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Pressure point

Getting buy-in from local GPs is key to opening new specialist services in the community, finds **Clare Connell** and **Henry Hunt** of Connell Consulting

Whilst local health and social care commissioners are keen to see the development of specialist care services, conflict can arise between what commissioners want a provider to deliver, and the limited resources and funding that are available, which can impact on the viability of new specialist provision. Increasingly we are seeing availability of general practitioner (GP) resource acting as a roadblock to service users accessing beds, with examples seen across learning disability, mental health, acquired brain injury (ABI), neurorehabilitation, and elderly discharge to assess services.

The ambition to move care closer to home and reduce length of hospital stay has led to rising demand for local specialist care services. However, with joint commissioning arrangements few and far between, ensuring funding arrangements are in place, and getting buy-in from other community support services, such as GPs, can be challenging, and often requires providers to have good channels of communication with all parties.

The reason for the reluctance from clinical commissioning groups (CCGs) and GPs to support, particularly the development of new specialist care services, is the additional pressure these developments will add to the delivery of GP services locally. As with other areas of health and social care, GP services across the UK are coming under huge strain. Dr Steve Mowle, honorary treasurer for the Royal College of General Practitioners, says that over the last seven years there has been a 16% increase in the workload a GP can expect. There are both demand and supply side explanations for this change. In addition to population increases, GPs have been leaving the NHS at a rate of more than 400 a month, meaning fewer GPs amongst whom to spread the load. The squeeze is not helped by the fact that between 2005 and 2014, the proportion of GPs aged 55 to 64 leaving the workforce has doubled. The National Audit Office (NAO) suggested this could be down to pension arrangements, which encourage GPs to retire early if they've maximised their pensions before they're 60.

To deal with this pressure the NHS launched 'The General Practice Forward View' in April 2016. The headline figures were increasing investment in primary care from £9.6 billion in 2015-16 up to £12 billion a year by 2020-21, and increasing the number of GPs through recruitment and training by 5,000 as well as another 5,000 staff in the wider GP team, including mental health therapists. A year on, there isn't compelling evidence that expansive training and recruitment campaigns have worked out exactly as planned. In 2016-17, Health Education England, responsible for NHS staff training, filled only 3,019 GP places out of the targeted 3,250 – whilst this is an increase of 9% on the previous year, it does not signpost overwhelming enthusiasm for general practice. Nor does the fact that around a third of GPs in training have no intention of working in full-time general practice even just one year after qualification. The NAO also note that female and salaried doctors are increasing as a proportion of the workforce, however, they are also the least likely to work full-time.

The latest move is to look further afield to plug gaps in GP resource. The NHS has announced plans to spend up to £100 million on recruitment agencies to meet the additional 5,000 GP target with 2,000 to 3,000 of these expected to arrive from overseas. This is good news for the eight agencies expecting to win these contracts (including Hays, whose share price rose roughly 10% from when news broke to the first week of September), but possibly not for the NHS which could be expected to pay up to £20,000 per new GP if it recruits all the 5,000 this way.

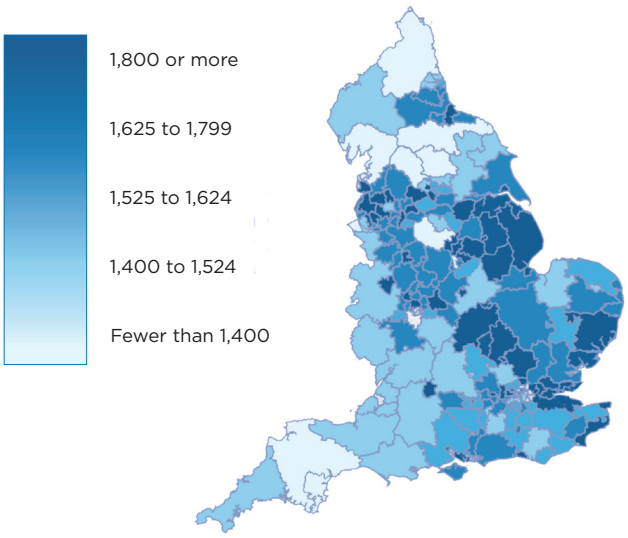
Whilst funding arrangements and access to GPs will vary between local authority and CCG areas, there are some service models that will have a greater tendency to cause initial concern if they are developed due to the possibility of increased pressure on local GP resources. For example, specialist services are more likely to attract service users from out of area, which will place additional strain on local GP services.

Services such as mental health and ABI and neurorehabilitation units operate at a regional, rather than a local level, and as a result are going to bring high acuity, out-of-area cases, into a given local authority. With specialist provision such as this thin on the ground, there is demand for the development of new services. Despite this, situations have arisen where the opening of new provision has been blocked, despite local commissioners keen to see the development of additional beds, because the CCG would not fund local GP cover for the service. An additional concern is that the care pathway delivered in such services means that, in time, there is the hope that individuals can be stepped down into community-based provision – where nurses in a hospital or care home setting may have the duty of care initially, this may be taken over by local services once they re-join a community. This step-down provision is often in close proximity to the hospital or care home unit and can lead to these out of area service users becoming permanent residents in the host authority. In the long run this could add significant additional pressure on GP services, especially given that these individuals are likely to need higher levels of support and in turn require many GP contact hours.

