Paper I

WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP (WLCCG)
BOARD MEETING

14th May 2019

Title of the report:	Recommendations on the future of the West Leicestershire Clinical Commissioning Group Extended Access Scheme
Section:	Delivery
Report by:	Lindsay Widdowson, Primary Care Delivery Manager, WLCCG
Presented by:	David Muir, Head of Primary Care Redesign and Delivery WLCCG

Report supports the following West Leicestershire CCG's goal(s):			
Improve health outcomes	✓	Improve the quality of health-care services	✓
Use our resources wisely	✓		

Equality Act 2010 – positive general duties:
1. The CCG is committed to fulfil its obligations under the Equality Act 2010, and to ensure services commissioned by the CCG are non-discriminatory on the grounds of any protected characteristics. 2. The CCG will work with providers, service users and communities of interest to ensure any issues relating to equality of service within this report are identified and addressed.

Additional Paper details:	
Please state relevant Constitution provision	5.2 General Duties … 5.2.5 Assist and support NHS England in relation to the Board's duty to improve the quality of primary medical services
Please state relevant Scheme of Reservation and Delegation provision (SORD)	N/A
Please state relevant Financial Scheme of Delegation provision	N/A
Please state reason why this paper is being presented to the WLCCG Board	Board is asked to note and consider the contents of the paper and recommendations made in regard to the CCGs' provision of Extended Access to General Practice Services. The Board is also asked to recommend and delegate approval to the Procurement and Investment Committee.

Alignment with other strategies	WLCCG Operational Plan Delivery of general Practice Five Year Forward View NHS Long Terms Plan
Environmental Implications	N/A
Has this paper been discussed with members of the public and other stakeholders? If so, please provide details	No

EXECUTIVE SUMMARY

1. The recently published NHSE Long Term Plan (NHS LTP) and the associated "Investment and Evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan" (I&E) describe clinical model and contractual changes that potentially have significant implications and consequences for the way West Leicestershire CCG (WL CCG) may choose to commission and provide extended access to primary care services.

2. This paper describes the current commissioning/provision plan(s) for the WL CCG Extended Access Scheme, the key changes relating to extended access to primary care services within the NHS LTP and I&E and makes recommendations on the future of the existing scheme.

3. The paper makes reference to the changes to the Extended Hours DES in support of the recommendations made for the Extended Access Scheme. It does not intend to provide a recommendation on the future of the DES.

RECOMMENDATION:

West Leicestershire Clinical Commissioning Group is asked to:

NOTE The contents of the paper and work undertaken to develop extended access GP services for patients of West Leicestershire.

APPROVE delegation to the CCG's Procurement and Investment Committee to make a decision on the following recommendations

a. Provider plans to improve rota fulfilment.
b. Extend the pilot.

WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP
BOARD MEETING

14TH MAY 2019

Recommendations on the future of the West Leicestershire Clinical Commissioning Group Extended Access Scheme

PURPOSE OF PAPER

1. The recently published NHSE Long Term Plan (NHS LTP) and the associated "Investment and Evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan" (I&E) describe clinical model and contractual changes that potentially have significant implications and consequences for the way West Leicestershire CCG (WL CCG) may choose to commission and provide extended access to primary care services.

2. This paper describes the current commissioning/provision plan(s) for the WL CCG Extended Access Scheme, the key changes relating to extended access to primary care services within the NHS LTP and I&E and makes recommendations on the future of the existing scheme.

3. The paper makes reference to the changes to the Extended Hours DES in support of the recommendations made for the Extended Access Scheme. It does not intend to provide a recommendation on the future of the DES.

4. Board is asked to note and consider the contents of the paper and the recommendations made and to delegate to the Procurement and Investment Committee for a decision on the recommendations made.

BACKGROUND

5. The General Practice Forward View (GPFV) published in April 2016 set out plans to enable clinical commissioning groups (CCGs) to commission and fund additional capacity across England to ensure *"that, by 2020 everyone has improved access to GP services including sufficient routine appointments at evenings and weekends to meet locally determined demand, alongside effective access to out of hours and urgent care services"*.

