Opportunities of a Suffolk Super-partnership to Redesign the Primary Care Clinical Model - Discussion Paper

Background

Towards the end of December 2015 the Fed organised two open meetings to look at strategic options for primary care in Suffolk. There was interest in the idea of forming a super partnership, and a number of concerns and issues too. One of these was what the clinical model of a super partnership might look like, and how such a model could benefit patients and clinicians. This discussion paper looks at some options around the clinical model and future papers will address other issues including property, legal matters and finances.

Quick recap on what super-partnerships are

A super-partnership:

- Is formed by a series of list mergers with all partners joining on the same basis and becoming equity partners in the new organisation, which typically has a list of at least 100,000 and preserves existing PMS/GMS contracts.
- Is managed on a day to day basis by a group of elected GP managing partners, supported by managers. Partner time is freed-up from not having the day to day responsibility of managing a practice.
- Has a single workforce of whom most will be based either in their existing surgeries or local clusters.
- Centralises some functions e.g. clinical governance and some administration but retains local 'practice' level autonomy over how services are delivered and the 'look and feel' of the surgery.

Why a super-partnership provides opportunities to do things differently?

Central to the argument for super-partnerships is that given the historic and planned lack of investment, the traditional clinical model is no longer sustainable. It has become simply too much work, financial risk and responsibility. GPs are voting with their feet and opting out of it.

From the point of clinical workload alone, it is no longer the case that a single GP or practice can see minor cases, urgent cases, provide continuing care for ongoing and complex cases, manage LTCs, offer end of life care, manage frail patients, carry out home visits and carry all the other clinical responsibilities that are asked of us. We are running faster and faster on our treadmills yet making no progress.

A super partnership is well placed to look at delivering these services in new ways utilising models which are already in use locally or nationally:

- They have managing GP partners with headroom to consider new approaches.
- The organisation is large enough to employ a wider range of staff, for example pharmacists, Physicians Associates etc, provide them with appropriate training and support, and sufficient of them for holiday cover.
- A support team of senior managers exists to lead implementation e.g. specialist IT, patient communications and HR which is relevant if non-traditional practice staff are introduced

- Implementation costs are shared across a large list size and are therefore more affordable. The 'wheel is not reinvented' each time a change is introduced.
- Changes can be piloted and refined, before being rolled-out - with the risk being taken at the super-partnership rather than the surgery level.
- The organisation is large enough and holds a contract of sufficient value to become a powerful force in the local health economy with the potential to access new funding streams.

Current clinical model

Suffolk practices all have slightly different clinical models. A small number use telephone triage such as Dr First, but most have a GP focused clinical model, supported by nurses and other allied health professionals.

In 2012 the Fed analysed the capacity of 17 East Suffolk non-Ipswich practices and found GPs provided 54% of weekly clinical contact time, nurses/NPs 33% and HCAs the remainder (note this excluded 'extras' so underestimates GP time).

The existing small business model has served patients and the NHS well since 1947 and it is not to be discarded lightly. On the other hand, successive administrations have starved primary care of funds making the present model unsustainable. GPs are voting with their feet. Even if the government's promise of 5,000 extra GPs comes to pass, the extra 0.78 WTE GPs per Suffolk practice will not even start to address the difficulties we face.

Principles of a new clinical model

Based on comments at the open meetings and subsequent feedback, we have prepared a list of principles which we believe members would want a super-partnership clinical service delivery model to meet:

- Offers high quality patient centred holistic clinical care.
- Emphasises personal care and continuity – which is popular with patients and GPs, and is safe and efficient.
- Introduces sustainable realistic workloads for clinicians.
- Envisages a change in the role of the GP. Surgery work will involve longer consultations for more complex cases, and some sessions will be spent leading multidisciplinary teams instead of holding a traditional surgery session.

Elements of a new clinical model

Based on the service redesign work taking place in emerging super-partnerships, new models developed by some of our own practices and topics under discussion nationally we have identified six broad opportunities:

1. **Segmenting patient need and matching this to the most appropriate clinician**
   Making Time for General Practice – NHS Alliance 2015 found that in 27% of GP appointments the patient was better seen by someone else in primary care. Audit work by a local practice concluded:

   - 38% of patients requesting appointments needed to see a GP because they had undifferentiated, complex or continuing cases. The largest group

of these patients are the frail elderly, care home residents and those at end of life which we consider in more detail below.

- 35% are minor illness which can be dealt with by a team of practice nurses, NPs and Health Visitors providing they have support from a GP when needed.
- 13% of patients can be seen by an allied health professionals (AHPs) particularly physio or mental health workers.

