 115 appointments at 15 minutes each = 28.75 hours
- 115 appointments over 9 sessions is 13 face to face per session
- 13 appointments at 15 minutes each gives a clinic session of 3.2 hours. (BMA contract suggests 9 sessions of 3.5 hours)

There is an argument that 115 appointments per week should be considered to be the quantified commissioned activity of an NHS GP.<sup>ii</sup> This figure also brings the daily face to face total down to below 25, which has been proposed as a sustainable level of activity when looking at European comparators (BJGP Jan 2016).<sup>6</sup>

Clearly the above only refers to direct patient contact and does not take into account additional activities undertaken during the day, such as dealing with test results, letters, referrals and other administration, audits, practice development, travelling to home visits etc.

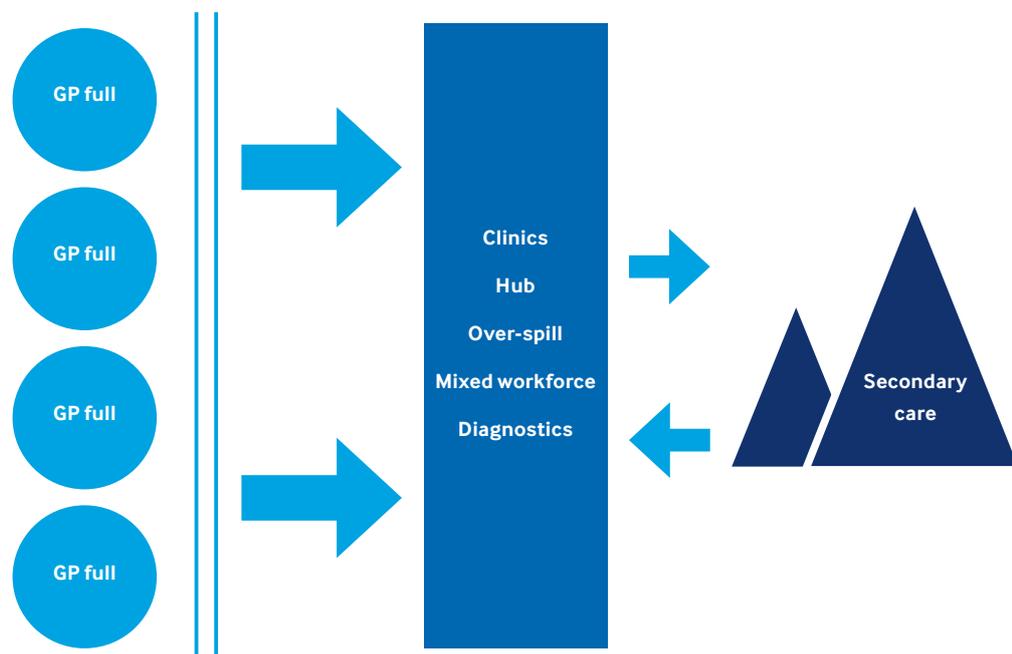
i Please note that nurse appointments have not been taken into account in this paper, but it is anticipated that within a safe working environment practices will have considerable leeway to plan how they address patient needs.

ii While the numbers used in the worked example are derived from English data, the method could be followed with equivalent data from Scotland, Northern Ireland and Wales.

## Commissioning

A quantified level of activity could be commissioned as part of a more integrated primary care environment. The GP Forward View quotes *Making time in general practice* (October 2015), published by the NHS Alliance and Primary Care Foundation, in which it was estimated that 27% of GP appointments could be avoided through greater integration, use of a wider primary care team and improved administration.<sup>7</sup>

If the NHS commissioned an integrated service from practices, with a modest 20% reduction in GP activity, both patients and clinicians might improve their demand management and focus more accurately on actual clinical need. The excess demand could then be separately commissioned from practices working together – one method for doing this is a locality hub model as described later in this paper. The diagram below illustrates the proposed commissioning change.



Limiting workload to within safe limits makes sense for patients and greatly increases the chance of retaining and recruiting GPs by reducing the likelihood of stress and burnout.

The commissioned work of an NHS practice could be quantified using, among other variables including non-clinical workload, the figures above. This means that the GMS/PMS contract would be quantified in terms of the number of appointments offered. Clearly this could be translated by practices into allocations of face to face or telephone time, but the important point is that for the first time practices would be actively encouraged to limit their clinical work to within safe parameters.