6. The Refreshing NHS Plans for 2018/19 required all CCGs to provide extended access to general practice to their whole population by 1 October 2018; the minimum required available hours of access being an additional 30 minutes per 1,000 registered patients per week.

7. The aim of the WLCCG model is to provide the CCG registered population with additional increased capacity for routine acute but non-urgent general practice service appointments in the evenings (after 6.30pm) and on

Saturdays and Sundays[1]. Access to same day and advance (+24 hour) appointments is by bookable appointment. The WLCCG approach is centred on individuals being identified as 'appropriate' for an extended access appointment not on self-referral.

8. In 2017/18, a financial allocation was provided to WL CCG of £3.34 per head of weighted population to meet a range of criteria which would then be developed into the seven core requirements for the delivery of extended access as part of the GPFV (see Appendix 1). As per the GPFV, this allocation has risen to £6 per head of weighted population from 1st April 2019.

9. Prior to the GPFV, (and to receiving the funding therein), WL CCG commissioned a quantum of extended access through its' procurement of the Integrated Community Urgent Care Service (ICUCS) delivered from Loughborough UCC and the Hinckley and Coalville Primary Care Hubs.

10. Based on this prior provision, WL CCG agreed a phased plan to utilise the GPFV funding to offset expenditure on EA through ICUCS and develop and increase its' total EA provision in line with the 7 Core Criteria expected of EA in the GPFV.

    - 17/18 would be a 'test' year
    - 18/19 would see the test model piloted at scale (and meeting the GPFV capacity and access criteria) AND the procurement of full service
    - 19/20 – 22 would see delivery of commissioned full service AND the procurement of the basket of integrated urgent care services, (including ICUCS, Acute Home Visiting Services), and EA, all to be delivered from 1st April 2022

GOVERNANCE ARRANGEMENTS

11. The Senior Responsible Officer (SRO) is Ian Potter, WLCCG Director of Primary Care, Dr Geoff Hanlon, WLCCG Board GP is the clinical lead.

12. The Extended Access Steering Group was established April 2017 to develop the clinical model and oversee implementation and delivery of the service whilst identifying and managing conflicts of interest, reports to the Primary Care Commissioning Committee, WLCCG Board and the LLR General Practice Resilience Programme Board as required.

13. Since the contract variation with 4Fed/DHU (October 2018) the extended access scheme has been included in the monthly formal Integrated Urgent Care contract meetings with 4Fed/DHU.

[1] Individuals who require an urgent response are referred into the IUC/UEC system accordingly.

TIMELINE OF EVENTS

17/18

14. In April 2017 the Extended Access Steering group developed the clinical model. See Appendix 3 for further detail.

15. Agreed clinical model tested by the incumbent integrated community urgent care service provider (4Fed/DHU) at the Loughborough Urgent Care Centre (LUCC).

18/19

16. In September 2018 Board delegated approval of a three phase plan to Procurement and Investment Committee (PIC).

17. From October 2018 to September 2019, 4Fed/DHU were commissioned to pilot the test model at scale and provide the remaining quantum required to meet GPFV capacity and access criteria via a contract variation to the ICUCS[2].

18. The intention was to evaluate the pilot and procure an interim service operating from October 2019 to March 2022 to bridge the gap between the end of the 4Fed/DHU pilot and EA being delivered as part of a basket of integrated urgent care services from April 2022.

19/20

19. The recently published five year framework for GP contract reform (I&E) introduces significant changes in the approach to the commissioning of both the Extended Access Scheme and the Extended Hours DES.

20. The procurement of the interim service has not started due to uncertainty introduced by I&E about the future model of extended access, its relationship with the extended hours DES and the implication of funding transferring to PCNs by April 2021.