As part of the Federation bid to NHS England for pharmacists in primary care we also looked at requests for GP advice in a local practice. 20% of such requests related to medication queries, mostly repeat prescribing, consuming 5.6 GP days per annum per 1,000 patients and is work that could be undertaken by pharmacists.

These and many other national studies illustrate that between a third and a half of patients presently seeing a GP could be seen by another health professional.

- Minors teams consisting of practice nurses, NPs, HVs and led by a GP could deal with most on the day requests.
- AHPs such as physios and mental health workers could see a significant proportion of patients who presently see the GP.

2. **Redesigning the service model for the frail elderly, care home residents, end of life and domiciliary visits**.
With an ageing population, advances in medicine and increased expectations, management of this group is increasingly challenging. One of the drivers for forming the Lakeside super-partnership in Corby is to enable it to change the way it manages frail patients. Options include:

- **Managing frailty in a different way** – nationally there is debate about making a positive diagnosis of frailty. Such a diagnosis would move away from the tick box medicine of the QoF and towards proactive holistic care as advocated in the NHSE document “Safe, compassionate care for older people”. The document proposes the identification of people living with different grades of frailty. Early grades might call for a focus on preventive care and supported self-management. Later grades could mean sympathetic symptomatic community based management from multi-disciplinary teams led by GPs and including geriatricians, and with adequate time for the patient.

- **GPs no longer undertaking visits to the non-frail or non-end of life** – opportunities include providing transport into the surgery for those who are not mobile and visits carried-out by urgent care practitioners – a scheme already used by some local practices.

- **Establishing dedicated Domiciliary Teams working across the super-practice** – multidisciplinary GP-led domiciliary teams could manage care home patients, the frail elderly and deliver end of life care when the patient and their GP agreed this was the most appropriate option. They could be resourced to work closely with the other agencies involved. The list GP could continue making domiciliary visits if they wanted. The GP role would include leading and co-ordinating care, taking clinical decisions about complex clinical situations and accepting clinical responsibility for them. The restoration of such leadership would, we believe, enable far

more frail patients to be treated at home rather than by going to hospital where so many deteriorate.

This group of patients are expensive for the health system as a whole and there will be many opportunities for a super-partnership to generate significant additional revenue as well as treat patients better and closer to home.

3. **Using simple technological solutions**
With all the pressures on practices just keeping their heads above water, the super partnership would offer the headroom to introduce simple technologies to help patients' self-care, navigate directly to a more appropriate agency or receive a phone call if this is what they want. A simple example is repeat medication requests which can go directly from the website to an in-house pharmacist for review. Another solution widely used in the US is where tech savvy patients upload their ideas, concerns and expectations about the consultation in advance, saving approximately 4 minutes a consultation.

4. **Redesigning how LTCs are managed**
Up to half of primary care appointments are related to LTCs and there are significant redesign opportunities which could include:

- **Dedicated LTC teams** led by a GP with an interest but likely including specialist PNs, HCAs and Physician Associates - which either move from surgery to surgery or are based in a small number of locations in urban areas. Patient volunteers and third sector staff might be included.

- The teams could have **access to clinical dashboards** providing outcome data and allowing a focus on individual patients - for example those not on target or having frequent admissions or emergency attendances.

- The teams could use **new approaches to LTCs** which encourage self-management and are associated with better outcomes. One such approach is the nationally sponsored “Year of Care” which the Fed rolled-out in the North East Essex Diabetes service. The two QoF appointments are closely spaced with an HCA carrying out the first for tests and routine examinations. Following this the patient is sent their results with an interpretation booklet and the second QoF appointment is a half hour session with a practice nurse. The appointment builds motivation by exploring the patient’s aims and objectives over the coming year and allows self-management techniques to be taught.

LTCs are a major driver of hospital admission and there are revenue opportunities for a super-partnership to shift work from hospitals.

5. **Using GP time more efficiently**
For example:

- Ensuring GPs have adequate secretarial and Physician Associates support so they are not carrying out administrative tasks such as completing investigation requests, typing letters or bringing equipment from elsewhere in the surgery.

- Deploying a Social Prescribing scheme so patients with housing, financial and employment issues can see an adviser (possibly from the third sector) in the practice with their time managed by the practice.

- Simple tech solutions including those set out above.

6. Triage

In a model where far more patients (perhaps half the existing GP workload) is seen by other professionals, high quality triage is key to making sure each patient sees the right professional.

More thinking is needed around this area. The Doctor First model has some evidence, but is expensive and not popular with all GPs. Internet submitted queries can be triaged easily and some patients appear to be comfortable giving more information online as opposed to a receptionist. Evidence from using NPs and non-doctors to triage is weak but may be worth exploring further.