This can be a difficult concept for GPs who have for generations seen themselves as proudly picking up patients' every issue and acting as their advocates within the NHS. This proposal does not threaten these two principles, but the idea that GPs can continue to manage any number of increasingly complex clinical situations is outdated and unsafe. Limiting workload to within safe limits makes sense for patients and greatly increases the chance of retaining and recruiting GPs by reducing the likelihood of stress and burnout.

Commissioning an integrated system will be necessary in areas where the demand on general practice outstrips capacity. The provider of the overflow service should ideally be a practice or GP owned company or super-practice, but funding must come from the commissioner (channelled through practices) and not from existing practice income. The system can only operate if practices are freed to operate at a safe level within the resources available.

The GP Forward View commits to providing additional capacity for appointments within core and extended hours. It promotes the model of practices working collectively at scale to extend access and it proposes to support CCGs in commissioning additional capacity via hubs, building on lessons learned from the Prime Minister's GP Access Scheme.

The locality hub model as proposed in this paper offers a GP-led overflow model that CCGs could commission from practices as part of an integrated system which supports safe working.

### Essex CCG moves to reduce workload

One Essex CCG is currently working on precisely the model outlined in this paper.

The figures below are taken from an activity return completed by practices in a single week in the CCG towards the end of 2015. The initial numbers are therefore actual, and the proposed changes to the system are based on moving or managing such an actual workload.

– Registered Population	155,425
– Total GP Appointments offered	11293
– Total GPs (WTE)	80.95
– Appointments per GP per week	139.5

If the CCG were to commission an integrated service such as the locality hub described in this paper, one could make the assumption that 20% of this activity should move to the hub to be dealt with by a wider team and properly organised triage.

**This would reduce the appointments per GP to 111.6, a figure remarkably close to the number of appointments in a quantified GMS contract as described earlier in this paper.**

## The concept of locality hubs

The sole initial purpose of locality hubs is the stabilisation and sustainability of general practice.

The sole initial purpose of locality hubs is the stabilisation and sustainability of general practice. Hubs are not walk-in centres: each hub would help manage demand across a number of practices and their respective patient lists, ensuring that patients in excess of safe working limits can still be seen by a GP or the wider primary care health team.

However, to gain traction and make a significant difference, the wider benefits of the model will also need to be articulated to commissioners, patients and clinicians.

In addition to supporting safe working, hubs would enable GP practices to achieve benefits from working collaboratively at scale. These benefits could include: workforce development; flexible employment patterns and paths, which would support recruitment and retention; opportunities for wider service provision across a range of healthcare professionals; and improved access for patients.

The model described here could be used by localities across the UK, altered and adapted to suit local structures, geography and patient needs.

In line with the vision behind MCPs (multi-speciality providers), well-developed models would help integrate primary and community services and could help to reduce pressure on emergency departments and referrals to secondary care. The model described here could be used by localities across the UK, altered and adapted to suit local structures, geography and patient needs.

### Funding

In England, the GP Forward View commits to the commissioning and funding of services to provide extra primary care capacity across the country, backed by over £500 million of recurrent funding by 2020/21. It also commits to a £171 million one-off investment by CCGs from 2017/18 for practice transformational support. Recurrent funding is essential if hubs are to establish a permanent workforce and provide sustainable support. Funding is also available to localities through the national Sustainability and Transformation Fund, which will prioritise initiatives such as the spread of new care models and improving primary care access and infrastructure.

Centred on the support of local practices, hubs will form an integral part of a new model of primary care, and resources must therefore be channelled through individual practices. This could take the form of a "locality payment", which, with the agreement of commissioners, would be paid to practices, but available only for the purposes of running the locality hub.

### Scale

Hubs could operate across different numbers of GP practices and their associated patient lists. The size of care community will depend on local demand, structures and geography, but hubs are more likely to develop within existing collaborative or partnership boundaries.

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The case studies in this paper illustrate five different hub models that are already being trialled in Oxfordshire, Lambeth, Gosport, the New Forest and Southwark. All of the GP practices involved in these hubs were already working together in an alliance or federation before their hub was established. At present, the hubs individually cover anything from between 39,000 and 152,000 patients, or four and 22 GP practices. The hubs in Gosport and the New Forest are both standalone, and although they both fall within the broader Hampshire MCP vanguard, each locality is semi-autonomous. The other three examples are networks of between two and six hubs. As the model in Gosport demonstrates (currently four practices covering 39,000 patients), a small number of practices could pilot a hub, with the intention of then opening it out to other practices in their federation or locality. Alternatively, the hub could launch at scale.

