GP at hand's approach to addressing complex patient needs

Th GP at hand service has been serving people resident in multiple CCGs in and around London for over seven months, with clinical assurance led by NHS England (London) Medical Directors, and has demonstrated that people with complex conditions wish to access the service and are being safely and effectively cared for. A full Equalities Impact Assessment is being carried out by the partnership, including a commitment to EDS2 mapping - the first NHS general practice to do so.

Features of the GP at Hand service
GP at Hand has been specifically designed and set up to provide high quality care for all patients. There are a number of features which are particularly relevant to those with more complex needs.

Access
In order to ensure high quality care for all patients, but particularly those with extra needs as detailed below, timely access to appointments is of vital importance. Over the past six months, the average wait for a GP at Hand appointment has been 38 minutes, compared to national average waits for routine NHS GP appointment of a week or more.

Continuity
Continuity of care is also very valuable for these groups of patients. Because GP at Hand operates 24 hours a day, 365 days a year, there is unparalleled continuity of care overseen by a single provider, without the risk of patient notes being unavailable across out of hours services. The full SystmOne notes are available at every single appointment. Our GPs work regular shifts each week, so continuity of doctor is easily arranged where this is needed.

The Complex Care Team
In order to facilitate care for patients with extra needs, we have established a multidisciplinary Complex Care Team to provide inter-consultation continuity and care coordination for our most vulnerable patients. This is led by a medically-qualified full-time Complex Care Coordinator, with input from a team of four GPs, a Nurse and administrative support staff. We are currently recruiting additionally for a mental health nurse to join this team. The role of the Complex Care Team is to provide coordination for a patient's care in between appointments, ensure referrals are processed, liaise with other clinical professionals and social care, signpost the patient to sources of support including the voluntary sector, ensure continuity of care for patients and more. There are currently 51 patients being actively managed by this team, many of whom are in the groups below. Patients are identified for this service by GPs, notes summarisers, and patients themselves. The team meet weekly to consider all current patients and new referrals, as well as all patients on the practice Safeguarding lists.

Recording and sharing consultations
As well as access and continuity, there are a number of additional features of the GP at Hand service which mean that it is particularly suitable for those with complex needs. All consultations are recorded and as well as viewing the full notes from the consultation, the patient can play back the video and audio recording at any time. For those who find remembering information difficult, or who wish to share their consultation with their carers or family, this facility is very helpful.

Physical appointments
Physical appointments with GP at hand doctors are of course also available throughout and beyond core GMS hours and can be arranged urgently on the same day where needed.

Coordination with local teams
Since first treating patients with a digital-first model in July 2017, the GP at hand clinical and support teams have been building relationships with providers of community services (e.g., radiology, phlebotomy, mental health) across more than 30 clinical commissioning groups. This includes the work of the Complex Care Team described above and in the case examples below, as well as the support team who ensure that referrals and investigations are tracked and followed up.

Specific patient groups

Adults with a safeguarding need
In addition to access and continuity, inter-agency communication and information sharing is of paramount importance for those with a safeguarding need. GP at Hand have a designated Safeguarding Lead who attends Safeguarding Lead meetings regularly. In addition, our weekly multidisciplinary Complex Care Team meeting provides assurance that such patients' needs are continually reviewed.

Case Study: Miss S is a 49 year old lady with multiple comorbidities, polypharmacy and mental health problems. She is known to multiple services and has documented safeguarding needs. She has been actively managed by our Complex Care Team since her registration with GP at Hand in September 2017. We have attended multidisciplinary case conferences and liaised closely with social services and local community teams. A GP speaks with her on a weekly basis. Her medication has been rationalised after discussion with hospital specialists involved in her care and she has a detailed care plan in place. All monitoring is up to date and we are working with her to increase her attendance at secondary care appointments.

People living with complex mental health conditions
In their paper looking at Mental Health provision in London, the Healthy London Partnership identified a number of key themes to improving mental health care within and beyond primary care. Key themes included providing care in a less stigmatised, more familiar and closer to home environment, improved accessibility to uncover unmet needs, and robust data sharing to facilitate care. The GP at Hand service has been specifically set up to provide for these needs. We have 213 patients on our Mental Health register, 176 of whom have more severe conditions. All patients in this group have been comprehensively reviewed by a GP and continue to be seen regularly.

Case study: Mr M is a 39-year-old man with Bipolar Disorder and Borderline Personality Disorder. He registered with GP at Hand in November 2017. His care has previously been compromised by his inability to leave the house most days because of anxiety. In the year prior to joining GP at Hand, he failed to attend multiple appointments with his GP and failed to attend for review appointments frequently. Since registering with us, he has been seen every 3-4 weeks by a GP and has not missed a single appointment. He had been lost to follow up by local mental health services due to his failure to engage; our Care Coordinator has been able to liaise frequently with local teams and is in the process of facilitating a domiciliary assessment by his local CMHT.

People with complex physical, psychological and social needs

For those with particularly complex needs, our Complex Care Team provides an essential service. This multidisciplinary team meets weekly and helps to support patients between consultations. We have a number of patients with a combination of physical, psychological and social needs.

