

**SPECIFICATION FOR A NORTHERN IRELAND DIRECTED  
ENHANCED SERVICE IN:  
ACCESS TO PRIMARY CARE SCHEME 2006/07**

**Introduction**

1. It is the Department's continuing priority for Northern Ireland to improve patient access to primary medical care. These improvements will mainly be delivered in and by general practice.
2. Boards will have a duty in 2006/07 to work with local practices (and other providers) to develop and implement plans to secure improvements in access. This DES therefore focuses on four key dimensions of access for patients:
  - (a) Opportunity of a consultation with a GP or appropriate primary care professional
    - i. for patients with a acute condition, including exacerbation of an existing chronic condition within 24 hours for clinical advice or treatment, where this is requested;
    - ii. For all other patients, within 48 hours for clinical advice or treatment, where this is requested;
  - (b) Opportunity to book appointments in advance of 24 hours
  - (c) Ease of telephone access
  - (d) Opportunity to be seen by a preferred GP (without a timeframe)
3. This specification is for 2006/07. The DES itself will be later reviewed for 2007/08. The investment for 2006/07 will be the total of the value of 50 points associated with access that is in the Quality and Outcomes Framework 2005/06 and the value of the 2005/06 Access DES. This equates to approximately £4 million for Northern Ireland.
4. The incentive payments, which will be weighted by the patient population of each participating practice against the Northern Ireland average practice population, are for 2006/07 and will comprise two components:
  - **Component 1:** This will represent one half of the total investment available which will be awarded to practices in response to a written commitment from the practice to work towards delivery of all the access areas referred to in paragraph 2 above.
  - **Component 2:** The remainder paid at the end of the year triggered by the results of the monitoring exercise to measure the performance of the contractor in all of the four key areas. This will represent half of the total investment available.

### **Board payments to practices**

5. Boards will have a duty in 2006/07 in respect of this DES to make an aspirational payment (component 1) to participating practices at the beginning of the year and another (component 2) at the end of the year providing that the results of the monitoring exercise reveal that performance falls within the thresholds specified below.
6. From 2007 onwards, it is likely that there will be a continuing emphasis on improved access to general practice. However, this current DES will be reviewed in the light of experience and developing policies.

### **Measurement**

- The introduction of the DES will be accompanied by a local press campaign by the Boards which will inform all patients of the service which should be offered in relation to each of the four key areas and advise them of their right to make representations to the Board where they are dissatisfied with the level of service actually provided. This campaign may, at a Board's discretion, be repeated on further occasions during the year. It will also be a requirement for participation in the DES that a notice (to be provided by Boards) shall be placed in a prominent position in all the premises used by the contractor clearly outlining to patients their DES Access rights under the new contract and setting out the process to be followed if a patient is dissatisfied. The content of such press campaigns and the content of notices to be displayed in practices should be negotiated with the appropriate LMC with a view to agreeing the content and discussed with bodies which are representing patient interests.
- Each expression of dissatisfaction from patients in relation to these four elements of the Access DES will be considered by the Board to determine whether or not the access service offered by the contractor in each case falls within what was expected of it under this specification. The consideration should be undertaken outside of the formal complaints procedure, liaising as appropriate with the patient and the practice and discussions with the contractor should include what measures might be put in place to prevent a reoccurrence of the circumstances leading to the patient's dissatisfaction and should take account of any exceptional circumstances prevailing in the practice at that time. The contractor and the patient will be notified of the outcome of each investigation by the Board.
- The level of patient satisfaction under each of the four key elements will be measured by the number of **substantiated** episodes recorded against the contractor over the year. "Substantiated" episodes are those where, following considerations described in paragraph 8, the view of the Board is that the level of access provided by the contractor on that occasion has not been to the standard required.

## **Validation and Payment**

10. Payment of Component 2 will be made according to practice achievement based on the number of substantiated representations per 500 patients in the practice population as set out below.

**No payment:** more than 10 substantiated representations per 500 patients per annum;

**Lower:  
(50%)** at least 7 but less than 10 substantiated representations per 500 patients per annum;

**Middle:  
(75%)** at least 5 but less than 7 substantiated representations per 500 patients per annum;

**Full:  
(100%)** Less than 5 substantiated representations per 500 patients per annum.

## **Amount of payments**

11. The amount of payment per practice for each of the components referred to in paragraph 4 is as follows:

<b>ASPIRATION PAYMENT (Component 1)</b>	<b>ACHIEVEMENT PAYMENT (Component 2)</b>		
	<b>Lower</b>	<b>Middle</b>	<b>Full</b>
<b>£5,460</b>	<b>£2,730</b>	<b>£4,100</b>	<b>£5,465</b>

## **Weighting payments**

12. The payments for each practice in respect of both components in the table in paragraph 10 are to be weighted by a ratio of the practice population against the average Northern Ireland practice population (4937 at January 2006)

## **Definitions**

13. The following definitions of terms used in the target provide a fuller explanation:
- (a) **Patients with a chronic condition** – these are patients in one of the clinical domains in the Quality and Outcomes Framework with effect from April 2006, namely, Coronary Heart Disease, Stroke and Transient Ischaemic Attacks, Hypertension, Diabetes, Chronic Obstructive Pulmonary Disease, Epilepsy, Hypothyroidism, Cancer, Mental Health, Asthma, Heart Failure, Palliative Care, Dementia, Depression, Chronic Kidney Disease, Atrial Fibrillation, Obesity and Learning Disabilities.
  - (b) **Patients** – Patients (including temporary patients) registered with the practice;
  - (c) **Consultation with** – Face-to-face personal contact where professional, clinical advice, diagnosis or treatment is requested. The use of alternative consultations such as telephone can be used to reduce demand for face-to-face appointments where these alternatives appropriately deliver, to the patient’s satisfaction in terms of access the necessary professional, clinical advice, diagnosis or treatment during that contact. These alternatives can be used to support delivery of the 24 hour target but should also be delivered within the target. Where such consultations result in referral to another professional the delivery of this will not be contained within the 24 hour standard;
  - (d) **Primary Care Professional** – any health or social care professional, member of the primary care team, including practice nurses, allied health care professional or other health care staff within the practice with which the patient is registered or is co-ordinated by the practice and who is competent to deal with the patient’s clinical needs;
  - (e) **Ease of telephone access** – means that where patients contact the contractor by telephone, that:
    - (i) contractor has in place a telephone system appropriate to meet the demand in respect of that practice population;
    - (ii) where there are delays in initially answering calls during times of high call volume, the practice has in place a system to inform patients within a reasonable time, about the situation; and
    - (iii) when the call is answered by a person in the practice, the patient receives clear information as to how the matter which is the subject of the call is to be dealt with.
  - (f) A GP – a general practitioner, not necessarily the preferred GP.

## **Exclusions**

14. The target definition excludes:

- (a) Situations where the patient specifies a particular individual or professional where an appropriate, alternative is available within 24 hours;
- (b) Requests for emergency or urgent treatment which should be dealt with immediately in accordance with the clinical need;
- (c) Pre-planned courses of elective treatment or care programmes where access arrangements are established in advance, for example, chronic disease management, treatment or screening programmes;
- (d) Out-of-hours coverage, that is, outside the normal working hours of the practice;
- (e) Planned closures, for example, public holidays or staff training;
- (f) Requests for non-clinical advice or input.