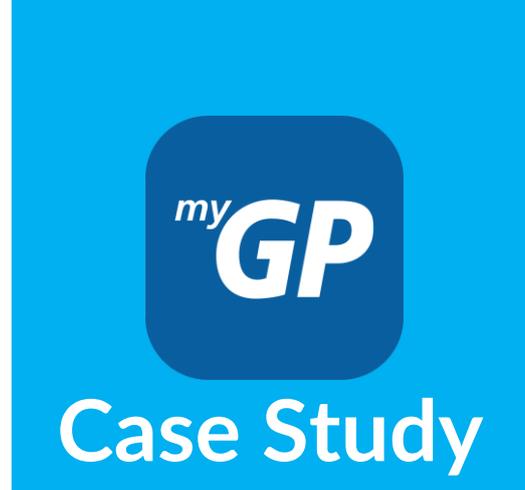


iPLATO Healthcare: preGP® smart virtual waiting room to free up GP capacity



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October 2017

Background

General Practice is under great strain with workload and patient demand at unprecedented levels and continuing to rise. Total clinical contacts in General Practice are estimated to have increased by more than 15% between 2010/11 and 2014/15 [Baird, 2016], with a 13% increase in face-to-face contacts and a 63% increase in telephone contacts. However, this increase in workload has not been matched by the proportion of funding or staff. Spending on General Practice in England was £9 billion in 2014/15, with the share of NHS spending allocated to General Practice standing at 7.94%, the lowest share in 10 years [Department of Health, 2015]. Although the number of full-time equivalent (FTE) GPs increased at a greater rate than the growth in the general population, there has been a 19% increase in the number of people aged 85 and over [Baird, 2016]. As a consequence, the ratio of FTE GPs to the number of people in the general population aged over 85 has fallen steadily.

This strain impacts on patient experience, with increasing patient dissatisfaction and longer waiting times. The 2017 National GP Patient Survey identified that 15% of patients had a poor experience at their GP surgery in 2017. Patients find appointments hard to make: 32% of patients struggled to get through to their GP surgery on the phone and 15.7% of patients said that they were unable to get a GP appointment the last time they tried [Ipsos MORI, 2017].

As a consequence, there is an increased risk of patients by-passing Primary Care and attending expensive and often inappropriate urgent care. Around 11% of people who attend A&E are discharged without requiring treatment, and a further 38% receive guidance or advice only [NHS Digital, 2017]. Although this does not mean that all of these patients are attending A&E unnecessarily, a study conducted at Imperial College London suggested that the lack of GP appointments

contributed to 5.77 million A&E attendances in 2012-2013 [Cowling, 2014]. Of the 15% of patients unable to get a GP appointment identified by the National GP Survey, around 4% reported going to A&E instead [Ipsos MORI, 2017]. This inappropriate attendance brings about a significant extra cost: at an average of £138 per A&E attendance [Department of Health, 2016] compared to an estimated £37 for a 11.7-minute appointment to the GP [PSSRU, 2015].

Technology exists to act as an interface between patients and GP surgeries to book and cancel appointments and for online consultations for triage. Patients increasingly say they book appointments to see a GP or nurse online (8.7%), increasing by 1.3% from 7.5% since 2016 [Ipsos MORI, 2017]. Development of online triaging platforms to better inform GPs on the patients prior to appointments or direct them to alternative care would free up GP capacity, reducing the current pressure on GP surgeries.

Proposed technology

iPLATO Healthcare are an established company that provide a smartphone-based appointment booking and cancellation services to patients in 16,000 GP surgeries, contracting with 45 Clinical Commissioning Groups (CCG). The objective of the current project is to expand the functionality of the system in order to ensure that patients are directed to the most appropriate person who can deal with their problem at the earliest opportunity. Their intention is not to carry out a pre-consultation or to block access to the GP, but simply to make the patient aware of the availability of various options in order that they make the most advantageous appointment.

From the patient's perspective, the intention is that they should be able to access the most appropriate care in the simplest way possible. From the Practice's point of view there is a process saving associated with reducing incoming phone calls. Additionally, by directing patients to the most appropriate individual and ensuring that did not attend (DNAs) are kept to a minimum, the most efficient use of the available workforce is ensured, whilst minimising the requirement for extra locum cover. In one trial practice, over a 1-month period, 57 appointments were cancelled using the system, of which 47 were immediately taken up by urgent appointment requests. Had this not happened, there would have been an additional requirement for at least one full day's locum cover to fill this demand. From the CCG's perspective, improved availability of appointments should mean that fewer patients resort to attending A&E which incurs a Tariff cost.

Market access

The cost model that iPLATO will use is built around an assumption that they should charge around 10% of the money saved by the customer. This is not however, how their customer-facing price structure is presented. Instead, they will use a sliding scale based on population, which will equate to around £80,000 - £120,000 per year for a typical CCG. This compares to around £50,000 which iPLATO charge for their basic appointments module.

iPLATO are in an extremely fortunate position in that they are already contracting with around 20% of CCGs in England. This gives them a substantial established user base who will form the potential core subscribers to the new extended system. iPLATO have a dedicated sales or marketing team, comprising of eight account managers, who will be responsible for securing buy-in to the new system.

