


Qualitative baseline evaluation
of the GP Community Hub
Fellowship pilot in NHS Fife and
NHS Forth Valley
Briefing paper

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This briefing paper was prepared by NHS Health Scotland based on the findings from the evaluation undertaken by Fiona Harris, Hazel Booth and Sarah Wane at the Nursing, Midwifery and Allied Health Professions Research Unit – University of Stirling.

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Summary

In 2016 NHS Fife and NHS Forth Valley began to pilot a new GP Community Hub (GPCH) Fellowship model aimed at bridging the gap between primary and secondary care for frail elderly patients and those with complex needs. NHS Health Scotland commissioned a baseline evaluation to capture the early learning from implementation of the model. The following summarises the key findings from the evaluation.

The evaluation was conducted between February and June 2017 when the model of delivery in the two pilot sites was still evolving. The findings may therefore not reflect the ways in which the model was subsequently developed and is currently being delivered in the two areas.

GPCH Fellowship model

The GPCH Fellowship model came about as a response to a number of drivers, including:

- To support delivery of the Scottish Government's vision that 'by 2020 everyone is able to live longer, healthier lives at home or in a homely setting'.¹
- The ongoing challenges associated with the sustainability of the GP workforce, including challenges to recruitment and a reduction in the numbers of GPs participating in out-of-hours work.²
- The need for improved integration between primary and secondary, community and social services, and further development of intermediate care between support at home and acute hospital care. This would require a 'new kind of doctor' with more generic skills who could work across this interface.^{3,4}

¹ The Scottish Government. [2020 Vision](#). Edinburgh; 2011.

² Finlay I, Gillies T and Bruce D. (nd) Draft Community Fellowship proposal, V8.

³ The Scottish Government. [A National Clinical Strategy](#). Edinburgh; 2016.

⁴ The Shape of Medical Training Review. [Securing the future of excellent patient care](#). Final report of the independent review led by Professor David Greenaway. 2013.

The GPCH model comprises a one-year GP post-CCT⁵ Fellowship, funded by NHS Education for Scotland (NES), followed by a two-year Health Board funded position in newly developed community hubs.

In the draft proposal for the model⁶ it was envisaged that, in their training year, GP Fellows would receive training and work experience in an acute secondary care setting (four sessions per week), with a host GP practice (two sessions per week) and a local out-of-hours service (one session per week). It was anticipated that as part of their secondary care training the GP Fellows would rotate between the acute medical ward, emergency medicine department and acute assessment unit. In primary care the GP Fellows would be mentored by the host GP. In secondary care mentoring would be provided by a secondary care specialist.

Following their training year the model proposed that the GP Fellows would be based part time in a community hospital and part time in general practice and GP out-of-hours services. During this period the secondary care specialist would continue to act as mentor and trainer as the GPs developed their skills in managing patients admitted to the community hospital.

The model envisaged that the community hospital could form the core of the hub, which, once developed, could provide a range of services, including out-of-hours/minor injuries and short-stay in-patient beds. By bringing together the extended role of the GPs, able to support patients referred to the community hospital, with the enhanced role of nurses and Allied Health Professionals (AHPs), it was anticipated that the care of patients not requiring the full support of an acute hospital could be transferred to the community hub.⁷

The model was piloted in two sites, NHS Fife and NHS Forth Valley, and adapted to reflect local circumstances. In Forth Valley, for example, a number of options including the community hospital and frailty unit were considered,

⁵ Certificate of Completion of Training

⁶ Op cit, Finlay et al (nd)

⁷ Op cit, Finlay et al (nd)

prior to locating the GP Fellows with the Enhanced Community Team (ECT). At the time of the evaluation the GP Fellows in this area were also not part of the local out-of-hours service.

The evaluation

Early in the development of the GPCH model NHS Health Scotland led an evaluability assessment.⁸ This included among its recommendations a qualitative process evaluation to capture the views of a range of key stakeholders involved in the planning and implementation of the model in the two pilot areas.

