Physician Associates

Value Proposition

April 2016

Version 5

Transforming London's health and care together

Contents

Background

To enable the delivery of a modern health and care workforce in London for Londoners, a collaborative workforce transformation programme has been established on behalf of London's clinical commissioning groups (CCGs) and NHS England (London) together with Health Education England (HEE). Through working with partners, including ADASS and NHS Improvement, this programme of work is recognised as an enabler to mitigate existing service workforce challenges, and ensure the successful delivery of new care models across London. This programme is called Healthy London Partnership and has thirteen programmes of which workforce is one of those programmes.

In January 2016, the Healthy London Partnership Workforce Programme established a Task and Finish Group, with a remit to focus on Physician Associates. The meeting is supported by representatives from LETBs, HEE, Strategic Planning Groups, St George's University, GPs, Physician Associates and the Faculty of Physician Associates across London. In its first meeting, the group developed a 7 point action plan which included the requirement to develop a high level value proposition to explore how funding of new roles such as PAs could be achieved in the current system.

Introduction

The principle of the value proposition is to demonstrate the benefit and determine indicative costs of introducing new roles such as Physician Associates in Primary Care in London.

The value proposition is intended for workforce leads, practice managers, GPs and interested parties looking to develop the Primary Care workforce and seeks to test whether practices can improve patient access and patient care. This could be achieved by reducing locum spend or funded through additional income from full delivery of their Quality Outcomes Framework (QOF), Direct Enhanced Services (DES), National Enhanced Services (NES) and Local Enhanced Service (LES) achievements. The later would be achieved through focusing on blended skills mix with the practice through the introduction of Physician Associates in to General Practice.

The findings within this document are intended to provide an insight into the potential opportunities available in Primary Care and should be considered as indicative, therefore further financial analysis and workforce planning using local data should be undertaken to understand how these roles could be introduced and what could be achieved at a local level over the long term.

Reducing locum spend at a CCG or Federation level

Historically, workforce planning has not been undertaken on a strategic level resulting in under-resourcing in practices and an increased use of locum cover. This is coupled with an under-supply of General Practitioners nationally.

The Task and Finish Group recommended that the spend on locum could be an area which could potentially be realigned to fund permanent, substantive Physician Associates positions and the following case study outlines the potential spend at a CCG level and number of full time equivalent Physician Associates that could be employed if this spend was realigned. This does not mean all GP locums could be replaced by PAs and should be considered as part of blended team solutions.

The following methodology uses assumptions to determine the full time equivalent of PAs that could be employed and the examples presented give indicative figures of the potential opportunity.

Methodology

The data sources used in the analysis are:

- Primary Care Web Tool, NHS England
- North London Locum Group Locum Rates

The estimated daily cost of locum cover is calculated using the following assumptions:

1. The indicative hourly rate for locum cover is £85 per hour
2. An additional 14.3% is charged for pension contributions
3. The cost of locum per day is calculated on a session being 3 hrs and usually 2 in a day, totalling 6 hours.

Number of Locum days required for all practices is calculated using the following assumptions:

4. Half of all practices within a CCG will need locum cover in a year
5. The amount of locum days per practice, per year is estimated as 33 (this comprises of 30 days (6 weeks) holiday and 3 days CPD per practice)
6. Estimates are for one GP member of staff only

Estimated total cost of CCG locum cover is calculated by multiplying the daily cost of locum cover by the number of locum days required by practices that require cover.

Potential number of Full Time Equivalent (FTE) Physician Associates is calculated by dividing the total PA employment costs by Total PA employment costs using the following assumptions:

7. The PA salary is £40K which is an indicative cost for an experienced PA
8. On-costs are estimated to be 20% of the total salary

Estimated PA Salary costs are calculated by multiplying the potential number of FTE PAs by Total PA employment costs.