In addition to securing CCG buy-in there is a further requirement to ensure that individual GP practices promote the use of the system with their patients. This will help to ensure that the predicted savings are realised. With the current basic appointment system only around 1% of registered patients are active users. Increasing this to say 10% should be achievable provided that GPs can be appropriately motivated. We believe that the potential to reduce expenditure on locums may be the appropriate tool to leverage this outcome. We have considered this in a little more detail in the next section.

Health Economics

iPLATO have evaluated their preGP system in one practice for a period of a month, in order to assess the likely benefits of the system. We have used this performance data to run our budget impact scenario, although clearly the data will need to be validated on the basis of a wider range of practices as they move into phase 2. The results of the budget impact analysis are documented in table 1 below.

Assumptions made are:

- The cost of a GP appointment is £36, based on a mean consultation duration of 9.2 minutes – this is the standard estimate used for this type of model and is taken from the annual publication: Unit Costs of Health and Social Care. [PSSRU]
- The cost of a receptionist phone call is £1.00 – this is an arbitrary assumption as it will have a non-zero cost, but no published data exist to quantify this

- 10% of patients who are unable to make an appointment will attend A&E or another NHS service instead. This is based on the results of the 2017 GP Patient Survey [NHS England]
- Attendance at A&E incurs a cost based on the level of investigation required and the type of treatment given. For most patients who could have been more appropriately be seen within primary care, they will either come under category VB11Z (no investigation or treatment) or category VB09Z (basic investigation and treatment). These incur tariff payments of £57 and £83 respectively. We have assumed that 75% of patients will be in category VB11Z and 25% in VB09Z, making a mean cost of £63.50 [NHS Tariff]

Table 1 – projected savings from myGP + preGP extrapolated from trial practice results

Item	Trial Practice		UK		Source of estimate
	Monthly	Annual	Monthly	Annual	
Population	10,000		63,000,000		
	Monthly	Annual	Monthly	Annual	
Practice switchboard savings (avoided calls)					
Digital bookings + cancellations (calls to switchboard)	257	3,084	1,619,100	19,429,200	Results of pilot study
Switchboard saving per avoided call	£1	£1	£1	£1	Assumption
Saving on calls to switchboard	£257	£3,084	£1,619,100	£19,429,200	
Freed up urgent GP appointment capacity					
Cancellations (during 30-day trial)	57				
Filled urgent appointments created by preGP	47	564	296,100	3,553,200	Results of pilot study
Cost per GP appointment	£36	£36	£36	£36	PSSRU
Value of created capacity	£1,692	£20,304	£10,659,600	£127,915,200	
Urgent care avoidance following better access to GPs					
Avoided urgent care episodes	4.7	56.4	29,610	355,320	GP Patient Survey 2017
Cost of A&E attendance	£63.50	£63.50	£63.50	£63.50	NHS Tariff
Savings from A&E avoidance	£298	£3,581	£1,880,235	£22,562,820	
Overall benefits across primary and urgent care					
GP efficiency saving	£1,949	£23,388	£12,278,700	£147,344,400	
CCG saving from urgent care avoidance	£298	£3,581	£1,880,235	£22,562,820	
Total cost benefits from myGP + preGP	£2,247	£26,969	£14,158,935	£169,907,220	
Cost of myGP + preGP					
Cost of myGP + preGP	£225	£2,697	£1,415,894	£16,990,722	10% of savings
Net saving	£2,023	£24,272	£12,743,042	£152,916,498	

Based on this extrapolated model, we can estimate potential net savings for the UK as a whole of £153 million per year.

It is worth noting that the data from the trial practice only represent throughput from 200 original appointments made using the system. A practice of this size would be expected to have around 3,000 GP appointments available each month, so the demonstrated cost benefit only represents 7% of the potentially deliverable savings.

The bulk of these savings (84%) are attributable to a freeing up of GP appointments. GP time savings are traditionally considered notional in this type of analysis, as thanks to the contractual basis on which primary care is funded, a reduction in time spent cannot be converted into a cash saving at CCG level. However, from the practice's perspective this is not the case. As many practices depend on the support of locums and sessional doctors, the reduction in GP time can be directly translated into a benefit for the practice – in the case of the trial practice the projected time saving of 47 appointments per month is equivalent to 3 fewer locum sessions required by the practice. At a typical rate of ~£300-£400 per session, this can be translated into a monetizable saving to the practice of £10,000 - £15,000 per year, even based on 7% uptake of the system. Given that the annual cost of the system is likely to be around £3,000, this may represent an attractive investment for individual practices.

For the CCG, the projected benefits in terms of reduced A&E appointments more than cover the cost of the system, with a small additional saving. If use of the system can be boosted above the current 7% figure, the potential for substantially greater savings exist, making it a highly cost-effective investment from the CCG perspective.

Conclusions

iPLATO have built on an existing GP appointments management system to develop a comprehensive system to manage patient demand within a practice. Even at the low levels of uptake seen in their pilot project, the system offers very attractive gains for the individual practice and is at least cost neutral from a CCG perspective. Provided the company can confirm these benefits across a broader range of practices in Phase 2 and boost the level of patient uptake, the prospect exists to substantially increase the observed savings to the NHS.

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