Review of Direct Access Services

Notes of meeting held with the One Medicare (Open Access Centre) on 22 February at Saxon House

Attendance
Councillors Ruth Skelton, Fareed Hussain, Robin Turner, Baggy Shanker, Lorraine Radford, Roy Webb

One Medicare – Rachel Beverley-Stevenson, Jennifer Brailsford, Dr Feroz Messenger, Dr Richard Jenkins

Cllr Skelton welcomed the representatives from One Medicare (Derby Open Access Centre) and thanked them for providing a written statement in advance of the meeting. Cllr Skelton asked One Medicare if they want to make further presentation to the Commission.

The Commission was informed that the Derby Open Access Centre (DOAC) opened in December 2008 at the former DRI site and was initially based in the same building as the Walk in Centre before relocating to Lister House in June 2009.

The DOAC was established with two main aims, to address long GP waiting list and to address acute problems presented by patients. It gave access to GP services to new patients.

The DOAC provides advance nurse practioners who work in consultation with GPs and operates a GP surgery from the site with its own list of patients. The DOAC can prescribe drugs any normal GP can except methadone (replacement for heroin addicts). It see's patients who can't access their own GP or are not registered with any practice. Occasionally patients from the Walk in Centre are seen by the DOAC. It can deal with general chronic diseases such as diabetes. DOAC also has extended services into the community and provides outreach services through which it has diagnosed symptoms such as diabetes, high cholesterol. The centre also offers weight management and smoking cessation advice.

It provides opportunistic screening especially to people who don't normally see a GP by offering checks on diabetes and blood pressure.
The main difference between the WiC and DOAC is that WiC is unable to provide obstetric advice to pregnant women. These patients either have to see their own GP or go to the A&E.

The DOAC is situated in very densely populated area and sees patients from a wide range of backgrounds such as asylum seekers and Eastern Europeans who can't/ don't approach their own GP. The DOAC has been able to pick up many early symptoms such as heart conditions, cancers, diabetes etc. Earlier diagnosis helps to improve the quality of life and if these symptoms are not diagnosed early they can lead to complication at a later stage.

People want to see their GP when they have a health problem. The major advantage of the DOAC is that patients are seen by the GP when *they* are motivated to come to the surgery and want to see the GP. It is important for GPs to see them during this period in order to be able to diagnose the problem. Delays may exacerbate the health problems. It was partly in response this concern that Lord Darcy established open access centres.

The DOAC focuses on prevention although not all patients are screened. Screening will depend on the symptoms they exhibit at the point of attending the surgery. The DOAC will carryout basic data gathering such as weighing, checking blood pressure etc. Every patient's notes are sent to their own GP.

Patients falling within risk categories would be screened.

The DOAC was established to improve access to GP services. The centre provides services to people who prefer to see a doctor in an informal environment and don't want to make an appointment as well to unregistered patients. If this service was not available there is question mark on where these patients would go.

It was felt that cost is the main factor for considering closing DOAC.

Two different contracting processes were used for contracting with the two services. The DOAC contract was based on a national contract using price per patient. At no point has the PCT contacted the DOAC about their contract. The DOAC would be happy to renegotiate with the PCT if required. There is also a question mark on the current consultation process used by the PCT which favours one centre over another.

In response to their contribution to tackling health inequalities, DOAC conducts outreach into the community. There are groups of people who miss out in the screening processes who are screened by the DOAC. The DOAC offers health advice on the local community radio station and runs a drop in sessions targeted at eastern Europeans and young pregnant mothers. In all they provide 2-3 outreach sessions per week. Feedback from those attending the drop in is good.

There are verified improvements backed up by evidence of patients taking up services such as smoking cessations. The PCT have various Key Performance Indicator targets linked to volume and clinical management. Quality and Outcomes Framework (QOF) which measures GP on how well they care for patients, figures for the DOAC are extremely good.

The DOAC provides high quality services by experienced GPs to members from the disadvantaged community. The DOAC is run efficiently and governed to national standards. Local GPs know the area and the patients and therefore can provide an effective and efficient service.

The DOAC has current contract with the PCT for £1.2m and sees approximately 50,000 patients per year. It has a database of all patients

based on the postcode of where they live and not just which surgery they may be registered at. This may explain the slight difference between their mapping and that of the PCT. All patients are seen at the surgery irrespective of whether or not they are registered with a GP.

The main difference between nurse led centre and the GP led open access centre is that the WiC offers services to patients with minor ailments whilst the DOAC offers all GP services. Nurse prescribers are unable to treat obstetric and other complications related to pregnancies. Also due to differences in the provision of training between the two professions, nurses will have less expertise and experience in treating patients with complicated health problems. The nurse led system offers regimented process and provides treatment in accordance with policies and protocols. Anything that is outside their protocol is passed to a GP. It was stated that approximately eight patients are passed on to GPs in six hours. A further 5-10% queries are referred to GPs for double checking.

All patients are seen by GP where requested. This is available 365 days of the year.

It was stated that there will be an impact on the A&E if DOAC is decommissioned. It is difficult to accurately predict how many patients would go to A&E that would normally visit the DOAC however if 50% went to the A&E, that would be around 25,000 patients. Since A&E is also paid against numbers of patients using its services it is difficult to evaluate level of savings resulting from closure of the DOAC.

It is not correct to say that there has been no health gain from the establishment of the DOAC. The PCT contract with DOAC lists the outputs and KPI's required from the DOAC. These show the impact the service has had on local health improvements. The DOAC supports the reduction in health inequalities.

There are some similarities in the KPI for nurse led and the GP led but specifications are quite different. DOAC has received some referrals from WiC for second opinion.

The centre is used by 8% of patients not registered with any practice, equating to approximately 2800 patients per year and 6.7% of the patients live outside the city.

The Commission was informed that One Medicare has experience of successfully running nurse led access centre supported by GPs in other parts of the country. The DOAC stated that as part of their recent tender for the walk in centre they also proposed merging the GP and nurse led services. However they were told by the PCT that the financial element of this proposal was not considered.

DOAC is involved in the GP Consortia and regularly attends their meetings.