Please note: All figures have been rounded to whole numbers

Case Study 1 - Locum Expenditure Analysis

Hourly cost of locum cover	£ 85.00
Pension contribution (14.3%)	£ 12.16
Cost of Locum per day (6 hours per day)	**£ 582.93**
(Hourly cost of locum cover + Pension contribution (14.3%) x 6)	
Number of Practices in CCG	47
Number of Practices that require locum cover	**24**
Number of locum days needed by practices that require cover	**776**
(Number of Practices that require locum cover x 33 days)	
Estimated cost of locum cover	**£ 452,062**
(Cost of Locum per day x Number of locum days needed by practices that require cover)	
Experienced Physician Associate salary	£ 40,000
On-costs (20%)	£ 8,000
Total PA employment costs	**£ 48,000**
Potential number of FTE PAs	**9**
(Estimated total cost of CCG locum cover / Total PA employment costs)	
Estimated PA salary costs	**£ 432,000**
(Potential number of FTE PAs x Total PA employment costs)	
Surplus	£ 20,062

Potential Additional Income & Locum Expenditure Analysis at a Practice Level

To access whether opportunities exist at a practice level through additional income from full delivery of QOF, DES, NES, LES and reducing locum spend, the following methodology has been developed and practices evaluated with a weighted patient list size of less than 5K, greater than 5K and greater than 10K.

Methodology

The data sources used in the analysis are:

- NHS Payments to General Practice, England, 2014-15, Health and Social Care Information Centre.
- Primary Care Web Tool, NHS England
- NHS Choices

To determine practices that could be used for case studies, the NHS Payments to General Practice, England, 2014-15 was analysed to identify practices in London that were achieving low levels of QOF for their weighted patient population.

The Primary Care Web Tool was then used to review the performance of the practice to understand whether they were also experiencing issues achieving their General Practice Outcome Standards. The following indicators were reviewed as they highlight where there is potential for a multi-skilled, blended team to improve practice outcomes:

- Cancer Estimated Diagnosis Rate
- Cervical Cytology
- Recording Smoking Status
- Smoking Cessation Advice
- AF Estimated Diagnosis Rate
- Anti-Coagulation for AF
- Childhood Immunisations
- Flu Vaccination (over 65s)
- Flu Vaccination (at risk)
- COPD Estimated Diagnosis Rate
- Asthma Estimated Diagnosis Rate
- Diabetes Estimated Diagnosis Rate
- CHD Estimated Diagnosis Rate
- Dementia Diagnosis Rate (Adjusted)
- Emergency LTC Admissions
- %Naproxen and Ibuprofen
- Detection rate for Cancer
- A&E Attendance Rates
- Satisfaction (Quality) a-g
- Satisfaction (Overall Care) a-b
- Changing Practice
- Patient Experience
- Satisfaction (Access) a-c
- Significant Event Reviews
- Depression Estimated Diagnosis Rate
- Depression Assessment
- SMI Physical Health (BP)
- SMI Physical Health (d1+d2)
- End of Life Care

A sample of practices which were both underperforming in QOF, DES, NES and LES and not achieving their General Practice Outcome Standards were then selected from across London to form the basis of the case studies for a weighted patient list size of less than 5K, greater than 5K and greater than 10K. The practices that were the subject of each case study were compared with a cohort of practices selected from within the same locality and a similar weighted practice list size. Practices within in a cohort were also analysed to assure that these were of a similar patient demographic to enable comparison. Potential additional income was calculated by subtracting the case study practice QOF, DES, NES and LES achievements from the highest amounts achieved by another practice in the cohort.

Locum expenditure was calculated as a fixed amount based on the assumption that locum cover would be required for 2 x 3 hour sessions (6 hours) for 30 days (equivalent to 6 weeks holiday cover) and 3 CPD days per year at an indicative cost of £85 per hour plus pension costs at 14.3%.

Case Study 2 - Practice with a weighted patient list size less than 5K

This practice has 3 GPs and 3 Practice Nurses and 1 Nurse Practioner and a weighted practice list size of 4900 and operates on a PMS contract.

In 2014/15, the practice's Quality Outcomes Framework (QOF) achievement was £33K and the total achieved for all Direct Enhanced Services (DES) categories was £42K. An achievement of £398 was recorded for the National Enhanced Services (NES) and £21K was achieved for Local Enhanced Services (LES).