The case studies cover both rural and urban locations. They suggest that if hubs are in central, accessible locations and the model is implemented flexibly (for example, making allowances for patients who have transport issues), it can be successful across differing local geographies. However, as highlighted by the pilot in Oxfordshire, further research is needed into the potential for differing levels of service take-up. It may not be appropriate to establish

a hub in very remote areas, although localities could still consider using and adapting elements of the model according to local needs.

### Opening hours

In order to manage demand and support GP practices to work safely, hubs will need to be open during core hours. Given the drive for extended access, it is likely that hubs would also offer evening and some weekend appointments. Feedback from current sites suggests patients particularly value the ability to access appointments during the evening; offering these through hubs should ensure that individual practices do not all need to open during the evening.

While the GP Forward View states that the level of capacity required on different days of the week will be up to local commissioners and schemes to determine in light of patient demand in their area and to ensure best value for money, the drive for extended access is likely to continue. Indeed, there will be some minimum access requirements, which will be published later this year and tested with current Prime Minister's GP Access Fund sites.

While there is also a clear ambition to increase integration between different urgent care services, the service offered by locality hubs would be distinguishable from OOH (out of hours) services and NHS 111. It should be for local areas to decide how this integration is enabled and what (if any) level of OOH service hubs will provide.

Hubs are not walk-in centres: each hub would help manage demand across a number of practices and their respective patient lists.

### Appointments

Hubs need to be able to offer same day urgent appointments if they are to ensure that patients in excess of safe working limits can still be seen by a GP or the wider primary care health team. However, hubs are not walk-in centres: each hub would help manage demand across a number of practices and their respective patient lists.

Hubs could only offer urgent appointments, and they could offer them at any time, or only when practices have reached working limits. Alternatively, hubs could offer a combination that included some pre-bookable or routine appointments, as long as sufficient capacity was protected to support practices that reach working limits.

Peer pressure between practices should allow minimum levels of both quantity and quality of care across the locality. If necessary, safeguards could be put in place to ensure that practices do not manipulate the booking of appointments; however, the introduction of central management is likely to prevent practices from entering the system and would therefore be self-defeating.

Localities will need to decide how they wish to balance urgent and ongoing care needs between practices and the hub. For example, it might be appropriate for patients with long term conditions to receive ongoing care from well-developed hubs, due to the wide range of healthcare professionals that would be based there; however, localities may decide that the continuity of care that local practices can offer is of greater benefit to these patients. In a less-developed hub model it is likely that localities will try to ensure that patients with more complex care needs are managed by their own practice. This is a decision which each practice and its partners will need to make based on its circumstances. Nevertheless, it is important to avoid a "two-tier" system of care emerging and ensure that there is clear communication and engagement with patients in advance of any changes.

The hubs in the case studies mainly offer urgent appointments: Oxfordshire and Gosport only offer same-day appointments, whereas the others also offer a small number of pre-bookable appointments, particularly for routine nurse-led services or for evening or weekend GP appointments. As with opening hours, the GP Forward View states that while the balance of pre-bookable and same day appointments will be determined at a local level, some minimum requirements will be published later this year.

An integrated system, with a reduction in available appointments at each practice, should begin to reduce DNAs (did not attend), particularly if PPGs (patient participation groups) are closely involved in implementation. Appointments would start to have increased value

merely by becoming less available, although this must be combined with continued efforts to support self-care and patient education.

## IT

Hubs will need to be able to access (and edit) patients' full medical records (with their consent) and may need to operate shared triage processes. Appropriate IT systems will be needed across practices and hubs to facilitate collaboration: there are numerous examples of this working successfully, not just in the locality hubs already in operation, but in the many extended access hubs established through the Prime Minister's GP Access Fund.

## Triage

There is mixed evidence as to the clinical and cost effectiveness of GP or nurse-led telephone triage for appointments within individual practices.<sup>8</sup> However, it is likely that GP practices working in partnership to provide a hub service would work together to provide a co-ordinated, consistent and efficient triage process. Practices will need to agree how to operate the process for hubs in their locality. For example, would there be a centralised triage system operating from the hub, or would individual practices or small clusters carry out triage locally? And who would be carrying it out? The proper selection and training of triage clinicians should lead to a more consistent and effective system.