21. A full evaluation of the scheme will be carried out in 19/20 which will review the scheme against the seven core requirements for extended access as part of the GPFV (Appendix 1), provide lessons learnt and inform the full provision specification, including refinement of the clinical model, inclusion/exclusion criteria and the functional requirements of the Provider.

THE JOURNEY SO FAR

Current provision

[2]A Contract variation for 4 years (the remaining length of the current ICUCS contract) with the current Provider was deemed a risky option as it may be deemed as anti-competitive and the CCG could be open to a risk of challenge.

22. The WLCCG Extended Access Scheme is delivered from four locations; Centre Surgery in Hinckley and Coalville Primary Care Centre, Monday to Sunday, Loughborough Urgent Care Centre, Monday to Friday and Rosebery Surgery in Loughborough Saturday and Sunday.

23. Appointments are available from 18.00-21.00 Monday to Friday, 09.00-18.00 on a Saturday and 10.00-16.00 on a Sunday.

24. Appointments are provided by a mix of Advanced Nurse Practitioners (ANPs) and GPs.

25. The ratio of bookable appointments available to 111 and GP appointments are currently weighted toward GPs during the week and to 111 over the weekend.

Provider Performance

The following performance appraisal of the current service reflects two positions; a) the NHSE GPFV requirement of the CCG and b) the CCG requirements of the Provider.

a) NHSE GPFV requirement of CCG performance

26. The current scheme is meeting the seven core requirements for the delivery of extended access specified as part of the GPFV. NHSE confirmed this in a recent review[3] of the WLCCG scheme. The seven core requirements are:

    1. Timing of appointments
    2. Capacity
    3. Measurement
    4. Advertising and ease of access
    5. Digital
    6. Inequalities
    7. Effective access to wider health system working

27. The table in Appendix 2 provides a summary position.

28. The CCG is fulfilling the minimum NHS capacity requirement (30 mins per 1000 weighted population) through a combination of bookable appointments offered as part of the ICUCS and extended access appointments.

b) CCG requirements of the Provider (Oct 18-March 19)

29. Although the Provider is achieving the NHSE requirements, they are not delivering the consultation capacity commissioned by the CCG.

30. A number of operational actions have been taken by the Provider as part of an agreed recovery plan which have significantly improved fulfilment of the

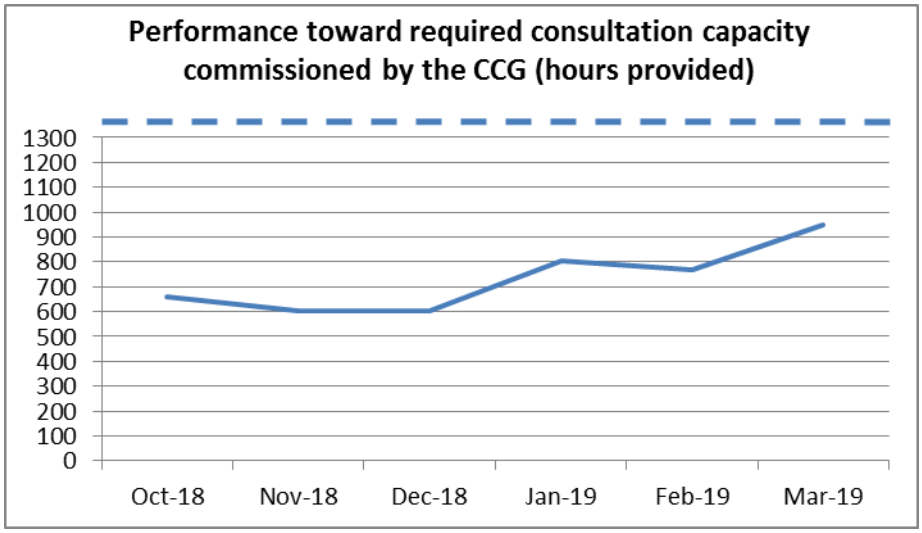
[3] GP Forward View Implementation: Extended Access Stage 2 Review of West Leicestershire CCG Version number: 1.0 First published: 28 December 2018

rotas and the trajectory of performance toward the commissioned consultation capacity:

a. Activity has been moved out of the Hinckley Primary Care Centre and into Centre Surgery
b. Weekend activity has been moved out of Loughborough Urgent Care and into Rosebery Surgery.
c. Appointment slots have changed from 10 to 15 minute slots
d. Extensive recruitment campaign for GPs and ANPs.