Total QOF, DES, NES and LES achievement for 2014/15 = £95K

The practice is experiencing issues with achieving its General Practice Outcome Standards in the following areas:

- Smoking Cessation Advice
- Dementia Estimated Diagnosis Rate

There are also concerns with:

- Recording Smoking Status
- Satisfaction (Overall Care)
- Satisfaction Access
- Patient Experience
- CHD Estimated Diagnosis Rate
- A&E attendance
- Anti-Coagulation for AF Estimated Diagnosis
- Satisfaction (Quality)
- AF Estimated Diagnosis Rate
- Asthma Estimated Diagnosis Rate
- COPD Estimated Diagnosis Rate
- SMI Physical Health (BP)
- SMI Physical Health (d1+d2)
- Depression Estimated Diagnosis Rate

Please note:

- Where no achievement is shown for the potential saving no practice achieved this outcome standard within the cohort
- Where the potential achievement is the same as the 2014/15 income the case study practice was the highest achiever in the cohort

The analysis shows that if the practice were to achieve a higher rate of QOF, DES, NES and LES and locum expenditure was reduced, a potential budget could be created to fund new positions within the practice.

	2014/15 Income	Potential Income
QOF	£ 31,642	£ 57,849
Potential Additional QOF Income		**£ 26,207**

DES	2014/15 Income	Potential Income
Alcohol	£ -	£ -
Childhood Vaccination and Immunisation Scheme	£ 12,045	£ 24,582
Extended Hours Access	£ 17,322	£ 17,322
Facilitating Timely Diagnosis and Support for People with Dementia	£ 2,243	£ 15,287
Improving Patient Online Access	£ -	£ 2,404
Influenza and Pneumococcal Immunisations	£ 7.63	£ 6,517
Learning Disabilities	£ 1,124	£ 1,124
Minor Surgery	£ 2,203	£ 5,597
Patient Participation	£ -	£ 5,855
Remote Care Monitoring	£ -	£ -
Risk Profiling and Case Management	£ 2,027	£ 4,006
Rotavirus and Shingles Immunisation	£ 573	£ 1,268
Services for Violent Patients	£ -	£ -
Unplanned Admissions	£ 5,432	£ 9,353
Total	£ 42,977	£ 93,315
Potential Additional DES Income		**£ 50,337**

National Enhanced Services	2014/15 Income	Potential Income
National Enhanced Service Total Income	£ 398	£ 713
Potential Additional National Enhanced Service Income		**£ 2,403**

LES Income	2014/15 Income	Potential Income
Local Enhanced Service Total Income	£ 20,870	£ 22,048
Potential Additional LES Income		**£ 1,178**

Locum Cover Expenditure Saving	Potential Saving
6 weeks holiday and 3 CPD days per year.	£ 19,237

Potential Additional Income from QOF, DES, NES, LES & Potential Savings	**£ 97,275**

Potential New Roles	Salary Cost
1 x FTE PA	£ 40,000
On-costs (20%)	£ 8,000
Underspend	£ 49,275

Case Study 3 - Practice with a weighted patient list size greater than 5K

This practice has 3 GPs, 1 Practice Nurse and 1 Nurse Practioner and a weighted practice list size of 5300 and operates on an APMS contract.

In 2014/15, the practice's Quality Outcomes Framework (QOF) achievement was £42K and the total achieved for all Direct Enhanced Services (DES) categories was £34K. No achievement was recorded for the National Enhanced Services (NES) and £37K was achieved in Local Enhanced Services (LES).