Formal evaluation of triage processes in the hubs currently operating has not yet been completed, but it will be important for localities to share best practice as it develops. As hubs become more widespread a national training system would help ensure co-ordination and appropriate quality standards. This is particularly important, as there appears to be a wide range of experiences from triage, and this may be due to a lack of co-ordination in selecting and training key personnel.

## Workforce and services

To support practices that reach working limits, hubs must, as a minimum, offer GP appointments. The size of the GP workforce needed in each hub would obviously depend on the level of demand across the locality relative to practices' capacity. If the service also offered pre-bookable appointments, then there would need to be sufficient capacity in the workforce to cover this.

If they are to provide the necessary additional capacity and reduce demand on GPs' time, hubs must make use of the wider healthcare workforce.

While recruitment to general practice is challenging, hubs offer an opportunity for workforce development and more flexible or diverse career paths. For example, GPs might be attracted by the opportunity to undertake triage, to work in a multi-disciplinary environment, or to focus on urgent care without responsibility for patients' ongoing management. GPs could choose to work solely in the hub, or both partners and sessional GPs could choose to split their time between the hub and their local practice. Creating new, flexible career options can only help with workforce retention and may even encourage GPs to return to practice. If the hub was large enough it would also be able to attract and develop trainees.

Still, localities should seek to minimise the number of GPs needed to work in hubs. If they are to provide the necessary additional capacity and reduce demand on GPs' time, hubs must make use of the wider healthcare workforce. The simplest locality hub model should include practice nurses or ANPs (advanced nurse practitioners) working alongside GPs. A more developed model could offer a wide range of services. Working at scale to provide this range will help manage demand more effectively across the locality and offer the most value to patients, clinicians and commissioners. Some healthcare professionals would be able to offer routine services on behalf of all local practices; others may be able to address urgent care needs. Some may be able to support both aspects. The case studies in this paper highlight some of the possibilities that are already used, planned, or being considered. For example, Southwark offers GP and ANP appointments, whereas Gosport also offers ECP (emergency care practitioner), paediatric and physiotherapy appointments.

An indicative list of roles that could be based in a hub might include: physiotherapists; health care assistants; physician associates; pharmacists; mental health practitioners; specialist nurses (such as emergency, paediatric or respiratory); paramedics; and radiographers.

As at the practice level, different workforce models will work well in different areas, depending on local demand and structures. In general, the recommendation from the Primary Care Workforce Commission's recent report should apply equally to hubs: a particular staffing model or ratio (for example GP or practice nurse per head of population) should not be specified.<sup>9</sup> However, some national targets, such as the ambition in the GP Forward view to fund enough clinical pharmacists to provide one per 30,000 patients, may influence decisions in localities. It will be important for existing hubs to share their experiences of workforce needs as they begin to expand the range of services that they offer.

## Principles

Locality hubs offer a GP-led model that could be commissioned to help manage demand and support GPs to practice safely. Based on the above considerations, and the experience in the case studies, the following principles should inform the development and implementation of the hubs:

- **Sufficient recurrent funding:** Recurrent funding channelled through practices, which provides sufficient additional capacity, is essential if hubs are to provide sustainable support.
- **Flexibility in the model according to local need:** The model should be developed and adapted according to local patient need, structures and geography.
- **Core opening hours:** Hubs must be open during core hours to effectively manage workload across practices and, taking into account local demand, could also offer extended access.
- **Co-ordinated triage:** Practices will need to agree locally how to work together to provide a co-ordinated and consistent triage process, learning from service evaluations and emerging good practice.
- **A range of services:** Hubs should make use of the wider healthcare workforce to provide the necessary additional capacity and reduce demand on GPs.
- **Collaboration supported by IT systems:** Appropriate IT systems must be put in place to enable the full sharing of medical records. Localities should be supported in learning from the numerous examples across the country where this already works successfully.

# Case studies

The case studies in this paper provide an overview of five different models that are already being trialled. Not all of the hubs were designed to provide an “overflow” function. Some seek to absorb demand for urgent same day appointments across core and extended opening hours. Others also offer some pre-bookable appointments, often utilising a wider primary care workforce. If working limits were to be introduced, localities could choose, with appropriate support, to incorporate the “overflow” function into their service, as they share many of the principles of a locality hub model.