With funding from Scottish Government, a team from the Nursing, Midwifery and Allied Health Professions – Research Unit, University of Stirling, were commissioned by NHS Health Scotland to undertake this baseline evaluation. The objectives were to:

- Capture the views and experiences of a range of key stakeholders to generate learning about the requirements for, and challenges of, designing and implementing the GPCH model.
- Capture perceptions of the potential impact of the GPCH model on the delivery of care for frail elderly people or people with complex multi-morbidities at or close to home.
- Capture perceptions of the potential impact of the GPCH model on working relationships across the primary and secondary care interface, and within multi-disciplinary community teams.
- Provide learning to inform ongoing implementation in the two pilot sites and for any future development of the GPCH model.

⁸ NHS Health Scotland. *Evaluability assessment of community hub pilots in NHS Fife and NHS Forth Valley*. Edinburgh; 2017. (Accessed 12 September 2017). Evaluability assessments are a way of thinking through whether and how to evaluate new policies and programmes. They provide a way of weighing the value of the evidence an evaluation would provide, in terms of informing future decisions, against the likely cost and practicality of gathering that evidence.

The study was undertaken over the period February to June 2017. It involved interviews and focus groups with a total of 36 participants. These included:

- primary care staff
- secondary care staff
- managers/planners
- a multi-disciplinary community health team
- GP Fellows.

Findings

At the time of the evaluation the two pilot areas were at different stages of implementation.

In May 2017 there were six GP Fellows in NHS Fife (including one person on maternity leave). Because of initial staff turnover the GPs in Fife were still in their fellowship training year.

In NHS Forth Valley there were five GP Fellows. Of these five, one person was on maternity leave and one on secondment at the time of the evaluation. Neither of these two had finished their training year. They completed this on their return later in 2017. The three who had completed their training worked with the multi-disciplinary ECT⁹ with whom they were co-located in a health centre.

There were also some differences in the ways the model was implemented locally (summarised in Figure 1 over the page).

⁹ The team is led by an Advanced Nurse Practitioner and includes nursing staff trained to Nurse Practitioner level with prescribing capability, Allied Health Professionals and mental health nurses. It provides a seven-day urgent, coordinated and enhanced response at times of crisis.

Figure 1: Implementation of the GPCH model in the two pilots sites

(as of May 2017)

| | NHS Fife | NHS Forth Valley |
|-------------------------------------|--|---|
| No. of GP Fellows | Six (including one on maternity leave) | Five (including one on maternity leave and one on secondment) |
| Area covered | Dunfermline and West Fife | Stirling, Falkirk and Grangemouth |
| GP Fellow – stage of implementation | GP Fellows in training, rotating around secondary care specialities including: psycho-geriatrics, palliative care, Hospital@Home | Three GP Fellows had completed their training year. The remaining two had not completed their training at the time of the evaluation |
| Base | Queen Margaret Hospital, Dunfermline | Health Centre; co-located with ECT. Proposal to move GP Fellows to Falkirk Community Hospital |
| Primary care input | Sessional input to GP practices as per NES contract Includes out-of-hours sessions | Sessional input to GP practices as per NES contract |
| Secondary care | GP Fellows in training, rotating around secondary care specialities, psycho-geriatrics, palliative care, Hospital@Home | GP Fellows provided input into the frailty clinic in the course of their training year |
| Community care | Contribute to Hospital@Home supported by consultant geriatricians | Work as part of the ‘Closer to Home’ model, providing teams with medical support Integrated with ECT, providing medical support including referring patients for diagnostic tests, scans, X-rays and other treatment |
| In-patient facilities | No community hub in-patient bed(s) | One in-patient ‘step-up’ bed at Bo’ness Community Hospital. Used once up to the time of data collection |

Some of the findings from the evaluation may be similar to those experienced when introducing any new service into an existing system. Some, however, may reflect the complexity of introducing a new model aimed at bridging three different systems: primary care, secondary care and community care. At the time of data collection some changes had already been introduced in response to the initially high turnover of GP Fellows, including 'ironing out' some of the practicalities.

