Innovations in the organisation of GP services

Why this research was needed?

NHS policy imperatives in recent years have focused on increasing the number of services provided in and by GP primary care. Organisational forms are changing rapidly in the NHS to accommodate new service functions such as ambulatory care from specialist services, and out-patient clinics in GP premises, and to collaborate in new organisational models to deliver more services. Research described addresses how GP services are responding to these imperatives.

Out-patients services and GP primary care:

For many conditions, high-quality care in the community can be provided and is popular with patients. Commissioners developing new models of care for the NHS have often predicated these strategies on assumptions that community-based care will be cheaper than conventional hospital-based care. However, possible reasons that healthcare in the community may be more expensive include supply-induced demand and addressing unmet need through new forms of care and through loss of efficiency gained from concentrating services in hospitals.

Recent research by Professor Martin Roland and colleagues found there is inconclusive evidence on the cost-effectiveness of the provision of more healthcare away from hospitals[1]. They reviewed international research, and evaluated promising UK initiatives such those where a GP or specialist reviews referrals. They suggest that further shifts of healthcare into the community can be justified only if high value is given to patient convenience in relation to NHS costs or community care can be provided in a way that reduces overall health-care costs, rather than cost-shifting[1].

There was broad support on at least some outcomes such as patient satisfaction and quality of care (a) for GPs to follow up patients after specialist care, which has been found to be safe and effective and may save costs, and conduct of minor surgery similarly is an example where it can avoid demand on secondary care but safety depends on operator skill, (b) manage long term conditions such as diabetes, (c) use a range of diagnostic tests, although whether this saves cost is not clear, (d) direct access to specialist services, although in musculo-skeletal services (MSK) the evidence suggests a high risk of greater cost through stimulating demand, which might be mitigated by strict protocols, (e) providing consultant clinics out of hospitals is usually welcomed by patients but does not reduce cost or re-consultation as support services are less accessible off-site, (f) with similar findings for shared care between specialists and GPs [1].

Conversely, they found little evidence to support the role of GPs with a specialist interest (GPwSI), telecare, or video consultation with patients. They found limited evidence for the benefits of relocation of specialists or shared-care methods, as advocated in the NHS Five Year Forward View, and, in particular, cost-effectiveness evidence for these interventions was very limited. From just two studies, they concluded that programmes which involve obtaining a second opinion from a colleague prior to referral (in-house review) have the potential to reduce referrals, but also can have additional cost and be less effective over time as GPs become more skilled. They found a growing evidence base for behaviour change interventions for clinicians, for example the use of audit and feedback along with using protocols. Studies in which GPs were able to obtain specialist advice by telephone or e-mail suggest that there is a substantial opportunity to reduce the number of patients seen in outpatient clinics[1].

Access to same day GP consultations

There are trade-offs between rapid access and having the consultation with the GP of choice. A decade ago, Professor Salisbury and colleagues evaluated a system mandated by NHS policy to increase access to GP appointments by offering mainly same day only appointments with an available doctor of the practice, rather than allowing appointments at times convenient to the patient and with their doctor of choice[2-7]. They found practices operating Advanced Access were able to offer patients appointments slightly more quickly than control practices, with no evidence of any decrease in continuity of care or difference in the increase in practice workload. Apart from speed of access, other differences between the experience of patients and staff were minor. This study supports earlier research findings that being able to choose to see a particular doctor or to be seen at a convenient time are more important than speed of access for most patients. Also that different groups of patients, such as those who have chronic illness, compared to those who are usually healthy but have an acute illness, have different priorities.

Integrating GP services with community and specialist services

Many NHS patients, especially frail older people, have 'complex needs', that is, co-morbidities, and they may also have complex living circumstances. These patients require assessment and need treatment and care from more than one service at once (e.g. general practice, community nursing and therapies, social services). It is assumed from many policy initiatives that the better coordinated these services are, the more likely it is that patients will receive more appropriate care, avoiding further illness and hospital admissions and to continue living in their own homes. In the NHS there is experience of general practitioner-lead health centres, 'case management' where a community matron or similar co-ordinates patients' care, 'polyclinics', and networks of services including partnership with the third sector in palliative care, cancer care and to support people with long term conditions[8]. Professor Rod Sheaf and colleagues have completed research to find out how these approaches compared in terms of improving the co-ordination of patient care across the range of services. The research included analysis of patient records and interviews with patients in England, and similar research in Sweden with a focus on polyclinics[8].

They found that combining general practice and community health services into one organisation, as proposed in vanguard 'Multispecialty Community Providers' (MCPs), is likely to co-ordinate care better that looser, more flexible networks and partnerships, which do little to address the current separation between general practice and other health services.