It should also be noted that the hubs in the case studies are all at varying stages of development, so do not illustrate the end-point of potential development. Expansion plans include increasing the opening hours, number of practices covered and the range and number of healthcare professionals.

# Oxfordshire

## Neighbourhood Access Hubs

### Scale

There are six hubs currently being piloted by the PML (Principal Medical Ltd) GP Federation, which contains 35 practices from across Oxfordshire, covering a population of 350,000. Each hub therefore covers approximately 58,000 patients from five or six practices.

### Funding

The scheme is funded through the second wave of the Prime Minister's Access Fund, as part of a larger £4.9m bid from federations throughout Oxfordshire.

### Operation

Appointments are only available to patients via their GP practice. The majority of hubs are open 9am-6pm although there is early evening provision in some areas. The hubs are reserved for same day urgent appointments and are designed to provide an overflow facility, releasing capacity for practices to offer more routine appointments and give more time to patients with complex conditions. Hubs have full access to patients' medical records through EMIS.

### Triage

Practices operate their triage individually, although they are working towards some locally agreed standards. The effectiveness of referrals and triage across the practices will form part of an evaluation of the hub. Patients can still choose to go to their practice rather than the hub, particularly if they have transport issues.

### Services

All of the hubs offer GP appointments and some also offer ANP (advanced nurse practitioner) appointments. At any given time, each hub is staffed by one or two (occasionally three) GPs, and in some areas one ANP.

There is a mixture of employment patterns: some GPs are salaried, some are locums and some are GP partners from the locality.

Similarly, some ANPs are salaried whereas some are agency staff. ANP recruitment has been particularly challenging, and has limited the number of hubs able to offer ANP appointments.

### Evaluation and future development

The hubs opened in autumn 2015 and a formal evaluation is underway, but feedback from patients has been very positive and the service has been well used by almost all practices. Some geographical differences have been noticed, with lower usage in the most rural areas. This too will be analysed in more detail within the evaluation. It is expected that further funding will be found to continue the scheme after the existing funding runs out in summer 2016, although there are currently no plans to extend the range of services.

# Lambeth

## GP Access Hubs

### Scale

There are four hubs currently being piloted by the Lambeth GP Federations, which contain 47 practices from across the three federations in Lambeth, covering a population of 378,000. Each hub therefore covers approximately 94,500 patients, or nine or ten practices.

### Funding

The scheme was awarded £3.5m from the second wave of the Prime Minister's Access Fund and Lambeth CCG committed a further £1.5m.

### Operation

Appointments are only available to patients via their GP practice or the OOH provider. The hubs are open 8am-8pm Monday to Friday and 10am-6pm weekends and bank holidays. Patients are referred to a hub of their choice if there are no appointments available at their practice within 48 hours, or if they cannot attend during their practice's usual opening times. All 47 practices use EMIS and hubs have full access to patients' medical records.

### Triage

Practices operate their triage individually. The OOH service also operates a clinical triage process and can arrange appointments at the hub.

### Services

The hubs offer GP, nurse and telephone consultations. GPs in the hubs all practice locally.

### Evaluation and future development

The hubs opened in autumn 2015 and following an extension of funding, an evaluation is due to be undertaken.

# Gosport GP Same Day Access

## Scale

A hub is currently being piloted by four GP practices covering 39,000 patients within the FGSEH (Fareham, Gosport, and South East Hampshire) Primary Care Alliance.

## Funding

The FGSEH Primary Care Alliance is part of the Better Local Care MCP vanguard in Hampshire and the hub is being funded through the vanguard programme.

## Operation

Appointments are only available to patients via their GP practice. The hub is open 8am-7pm Monday to Friday. The hub provides same day phone triage and face-to-face appointments. It is based at the Gosport War Memorial Hospital, which was chosen for its central location. There have been some concerns regarding parking, given its location in a hospital. Patients who cannot travel will still be seen at home or at their local practice. All practices in Gosport use EMIS and the hub has full access to patients' medical records.

## Triage

Patients seeking a same day appointment ring their own practice where the receptionist will take initial details. Patients are then called back through a centralised triage process in order of clinical priority, as determined by the triaging clinician. If the telephone consultation cannot address the patient's concern, an appointment at the hub will be offered with a GP or appropriate healthcare professional.

## Services

The hub offers GP, ANP, ECP (emergency care practitioner), paediatric and physiotherapy appointments. Staff are provided by the four participating practices.