Setting up and planning

Length of lead-in time:

The time frame for setting up the new model was felt to have been too short to ensure the systems and infrastructure were in place. A longer lead-in time is needed to ensure that systems and processes are in place to support the GP Fellow role both in the training year and in subsequent practice.

Communication and collaboration:

To support development and implementation the evaluation identified the importance of ensuring that all of those within and across the different systems are made aware of and support the model. This includes those at strategic and operational levels in primary, secondary and community contexts. This may also help to overcome resistance to change. Collaboration in planning, including with the GP Fellows themselves, was felt to be productive. It could provide an opportunity for the GP Fellows, for example, to contribute to the development of new services such as community frailty clinics.

Consistency of vision:

Communication across and down the different systems may also help to develop a consistent understanding of the GP Fellow role – avoiding a sense among GP Fellows of having 'too many bosses'.

Championing:

As with many new developments, there is a value in having a 'product champion', someone leading, communicating, and providing ongoing and sustained support for the new model. Without a clear driver, the model may lose momentum and find it harder to take root.

Infrastructure

A physical base:

While potentially more complex, given that GP Fellows are moving between primary and secondary care environments, at a very practical level there is a need to consider basic accommodation and operational needs: desk and desk space, IT equipment and telephones. Co-location with other teams, such as the ECT, may bring added value, helping to build positive working relationships, but consideration also needs to be given to the suitability of the physical environment to encourage effective working.

Data access, sharing and transmission:

Although data sharing issues between different systems are not specific to the pilot, the GPCH model, by its very nature, suggests a need for IT protocols and processes to be in place to enable the GP Fellows to efficiently access and input clinical information across primary and secondary care systems. This may help to avoid, for example, the need for GP Fellows to enter the same data into a number of different systems.

Recruitment, training and retention

The evaluation did not focus specifically on GP Fellow recruitment and training. A number of suggestions were, however, made for improving recruitment and training and encouraging retention. This was in a context of what had been quite a high initial turnover of GP Fellows in both pilot sites.

Contractual complexities:

It was suggested that to facilitate the transition between NES (who support the training year) and the Health Boards who will employ the GP Fellows for

two years post-training, arrangements, including funding should be in place before the end of training year.

Role clarity:

Attracting and retaining GP Fellows may be supported by greater clarity about the nature of the role (including the anticipated career pathway) right from the stage of recruitment. There is a need to balance a degree of open-endedness to encourage flexibility and innovation against the risk of the role losing its distinctive purpose.

Allocation to GP practices:

Attracting and retaining GP Fellows may be helped by giving them a choice of GP practice (as they would expect in 'normal' practice). Again there may be a balance to strike between recognising the GPs' work-related preferences and allocating the GPs to where there is greatest need.

Out-of-hours commitment:

At the time of the evaluation GP Fellows in only one pilot site contributed to the GP out-of-hours service. The lack of choice of shifts given to the GP Fellows may have been a contributory factor to the initial turnover of trainees at this site.

Links and relationships

Being able to establish links and relationships within and across the different systems is key, given the bridging role of the GP fellows. As noted above, this needs to be supported by communicating and involving those with whom the GP Fellows will work, both in planning and in implementation and ongoing delivery, e.g. GPs, Geriatricians, Allied Health Professionals, nursing staff. If there is no consultation with key players at practice level it may be difficult for GP Fellows to establish and sustain links, potentially limiting the scope of what they can do.

One way of setting the foundation stones for ongoing relationships may be the system of rotation across different secondary care specialities during the GP Fellow training year. This provides the GP Fellows with an opportunity to meet

and work with professionals who they may subsequently work alongside when they have finished their training year. It may also help to generate enthusiasm for the model across sectors.