<u>Studies underway:</u>

How might Multi-Specilaity Community Providers (MCPs) work in England?

In MCPs, general practices will provide a wider range of services than now, including perhaps some outpatient services now provided at hospitals. As MCPs are new, Professor Rod Sheaf's team will find out what has already been established from similar models of integrating primary, community and some out-patient services in the UK and other countries (15/77/34). They will establish the policy aims of these models (for example, providing integrated care) and the evidence for the mechanisms (e.g. that integrated care reduces unnecessary hospital admissions) and build logic models of how the NHS may build in processes to achieve these aims based on established evidence of how these models already work elsewhere. The study is underway and will report in early 2018. https://www.journalslibrary.nihr.ac.uk/projects/157734/

Federations: How are they working and improving services?

GPs have been developing new forms of organization known as federations for some years, and have been actively supported by CCGs to build their infrastructure to enable them to take on providing new forms of service. Federations are a supra-practice level of organisation. They vary in scope and organisational form, from loose alliances of a small number of local practices, to much larger publicly limited provider companies. Potential benefits of federations include efficiencies of scale and scope, strengthening capacity to deliver services outside hospital and improving integration between services. Federations present many challenges including balancing individual practice ways of working, autonomy and identity with the requirements of more centralised and standardised procedures which federations imply. Professor Ruth McDonald and colleagues in the East Midlands and Manchester are about to undertake a two-year study to characterise the types of federations emerging and the views of commissioners, GPs and patients on how federations are achieving their aims (14/196/04). The study will produce a national picture of federations, classified according to a typology that they will create from their research, and an understanding from three different types of federations of how federations are working. There may also be lessons than can be applied to implementing other new forms of organisation such as MCPs and Accountable Care organisations.
https://www.journalslibrary.nihr.ac.uk/projects/1419604

How can GP services be improved using this research?

Assumptions that *moving care into services provided or managed by GPs* have only a very limited evidence base. Services provided by or at the GP location are broadly welcomed by patients, but evidence of cost saving is scant. More promising models such as discharge to GP follow-up, and review of referrals supported by protocols, require systems that support members of the GP practice to take on the new roles, to prevent unintended consequences such as cost shifting and re-consultation.

New models of care, such as *MCPs* where GPs are part of new managerial entity, compared to looser forms of network or the current separation of primary and community and specialist care, are more likely to achieve the proposed benefits of integration for patients with complex needs.

New research will test whether *federations and MCPs* achieve their aims. NHS commissioners may gain insight from this research to provide support to federations in order to establish safe and effective systems to deliver a wider range of services, along with tracking the patient experience and overall costs of investment to the health economy.

Offering same day access to an available GP produces few advantages to other systems which offer less rapid access but more choice of time and GP, particularly for patients with less urgent and long term conditions.

NHS Policy context for new models of GP services

The reasons for the need for organisational reform in the NHS are outlined in the Five Year Forward View (FYFV). These reasons include: people living longer and the increasing prevalence of long term conditions which is putting enormous pressure on the NHS. According to the Nuffield Trust, government health departments in the UK have promoted policies that put general practice as the cornerstone of reforms[9]. Organisational forms are changing rapidly in the NHS. In January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguards' for the new care models programme[10]. There are 50 vanguard sites for new models of care, each vanguard will take a lead on the development of new care models which will act as the blueprints for the NHS moving

forward. Of these, the multispeciality community providers, integrated primary and acute care systems, enhanced health in care homes, and urgent and emergency care vanguards most directly involve primary care[5].

Multispecialty community providers (or MCPs) are new models of care outlined in the NHS Five Year Forward View. GP group practices will expand, bringing in nurses and community health services, hospital specialists and others to provide integrated out-of-hospital care. These practices would shift the majority of non-urgent outpatient consultations and ambulatory care to out-of-hospital settings. Primary and acute care services (or PACS), are new care models which would provide GP and hospital services, together with mental health and community care, in single NHS organisations. They could evolve in different ways, for example, by hospital trusts opening their own GP surgeries. Both models aim to give better patient experience, better population health and more efficient use of resources.

Currently there are inequalities in access to primary healthcare provision within the UK. In some rural areas access to services may be limited by the lack of public transport. Lack of broadband service or mobile phone signal in some rural areas may limit alternatives to face to face consultation. Initiatives in the GP Forward View[11] are attempting to address recruitment of GPs in such areas. Service innovation, including case studies cited in the GP Forward view such as Modality Health in Birmingham, which uses several types of digital communication with patients, may address provision to these communities.

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