31. Chart 1 illustrates the improving trajectory of performance toward the commissioned consultation capacity over the first six months (October 18 to March 19).

Chart 1



Additional 'performance' information

32. The Provider is required to supply additional information on a regular basis as part of the pilot.

33. A summary position for March 2019 is presented in Table 1. A more detailed position for March is included in Appendix 4.

Table 1

Indicator	Summary position as at March 2019
Appointment utilisation	The percentage of available clinical slots taken by patients has increased to 73% in March. This is in line with national utilisation rates for this type of scheme. South Charnwood are the lowest users of the service and a significant outlier, making up only 8% of appointments. This is

	consistent with anecdotal reports from practices in South Charnwood that the current delivery sites are too far away from their registered population.
Service user demographic	Age - patients between the ages of 26 and 65yrs old account for over 55% of usage. This suggests that the service is be accessed by a group that anecdotally find it difficult to attend appointments during core hours. Gender - Male usage is consistently higher than female usage. Male usage averaging c60% and female usage c40%. This is the opposite of the trend in access to general practice suggesting that the service is improving access to primary care for a notoriously relatively hard to reach group.
WL CCG GP Practice referral analysis	Average usage in March was 35 patients per 10,000 population. 11 practices were using the service in excess of this rate and 37 below. Appendix 4 includes information to identify the top 10 practice users and the bottom 10 practice users. There does appear to be a correlation between usage and proximity to their nearest delivery site.
Did Not Arrive (DNA) rates	The DNA rate has improved in March from 9% to 8.2%. It has been confirmed to DHU that these rates do not position this scheme as an outlier[4].

Financial performance

34. The Contract for this Service is a Cost and Volume contract, based on the actual number of hours delivered. All invoices are raised monthly against West Leicestershire CCG with details of actual activity (hours delivered).

35. The Provider is paid monthly on a block contract basis based on the agreed monthly contract value (as above), with a quarterly reconciliation taking place to resolve any issues of credit for under-activity (against the Indicative Activity Plan above), as necessary.

36. The budget for the first 6 months (Oct 18 to March 19) was £634,000 with a spend of £251,000.

37. The budget for the extended access scheme for the period April 2019 to October 2020 is £697,000.

38. There is sufficient resource available to fund the scheme using NHSE allocated monies during 2019/20 and 2020/21.

[4] A specific DNA target has not been set. The DNA rate is reported as an indicator to inform evaluation of the model and not Provider performance.

"INVESTMENT AND EVOLUTION: A FIVE-YEAR FRAMEWORK FOR GP CONTRACT REFORM TO IMPLEMENT THE NHS LONG TERM PLAN" (I&E) - THE CASE FOR CHANGE

39. The recently published I&E introduced significant changes in the approach to the commissioning of both the Extended Access Scheme and the Extended Hours DES. An outline of the key changes can be found in Table 2 below. WL CCG will need to consider these in order to determine continuing provision plans for extended access to general practice services.

Table 2

2019/20
➢ Extended hours DES monies to transfer to PCNs in July 2019 with responsibility for ensuring and determining how 100% of their registered patients have access to 30 mins worth of additional clinical/routine extended hours access appointments per 1000 population per week
➢ Start of review of wider access arrangements by NHSE
➢ NHS England will work with stakeholders including GPC England on a single coherent access offer that PCNs will make, for both physical and digital services. This will deliver convenient appointments 'in hours', reduced duplication and better integration between settings such as 111, urgent treatment centres and general practice.
➢ EA scheme monies can be transferred from CCGs to PCNs anytime from 2019 through to 31st March 2021, if the commissioning arrangement for the Extended Access scheme allow.
2020/21
➢ April 2020 - start of transition to new single combined access offer.
2021/22
➢ April 2021 - requirement for full implementation of single combined access offer. EA scheme monies to have been transferred to PCNs by this date.