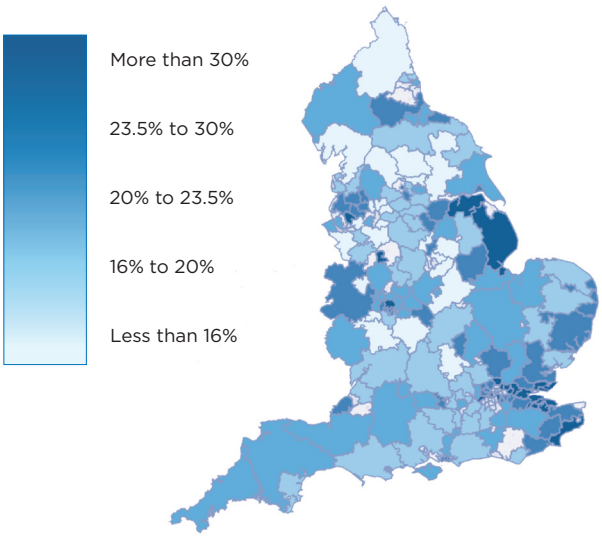
Whilst the 'Transforming care' agenda promotes local placements for service users ▶

FIGURE 1: GENERAL PRACTICE REGIONAL PRESSURES

Patients per GP



Practitioners aged 55 and over, %



- GP pressure is distributed unevenly across England. In some CCGs, general practitioners can expect to see over 1,800 patients. More patients in these areas are unlikely to be welcome, especially if they are of higher acuity requiring greater support
- Some CCGs can anticipate greater numbers of GPs retiring at 65 or earlier. These areas will see growing pressure and will need to recruit and retrain young GPs going forward.

Sources: Connell Consulting analysis, 2017

with learning disabilities, it is still common for a child or young person to be placed out of area. Children and young people may, for example, be placed out of area in order to access specialist educational provision that is unavailable in their home authority, but then end up staying in that area once their time in education has ended. Perhaps they have made friends, found work, or just got used to using the transport in their adopted authority, with a move back to their host authority possibly considered too disruptive. As a result, they will continue to access local provision on a long-term basis. As with other specialist services, for local GPs, these new entrants provide an additional strain on stretched resources. Providers should be conscious of these clinical externalities when looking to develop new services, and may be more inclined site services where GPs are under less pressure (*figure 1*).

As touched upon earlier, concerns don't just stem from the amount of time that a given GP has to spend with their patients. Cost, and often poor funding arrangements, provide an added complexity. The high medication costs associated with service users with more complex and challenging needs will be a key concern when assessing the additional burden that specialist services will place on local health and social care resources.

Another area of concern is whether health will release additional funding, where required, to ensure sufficient GP cover is in place. The successful implementation of 'discharge to assess' beds is another good example of a service where the availability and source of funding varies between local authorities and CCG areas, and there is a need for providers to engage directly with GP practices to ensure they are linked in. Where possible, patients receiving acute inpatient care will be stepped down from hospital as quickly as possible into their own home or another care setting. Social care is often keen to offer discharge to assess beds, as this is a better environment for a patient to convalesce, and also helps reduce bed blocking within hospitals. However, funding cannot always be made readily available to support this model. The head of contract performance at West Sussex County Council Said: "Depending on which CCG area you are in depends on the response that we get with regards to GP cover for discharge to assess."

Despite evidence that there is strong demand across the country for discharge to assess beds, in order to relieve pressure on inpatient hospital beds, some CCGs continue to be unwilling to provide the additional funding that is required to ensure there is sufficient GP cover in place. In Northamptonshire, for example, the council and local CCG has actually withdrawn additional GP services which enabled independent providers to offer rehabilitation services for elderly people following discharge from hospital. As a result, some existing services are now struggling to take on service users with higher needs.

Despite this, there are examples of successful multi-disciplinary engagement; models include South Warwickshire, where additional funding is provided by the CCG and NHS hospital trust, and Medway, which has seen a small cash injection from the CCG and local authority. Therefore, in order to implement a successful discharge to assess model, providers need to ensure they have buy-in from all relevant funding bodies. For example, one provider in South Warwickshire has two GP practices that have been commissioned to provide clinical input for 30 nursing home beds. Providers hoping to keep on the good side of commissioners should consider liaising directly with local GP services to ensure sufficient support is in place. It is in the interest of all parties to make sure the funding arrangements work.

Whilst the shortage of GPs is a chronic issue, plans are being put in place to reduce the pressure on local GP services. In addition, there are steps that providers of specialist services can take to ensure they generate buy-in from their local CCGs, with their ability to ease pressure on acute services a key driver for the development of new beds. When looking to develop a service, providers may wish to take into consideration the demand for GP services within local micro-markets; some areas will be under greater pressure than others and will be a lot less happy to receive more complex patients. Where providers have sited care homes and other services, they should be proactive in engaging with local funding bodies to clearly understand who will be funding services and communicate the benefit that local stakeholders can expect to receive. Ultimately, open dialogue will mean smoother transitions and better care for service users, which should be the goal of all care providers. ■

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