Case study: Ms E is a 56 year old lady with personality disorder and other complex mental health problems, chronic pain, and complex neurological problems currently under investigation. She has been registered with GP at Hand since February 2018. She has previously been registered with multiple GPs, each for a few weeks at a time. She was reviewed by a GP in a face to face appointment promptly after registering with us, and has a care plan in place. She is being actively managed by our Complex Care Team and sees a GP weekly. She has a number of social and housing needs that have been addressed by liaison with local services.

People living with dementia

Whilst the app used to facilitate consultations has been designed to be as simple as possible to use, we recognise that those with advanced dementia are unlikely to be able to use an electronic device to consult with a doctor. However, for the family and carers of such patients, who themselves are likely to be juggling many different commitments to family and work, having fast 24 hour a day access to appointments is vital. Additionally, the continuity of seeing the same team of doctors whatever the time of day is very useful. For such patients, the GP at Hand service is likely to be of benefit.

The practice has 13 patients with dementia, all of whom primarily access the physical service at Lillie Road.

Older people with conditions related to frailty

Patients with conditions related to frailty are likely to be less able to visit their surgery to see a GP. For such patients, having access to a GP without having to leave their home is of considerable benefit.

Case study: Mrs S is a 65-year-old lady with multiple diagnoses and indicators of frailty. She is cared for by her daughter, who manages most of her healthcare. As Mrs S finds it difficult to attend appointments due to her poor mobility, she has found the access to digital consultations very helpful. She is also able to share the notes and video of her consultations with her daughter. Our Complex Care Team have helped her to complete an application for Personal Independence Payment and facilitated outstanding reviews for her many long-term conditions.

People requiring end of life care

For those requiring end of life care, the 24 hour availability of the GP at Hand service is particularly helpful. Having access to a GP familiar with your care within minutes in the middle of the night is potentially very valuable.

There are 12 patients on our palliative care register. We do not currently have any patients who are in the last stages of life, but have a procedure in place to ensure continuity of care and access for such patients when needed.

Parents of children who are on the 'Child at risk' protection register

All children on the protection register are coded within SystmOne, and an alert added also to the parent's notes to highlight this. Families with a child on the register are discussed weekly at our Complex Care Team meetings so that extra support can be provided when needed.

GP at Hand actively participate in safeguarding meetings. We currently have 35 families using the digital service who have a child or children in whom there is a safeguarding concern. This list is reviewed by our Safeguarding lead on a fortnightly basis, with input from the Complex Care Team.

Case study: Ms E has four children, all of whom are on the protection register. Her children do not currently live with her, but she has access regularly. This adds to her mental health and mood problems, and she has been supported by regular GP appointments and community services. Our Complex Care Co-ordinator has facilitated referral to counselling services and continues to remind Ms E of these appointments and promote her attendance, which has previously been a problem for her. We have worked closely with her social worker and continue to attend case conferences as needed.

People with learning difficulties

We have 23 patients registered with us with learning difficulties. The babylon app that supports GP at hand is designed to be accessible to all patients, and the language used is simple and easy to understand. Recorded consultations can be played back by the patient at any time, allowing information to be absorbed in a manageable way as required. All our patient notes are written in easy-to-understand language.

Case study: Mr J has a diagnosis of Learning Disability, Asperger's Syndrome, Anxiety and Depression. He has been registered with GP at Hand since November 2017, having previously found it difficult to build a relationship with previous GPs leading to him avoiding care and failing to attend appointments. Since registering, he has built up a good rapport with a small group of GPs and our Complex Care Coordinator and attends appointments regularly. He has frequently presented with suicidal ideation and he has been reviewed regularly both by digital and face to face appointments. We have liaised closely with his local mental health and crisis teams and have been so far successful in encouraging him to engage with services in a way that he has not done for the previous few years.

People with drug dependence

It is recognised that continuity of care is of importance when managing people with drug dependence. With the 24/7 availability of the GP at Hand service, there is no need for such patients to suffer fragmented care via out of hours services in the evenings and weekends, in turn leading to a higher quality of overall care.

We have a clear and strict policy for managing requests for controlled medication, to reduce the likelihood of patients attempting to obtaining medication falsely. Our Pharmacy team run regular audits on controlled medication use to identify any patients who may be overusing their prescribed drugs.

Case study: Mr Z is a 40-year-old man with a history of opioid dependence. He is under the care of his local addiction team and using Buprenorphine maintenance therapy. When he registered

with us in January 2018, he had also recently begun to misuse clonazepam, obtained illicitly and also from his previous GP. We have worked with his addiction recovery team to agree with him a benzodiazepine reduction plan, and he has been having weekly GP appointments to manage this plan. He continues with his maintenance Buprenorphine treatment on a shared care basis.

Women who are or may be pregnant

We have demonstrated that we are able to look after women prenatally and postnatally, and that GP at hand is a service which a number of pregnant women actively wish to use as their NHS GP service. We are also engaging with the NHS England screening lead for London (as suggested by commissioners) and have met with several screening programme leads already. We have also shown that we are well able to coordinate with local services providing care to people with a range of different health needs. Health visiting is no exception.

References

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