INFORMATION TO SUPPORT RECOMMENDATIONS MADE

a. Provider plans to improve rota fulfilment

40. The Extended Access Steering Group has endorsed two proposed changes from the Provider which will further improve rota fulfilment and, in turn increase consultation capacity (see Table 3). Both can be made within the existing cost envelope for the scheme. Approval of both changes is a recommendation of this paper.

Table 3 – description of proposed changes

Proposal	Rationale
Changing the current ANP slots at Centre, Rosebery and LUCC to GP slots. See Appendix 5 for the numbers behind this proposal.	There is a national workforce shortage of ANPs (acknowledged by NHSE) and there is no short term solution local or national solution to this that will enable us to improve ANP rota fulfilment.
Moving the Mon- Fri activity at LUCC to Rosebery	No room capacity at the LUCC to deliver extended access and this is now impacting upon other contracts (IUC). The low practitioner fill at LUCC is heavily impacting heavily overall fulfilment Doctor rota fulfilment at Rosebery is currently sitting at 100%

b. Extension of the current pilot scheme

41. The Provider is achieving the NHS additional consultation capacity requirement and has plans to improve rota fulfilment to improve their performance against the commissioned capacity.

42. There is sufficient financial resource available within the budget to fund an extension.

43. NHSE is not likely to publish its guidance on a combined access offer until late 2019. It would seem sensible to wait for the offer and to develop a local model that will align.

44. It would seem sensible for the PCN extended hours DES schemes and any new EA scheme to complement each other. PCNs are in the process of considering their plans for the provision of extended hours from July 2019.

45. The more time that PCNs have to evolve as functional teams the more effective they will be in delivering what is being asked of them. Transferring money to the PCNs from October 2019 may be too early.

46. It allows more time to conduct a robust evaluation of the pilot scheme in order to inform a revised commissioning strategy following publication of I&E.

47. It allows more time to ensure that there is time to gather lessons learned, agree a revised commissioning strategy for beyond the pilot, conduct a meaningful procurement if applicable and allow a reasonable mobilisation period before a commencement of a new contract.

CONCLUSION

48. Although EA monies are transferring to PCNs to deliver extended access, commissioning responsibility is remaining with the CCG. The CGG will be accountable for ensuring that any applicable procurement rules are followed.

49. The recently published five year framework for GP contract reform introduces significant changes in the approach to the commissioning of both the Extended Access Scheme and the Extended Hours DES.

50. An extension to the pilot will enable time for the CCG to consider a revised commissioning strategy based on the changes outlined in I&E, initial findings from the evaluation of the pilot, conduct a meaningful procurement if applicable and allow a reasonable mobilisation period before commencement of a new contract.

51. WLCCG needs to respond by supporting PCNs with their delivery plans for the Extended Hours DES and reviewing its approach to the commissioning of the Extended Access Scheme.

52. The recommendations made on the future of the current extended access scheme should ensure that the CCG and the PCNs effectively mitigates against the risk of commissioning a model which will neither complement the Extended Hours DES or align with the NHSE combined access offer.

NEXT STEPS

53. An evaluation of the pilot scheme will be carried out in June 2019 which will review the scheme against the seven core requirements for extended access as part of the GPFV (Appendix 1), provide lessons learnt and inform the full provision specification, including refinement of the clinical model, inclusion/exclusion criteria and the functional requirements of the Provider.

54. The evaluation will include patient and staff feedback, utilisation and referral analysis, DNA rates, insight into the top 10 presenting conditions by site and the spread of activity across the week by site.

55. An options appraisal on the future provision plan for extended access, will be presented to September Board. This appraisal will be based on the changes outlined in “Investment and Evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan” and findings from the evaluation.