Potential clinical model

Putting the above together, we offer a "straw man" – a simple draft proposal intended to generate discussion of its disadvantages and to provoke the generation of new and better proposals:

Strawman Suffolk Super-partnership clinical service model

Presentation	Clinical division	Team members	Comment
Internet query or phone call e.g. consultation or repeat prescription request	**Triage/Pre-appointment**	▪ Pharmacist ▪ GP triager	▪ If telephone triage is used it needs to be individual practice based. Triage from website queries can be super-practice wide
Request for specific support which can be directed immediately to an allied health professional e.g. children's behaviour, Adult mental health follow up, MSK problem	**Allied health professionals**	▪ Physio ▪ Link Worker or other mental health worker ▪ Primary MH worker with children) ▪ HV ▪ OT	▪ Individual practice based ▪ Team would be integrated with practice i.e. direct control of their appointments ▪ As now some patients will need to travel for appointment
Complex undifferentiated or continuing cases	**Surgery based GP care**	▪ GP – supported by: ▪ Physician Associate ▪ Secretary	▪ Individual practice based ▪ Core generic GP skill - approx. 40% of all consultations ▪ Personal list based care remains ▪ Surgeries held in existing practices as now ▪ 15-30 minute appointments
Home visit requests Care home Frail elderly End of life	**Domiciliary Team**	▪ GP team leader ▪ Urgent Care Practitioners ▪ Integrated Neighbourhood Teams ▪ Social care ▪ Third sector – Age Concern, many other local organisations	▪ Super-practice wide
Walk-in, minor illness & paediatrics including full range of minor A&E clinical services e.g. suturing, foreign body removal, point of care testing, new technology diagnostics	**Minors Team**	▪ GP team leader ▪ Practice nurse ▪ NPs ▪ HV – trained to manage under 5s presenting with acute illness ▪ Assistive technology	▪ Super-practice wide ▪ Encourage booking via website ▪ HVs use a less medicalised model with emphasis on parent education and non-medical management. ▪ Where practices are geographically close likely to not have a Minors team in each location ▪ Available 8am to 8pm 7 days (e.g. Riverside)
LTC related problem and routine reviews	**LTC team**	▪ GP team leader ▪ Practice Nurses ▪ HCAs ▪ Physician Associates ▪ LTC third sector organisations such as Diabetes UK, BHF	▪ Super-practice wide ▪ Patients with multiple LTCs seen in one appointment
Social issues	**Social Prescribing**	▪ Social prescribing via CAB, practice based social worker	▪ Practice based

How might the GP job change?

Some aspects of the GP role will remain unchanged, for example individual consulting and personal continuing care. Other aspects will change:

- Presentations will be more complex but appointment times longer.
- More time will be spent leading multi-disciplinary teams such as the minors team, LTC teams or the frailty team.
- Less time spent managing the practice.
- Opportunities for personal and career development inside the practice in management, a clinical area, phone consulting, clinical technology implementation, referral management, education, minor surgery or offer locum sessions.

So an 8 session GP might, for example, choose to work:

- 5 sessions in surgery lasting 4 hours with say 16 patients at 15 minute appointments without extras or visits.
- 2 sessions leading the multidisciplinary teams referred to above.
- 1 session from the other opportunities set out above.

Developing the super-practice workforce

A super-partnership would have the ability to develop its own workforce and offer a wide variety of training using its partners & staff as trainers and its scale to make it cost effective:

- GP training, medical students, FY1/FY2 and postgraduate education or training.
- Nurse training – undergraduate, post graduate or specialist nurse training, student nurse placements.
- Allied health professionals – particularly Physician Associates.
- All staff – induction, mandatory training and personal development.

The benefits of developing a comprehensive in-house training offering would be:

- Peer support.
- Take advantage of the considerable funding which is available but currently goes to hospitals as only they have the infrastructure needed.
- Takes advantage of the skills of the super-partnership's personnel and expertise.
- Career development opportunities e.g. leading teams and GP leadership skills.
- Attractive for recruitment and retention.
- Potentially a source of income

Next steps

This paper is offered as a "straw man" – a simple draft proposal intended to generate discussion of its disadvantages and to provoke the generation of new and better proposals. Its aim is to initiate a discussion on a potential super-partnership's clinical model and illustrate how it could offer advantages to patient care and to partners compared to the existing model.

If enough practices are interested in parts or the whole of the model, or if alternate suggestions are contributed, the proposals will need to be costed.

We remain aware that although the clinical model can offer solutions to the current unsustainable workload and offer respite from the burdens of managing a practice, a super partnership model can also help with succession planning and property disposal, can endow GPs with a powerful voice as providers, and is likely to be better placed to face the future than the existing model. Future papers will address these points in more depth.