Co-locating GP fellows with other relevant teams, such as the ECT in NHS Forth Valley, is another valuable route for establishing relationships and providing the jumping-off point for joint working between professionals:

‘Yes, they’re actually sitting in the same office as us, and as we speak, working alongside the nurses giving advice...if they need any support or advice the GPs will give it and they’ll look at medications, they will go out and do joint home visits with the nurses...so very much integrated into that team.’

Developing the ‘hubs’

Although still at an early stage of evolution, the first shoots of the ‘hub’ component were beginning to emerge in each of the two pilot sites. The GP Fellows in NHS Fife, for example, were beginning to work on ideas for developing community frailty clinics based out of GP surgeries.

In NHS Forth Valley, the co-location and joint working between the GP Fellows and the ECT was the seedbed for the hub. At the time of the evaluation the scope may have been limited because the GP Fellows only covered a part of the catchment area covered by the ECT. What can be offered may also be limited by the extent of consultant cover. In NHS Fife the ‘Hospital@Home’ service is a consultant-led community service; the ‘Closer to Home’ service in NHS Forth Valley does not include consultant cover. This may have implications for who can be supported at home, even with GP Fellow input.

In addition to the links with the ECT the NHS Forth Valley GP Fellows also had access to an in-patient bed, located at Bo’ness Community Hospital. This had been used once at the time of the evaluation. It was suggested that the

potential to develop this resource may be limited for a variety of reasons, including, for example, the need at the time of the evaluation to coordinate rehabilitation support and travel considerations for staff, patients and their families.

Potential for impact

The pilot is very small scale, and in the early stages of development in each of the two sites. But those interviewed could perceive its potential as a model, and the potential too for growing the service.

The scope for the model to support people to remain at home, and improve the patient experience, was illustrated with reference to one example. The view was that by having the GP Fellows 'on board' they were able to keep an elderly patient with a chest infection at home:

‘..And that journey for that patient would’ve stopped at that point if we hadn’t had the GP Fellows to take them that bit further...That patient had a fabulous experience – and we kept him at home.’

The added value of the GP Fellows is that, in addition to providing support and advice, including in relation to medication, they are able to access diagnostic procedures, including X-ray or other radiology imaging tests that neither the nurses attached to services like the ECT, nor GPs in primary care can do directly. It was also suggested that more people could be retained at home if the ECT team could administer intravenous (IV) fluids and antibiotics. Subsequent to the evaluation it was suggested that the recent appointment of a consultant who could provide advice on suitability and support may mean that GP Fellows, as part of the ECT team, could support the administration of IV fluids and antibiotics. This was, however, still under discussion. But supporting people at home may also be contingent on the availability of social care resources to provide additional input.

For primary care and GPs, the role was felt to offer an attractive new career path – offering a varied role with a better work-life balance. But because of the

split nature of the role it may add only limited additional capacity (in the short term) to GP practices.

For community care, the GP Fellows were going on joint visits with nurses and were able to bring in expertise on, for example, physical health issues running alongside mental disorders, or issues relating to medication, etc. The co-location of GP Fellows with the pre-existing nurse-led ECT also increased the opportunities for providing support and advice.

For secondary care, it was suggested that the GP Fellows had the potential to bring in 'the real generalist perspective'.

Conclusions

Although experiencing initial start-up difficulties, some of which reflected the new and innovative nature of the model, by the time of the baseline evaluation the GPCH was beginning to take concrete shape in each of the two pilot sites. The potential for the model to achieve positive impacts for patients was also starting to emerge. But to develop and maintain momentum, the early stages also underlined the importance not only of a champion to drive the work forward, but also the need to get 'buy in' from the key strategic and operational players at primary, secondary and community care levels. To work and develop the hubs at the interface GP Fellows need to have the relationships and support from across the interface.