RECOMMENDATION:

West Leicestershire Clinical Commissioning Group is asked to:

NOTE The contents of the paper and work undertaken to develop extended access GP services for patients of West Leicestershire.

APPROVE delegation to the CCG's Procurement and Investment Committee to make a decision on the following recommendations

c. Provider plans to improve rota fulfilment.
d. Extend the pilot.

Appendix 1 – GPFV Seven Core Requirements

Timing of appointments:

- Commission weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) – to provide an additional 1.5 hours a day;
- Commission weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs;
- Provide robust evidence, based on utilisation rates, for the proposed disposition of services throughout the week;

2 Capacity:
Commission a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population

3 Measurement:
Ensure usage of a nationally commissioned new tool to automatically measure appointment activity by all participating practices, both in-hours and in extended hours

4 Advertising and ease of access:

- Ensure services are advertised to patients, including notification on practice websites, notices in local urgent care services and publicity that into the community, so that it is clear to patients how they can access these appointments and associated service;
- All practice receptionists able to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services
- Patients should be offered a choice of evening or weekend appointments on an equal footing to core hours appointments.

5 Digital:
Use of digital approaches to support new models of care in general practice.

6 Inequalities:
Issues of inequalities in patients' experience of accessing general practice identified by local evidence and actions to resolve in place.

7 Effective Access to Wider Whole System Working:
Effective connection to other system services enabling patients to receive the right care the right professional including access to and from other primary care and general practice services such as urgent care.

Appendix 2 – Performance against GP4V core requirements

Core competency requirement	Position
1 Timing of appointments: • Commission weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) – to provide an additional 1.5 hours a day; • Commission weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs; • Provide robust evidence, based on utilisation rates, for the proposed disposition of services throughout the week	**Fully met**
2 Capacity: Commission a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population	**Fully met** – this capacity has been commissioned. Recommendations for plans to improve clinical fulfilment to meet the extended target are included in this paper.
3 Measurement: Ensure usage of a nationally commissioned new tool to automatically measure appointment activity by all participating practices, both in-hours and in extended hours	**Partially met** – the National Workload Tool is available to all practices and being used by some. Work is planned to support practices in using the tool.
4 Advertising and ease of access: • Ensure services are advertised to patients, including notification on practice websites, notices in local urgent care services and publicity that into the community, so that it is clear to patients how they can access these appointments and associated service; • All practice receptionists able to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services • Patients should be offered a choice of evening or weekend appointments on an equal footing to core hours appointments.	**Fully met** Discussed with NHSE and advertising is considered to be appropriate to clinical model.
5 Digital: Use of digital approaches to support new models of care in general practice.	**Partially met.** NHSE have acknowledged that EMIS practices cannot directly book extended

	access scheme appointments but are happy with the work around in place.
6 Inequalities: Issues of inequalities in patients' experience of accessing general practice identified by local evidence and actions to resolve in place.	**Fully met.**
7 Effective Access to Wider Whole System Working: Effective connection to other system services enabling patients to receive the right care the right professional including access to and from other primary care and general practice services such as urgent care.	**Fully met.**

Appendix 3 – WLCCG Clinical Model

- Aim is to provide additional increased capacity for routine acute but non-urgent patients to be able to access general practice services in evenings (after 6.30pm) and on Saturdays and Sundays.

- Access will be by bookable appointments, for both same day and advance (+24hr).

- Access if aimed at patients whose presenting needs can be safely planned to be met via a booked appointment and do not require an urgent response (such patients will be referred into the IUC/UEC system accordingly.

- Patients/individuals will be identified as 'appropriate' for EA via normal undertaken within patient's own practice or by 111/CNH.

- Patients identified as appropriate for EA will be booked into EA appointments by practice or 111/CNH.

- Initially, it is not envisaged that WL CCG EA will be open to 'self-referral'.

Appendix 4 – Further information on 'performance'

The Provider is required to supply additional information on a regular basis as part of the pilot however this is to inform the evaluation of the pilot scheme and not Provider performance.