## Evaluation and future development

The hub launched at the beginning of 2016; monitoring is ongoing and if the pilot is found to be successful it is expected that some or all of the other seven practices in Gosport will join the service.

In the first six weeks, 5,500 patients were referred to the service: 61% had their needs met on the telephone and the remaining 39% attended a face-to-face appointment. Of these patients, approximately 40% saw a GP, 40% a nurse, 10% a paediatric nurse and 10% a physiotherapist.

Other healthcare professionals, such as pharmacists, may be added in the future and given the co-location with other NHS community providers based at the hospital, there is the potential to increase integration across a range of services.

# New Forest The Practice

## Scale

A Primary Care Access Centre, known as The Practice, has been set up by the seven GP Practices in South West New Forest working in partnership, covering 70,000 patients.

## Funding

The hub has received £0.8m through the second wave of the Prime Minister's Access Fund. South West New Forest is also one of three localities in the Better Local Care MCP vanguard in Hampshire. Funding from this has helped establish local structures and cover some clinical and managerial time.

## Operation

Appointments are available to patients via their GP practice, or from The Practice directly when it is open but their local practice is closed. It is open 8am-8pm, seven days a week and provides a mixture of same day and pre-bookable appointments. It is based at Lymington Hospital, but patients are encouraged to view it simply as an extension of their own practice. It has full access to patients' medical records and shares a VoIP (voice over internet protocol) phone system with local practices so calls can be transferred across sites.

## Triage

During normal hours patients ring their own practice; the receptionist will direct them to the Practice if appropriate. Patients can ask specifically for an evening or weekend appointment at The Practice.

## Services

The Practice offers GP and nurse appointments; there is one GP working at any one time. There is a mixture of employment patterns among those GP working sessions: some are partners in local practices, some are partners from outside of the immediate locality and some are sessional GPs, including recently qualified and partially retired.

## Evaluation and future development

The Practice opened in September 2015 and has received excellent feedback from patients via the Friends and Family Test, an NHS feedback tool. The lack of recurrent funding has posed challenges and has prevented a permanent, expanded workforce from being established. However, following a successful trial at one local practice, four MSK (musculoskeletal) practitioner sessions will be added to The Practice each week. Plans for a pharmacist will be considered later in the year, as will closer integration with the existing nurse-led minor injury unit that is located on the same site. Integration with the OOH service could also be explored.

With recurrent funding the service would likely be expanded to a minimum of two GPs per session, and additional clinical staff, such as a mental health worker, could be employed. The Practice could also offer other services on behalf of local practices, such as travel clinics, childhood immunisations and wound care.

# Southwark

## Extended Primary Care Access Hubs

### Scale

Southwark operates an Extended Primary Care Service from two hubs, one for each of the two GP Federations in Southwark that together cover 44 practices and 305,000 patients. Each hub therefore covers approximately 152,500 patients, or 22 practices.

### Funding

The two GP Federations together received £0.975m from the first wave of the Prime Minister's Access Fund to support infrastructure, GP engagement and set-up. Southwark CCG invests £2.1m to fund recurrent service costs.

### Operation

Appointments are available to patients via their GP practice or the OOH provider. The hubs are open 8am-8pm, seven days a week. They offer appointments for same day, urgent care needs, although one of the hubs also offers some appointments for routine tests, dressings and contraception. The service seeks to enable patients with more complex needs that are better managed by their own GP to be seen in their local practice. Patients are referred to the hubs if there are no appointments available at their practice, or if it is outside of their practice's opening times. EMIS is used across the locality to ensure both hubs have full access to patients' medical records.

### Triage

Practices operate their own clinical triage where a nurse or GP will offer telephone advice and arrange for a face-to-face appointment if appropriate. The OOH service also operates a clinical triage process and can arrange appointments at the hubs.

### Services

The hubs offer GP and ANP appointments.

### Evaluation and future development

The first clinic launched in November 2014, the second in April 2015, and from April 2015 to January 2016, a total of 36,294 additional appointments were offered through the service. Formal evaluation has not yet been concluded but there plans to expand the service during 2016 to deliver broader primary care services, routine appointments at weekends (including blood pressure management, dressings and cervical screening) and central provision of a telephone management of patients system. Access to GP appointments in Southwark has been a consistent problem in recent years and feedback suggests patients have valued the additional capacity.

## References

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