Total QOF, DES, NES and LES achievement for 2014/15 = £113K

The practice is experiencing issues with achieving its General Practice Outcome Standards in the following areas:

- Asthma Diagnosis
- CHD Diagnosis
- Patient Satisfaction (Quality)
- Patient Satisfaction (Overall Care)

There are also concerns with:

- Patient Experience Rate
- Satisfaction Access
- A&E attendances
- AF Estimated Diagnosis
- COPD Estimated Diagnosis Rate
- SMI Physical Health (BP)

Please note:

- Where no achievement is shown for the potential saving no practice achieved this outcome standard within the cohort
- Where the potential achievement is the same as the 2014/15 income the case study practice was the highest achiever in the cohort

The analysis shows that if the practice were to achieve a higher rate of QOF, DES, NES and LES and locum expenditure was reduced, a potential budget could be created to fund new positions within the practice.

	2014/15 Income	Potential Income
QOF	£ 41,753	£ 61,274
Potential Additional QOF Income		**£ 19,521**

DES	2014/15 Income	Potential Income
Alcohol	£ 2,282	£ 2,282
Childhood Vaccination and Immunisation Scheme	£ 3,600	£ 11,281
Extended Hours Access	£ -	£ 15,572
Facilitating Timely Diagnosis and Support for People with Dementia	£ 7,240	£ 6,927
Improving Patient Online Access	£ -	£ 2,225
Influenza and Pneumococcal Immunisations	£ 5,868	£ 5,868
Learning Disabilities	£ 409	£ 1,193
Minor Surgery	£ -	£ 217
Patient Participation	£ 5,368	£ 5,368
Remote Care Monitoring	£ -	£ -
Risk Profiling and Case Management	£ -	£ 3,276
Rotavirus and Shingles Immunisation	£ 138	£ 969
Services for Violent Patients	£ -	£ -
Unplanned Admissions	£ 9,272	£ 9,272
Total	£ 34,177	£ 64,450
Potential Additional DES Income		**£ 30,273**

National Enhanced Services	2014/15 Income	Potential Income
National Enhanced Service Total Income	£ -	£ 2,403
Potential Additional National Enhanced Service Income		**£ 2,403**

LES Income	2014/15 Income	Potential Income
Local Enhanced Service Total Income	£ 36,677	£ 64,724
Potential Additional LES Income		**£ 28,047**

Locum Cover Expenditure Saving	Potential Saving
6 weeks holiday and 3 CPD days per year.	£ 19,237

Potential Additional Income from QOF, DES, NES, LES & Potential Savings	**£ 99,481**

Potential New Roles	Salary cost
1 PA (FTE)	£ 40,000
On-costs (20%)	£ 8,000
Underspend	£ 51,481

Case Study 4 - Practice with a weighted patient list size greater than 10K

This practice has 3 GPs, 0.2 FTE Nurse Prescriber and 0.6 FTE Practice Nurse and a weighted practice list size of 10856 and operates on a PMS contract.

In 2014/15, the practice's Quality Outcomes Framework (QOF) achievement was £489K and the total achieved for all Direct Enhanced Services (DES) categories was £89K. An £84 achievement was recorded for the National Enhanced Services (NES) and £30K was achieved in Local Enhanced Services (LES). Total QOF, DES, NES, LES achievement for 2014/15 = £167K

The practice is experiencing issues with achieving its General Practice Outcome Standards in the following areas:

- Smoking Cessation Advice
- Patient Satisfaction (Quality)

There are also concerns with:

- Reducing Smoking Status
- AF Estimated Diagnosis Rate
- COPD Diagnosis
- Asthma Diagnosis
- A&E attendances
- Patient Satisfaction (Quality)
- Patient Experience
- Patient Satisfaction (Quality)
- Depression Diagnosis
- Depression Assessment
- SMI Physical Health (BP)
- SMI Physical Health (d1+d2)

Please note:

- Where no achievement is shown for the potential saving no practice achieved this outcome standard within the cohort
- Where the potential achievement is the same as the 2014/15 income the case study practice was the highest achiever in the cohort

The analysis shows that if the practice were to achieve a higher rate of QOF, DES, NES and LES and locum expenditure was reduced, a potential budget could be created to fund new positions within the practice.