DNA rate

The DNA rate has improved in March from 9% to 8.2%. It has been confirmed to DHU that these rates do not position this scheme as an outlier.

Capacity and Appointment utilisation

The Provider is continuing to balance the available appointments with clinical fulfilment. In March, appointment slot availability increased by 10% (300 slots) on February. This was in line with the improvement in rota fulfilment.

Utilisation of available slots increased to 73% in March. This is in line with national utilisation rates for this type of scheme.

Utilisation by locality

The table below shows appointment utilisation by locality.

Number of patients seen by locality

	Locality total	% of NWL total
NWL	473	36%
Hinckley	452	34%
NC	284	22%
SC	106	8%
NWL total	*1315*	

Utilisation by Practice – Top Users (weighted by list size)

Average usage in March was 35 patients per 10,000 population. 11 practices were using the service in excess of this rate and 37 below. The two tables identify the top 10 practice users and the bottom 10 practice users.

There does appear to be a correlation between usage and proximity to their nearest 'hub'.

The top 10 practice users in March 2019 were as follows:

		TOTAL VOLUME	Total volume - Per 10,000 registered practice population
Registered practice	Practice Populatio	1319	35.101
Dr Patel & Dr Tailor	3997	42	105.079
Markfield Medical Centre	6968	73	104.765
Broom Leys Surgery	7799	75	96.166
Maples Family Medical Practice	10425	96	92.086
Dishley Grange Medical Practice	7786	71	91.189
Long Lane Surgery	14444	131	90.695
Station View Health Centre	12659	114	90.055
Bridge Street Medical Practice	8467	74	87.398
Dr Virmani & Dr Bedi's Surgery	3585	25	69.735
Barwell Medical Centre	12236	75	61.295

The bottom 10 practice users in March 2019 were as follows:

		TOTAL VOLUME	Total volume - Per 10,000 registered practice population
Registered practice	Practice Populatio	1319	35.101
Dr Sjc Clay's Practice	3043	3	9.859
Field Street Surgery	2328	2	8.591
Birstall Medical Centre	7513	6	7.986
Manor House Surgery	3971	3	7.555
Quorn Medical Centre	8796	5	5.684
Dr Nw Osborne & Partners	7210	4	5.548
Desford Medical Centre	4449	2	4.495
Greengate Medical Centre	11391	5	4.389
aghela & Dr Gill Loughborough University Medical Ce	17062	4	2.344
Silverdale Medical Centre	#N/A	8	0.000
Unknown	#N/A	1	0.000

Service User Demographics

The profile of users of the extended access scheme has remained largely static.

Age

Patients between the ages of 26 and 65yrs old account for over 55% of usage. This suggests that the service is be accessed by a group that anecdotally find it difficult to attend appointments during core hours. The table below shows the age profile breakdown.

WLEA Age Profile			
Age Bands	Jan-19	Feb-19	Mar-19
0-2	7.6%	6.6%	11.4%
03-16	15.0%	16.8%	19.1%
17-25	13.5%	12.1%	14.0%
26-45	29.0%	27.1%	32.0%
46-65	22.8%	20.1%	24.5%
66-85	11.0%	9.6%	11.9%
85yrs+	1.0%	0.7%	0.8%

Gender

Male usage is consistently higher than female usage. Male usage averaging c60% and female usage c40%. See table below.

WLEA Gender Profile			
	Jan-19	Feb-19	Mar-19
Male	60.7%	58.5%	58.1%
Female	39.2%	41.5%	41.9%

This is the opposite of the trend in access to general practice. This suggests that the service is improving access to primary care for a notoriously relatively hard to reach group.

Appendix 5

The actual proposed change in hours from GP to ANP is presented in the table below. Both can be made within the existing cost envelope.

Model	**GP**	**ANP**
October 2018 start postion	2951	1690
Proposed change in ratio for 19/20	3822	832
Difference in hours	871	-858