	2014/15 Income	Potential Income
QOF	£ 48,580	£ 134,097
Potential Additional QOF Income		**£ 85,517**

DES	2014/15 Income	Potential Income
Alcohol	£ -	£ -
Childhood Vaccination and Immunisation Scheme	£ 31,426	£ 40,031
Extended Hours Access	£ 26,050	£ 26,050
Facilitating Timely Diagnosis and Support for People with Dementia	£ 4,117	£ 25,262
Improving Patient Online Access	£ -	£ 4,226
Influenza and Pneumococcal Immunisations	£ 191	£ 14,875
Learning Disabilities	£ 1,002	£ 2,758
Minor Surgery	£ -	£ 19,676
Patient Participation	£ -	£ -
Remote Care Monitoring	£ -	£ -
Risk Profiling and Case Management	£ 7,650	£ 8,566
Rotavirus and Shingles Immunisation	£1,329	£ 2,856
Services for Violent Patients	£ -	£ -
Unplanned Admissions	£ 17,579	£ 19,136
Total	£ 89,344	£ 163,436
Potential Additional DES Income		**£ 74,092**

National Enhanced Services	2014/15 Income	Potential Income
National Enhanced Service Total Income	£ 84	£ 813
Potential Additional National Enhanced Service Income		**£ 729**

LES Income	2014/15 Income	Potential Income
Local Enhanced Service Total Income	£ 29,699	£ 52,933
Potential Additional LES Income		**£ 23,234**

Locum Cover Expenditure Saving	Potential Saving
6 weeks holiday and 3 CPD days per year.	£ 19,237

Potential Additional Income from QOF, DES, NES, LES & Potential Savings **£ 202,809**

Potential New Roles	Salary Cost
2 FTE PA (£40K Salary)	£ 80,000
On-costs (20%)	£ 16,000
Underspend	£ 106,809

Conclusion

The case studies within this document demonstrate that there could be potential for practices to improve their General Practice outcome measures with the introduction of new roles such as Physician Associates.

The analysis of locum spend demonstrates this could be a source of funding which could be re-aligned to funding substantive Physician Associate positions within practices. It is envisaged that locality level workforce planning would be beneficial and provide an opportunity to transition away from a dependency on locum cover towards blended team solutions over a number of years, which is sustainable given the resourcing gaps currently with General Practitioners. It is also acknowledged that practices may pay different rates and the amount of locum cover will vary from practice to practice. The assumed costs for locum cover and associated costs used in this analysis should be considered for illustrative purposes only as they are likely to be an under-estimation of the true costs and it would be beneficial, if at a CCG/GP Federation level, the actual costs could be aggregated directly from practices to understand the true spend.

These studies also demonstrate, that by analysing the potential highest achievements for QOF, DES, NES and LES within a cohort of practices against that already being achieved by other practices, there are opportunities from national and local sources of funding which could be used to fund new positions, which at the same time, would greatly increase patient access, care and satisfaction. It is acknowledged that further analysis at a practice level is required for identifying the potential income to ensure this can be replicated at a local level, accounting for practice demographics. Therefore, this analysis should be considered for illustrative purposes only, providing a potential methodology that practices could adopt to determine the viability of this approach, as practices will have further detail on profit and loss of their individual practices which will also needs to be consider alongside this methodology.

Recommendations

- **Workforce modelling** needs to take place in every locality to determine where it would be appropriate to use Physician Associates and to understand how blended teams may offer solutions to resourcing issues in General Practice. The methodology needs to be tested with actual practice level data which includes profit and loss.

- **Jointly develop model for workforce planning** taking a long term view of at least 3-5 years to enable the development of Physicians Associates and to grow an available workforce that could be flexed to support local GPs and offer a blended solution for patients. This analysis should be done in conjunction with exploring productivity and access benefits. Financial analysis and workforce planning will need to model both demand and productivity as there is a limited supply of students each year that will require support and further training locally to become experienced and operate at full capacity.

- **Alignment between service commissioners, providers and LETBs:** GP Federations, CCGs and LETBs could adopt the methodology to test locally whether the model is replicable using local practice data, what quality improvements this could bring for patients and how funding could be pooled to develop a long term approach to funding and growing a talent pipeline to ensure consistency in supply.