

**GP USE OF ADDITIONAL TIME
AS PART OF THE GOVAN SHIP PROJECT**

DEEP END Report 29 : www.gla.ac.uk/deepend

SOURCES OF DATA

Summaries of all activity involving patient contact in the Blue, Green and David Elder practices during February 2016

15 GP diaries describing uses of additional time during two weeks in February 2016

OVERVIEW OF PATIENT CONTACTS IN FEBRUARY 2016

	BLUE	GREEN	DAVID ELDER	TOTAL
GP	926	1202	1567	3695
GP Registrar	303	274	511	1088
GP Retainer	-	149	206	355
SHIP locum	300 (45%)	186 (28%)	176 (27%)	662
ALL GP CONTACTS	1529 (26%)	1811 (31%)	2460 (42%)	5800
PRACTICE POPULATION	3606 (26%)	4630 (33%)	5860 (42%)	14096
Practice nurse	130	330	635	1095
Nurse practitioner	60			
HCSW	80			

GP CONTACTS IN FIRST HALF OF FEBRUARY 2016 (when GP diaries were recorded)

	SHIP LOCUM	GP	GP REGISTRAR	GP RETAINER	TOTAL
BLUE	172	482	142	-	796
GREEN	93	672	53	102	920
DAVID ELDER	51	806	257	111	1225
TOTAL	316 (11%)	1960 (67%)	452 (15%)	213 (7%)	2941 (100%)

CONTENT OF GP DIARIES (combined)

- 28 GP sessions were described, including :-
- 76 extended consultations, including home visits
- 14 case record reviews without the patient being present
- 9 sessions for correspondence
- 6 sessions providing reports
- 5 sessions involving case conferences
- 9 sessions involving other types of meeting
- 11 sessions involving other types of activity
- 6 sessions involving GP leadership activity
- plus
- 14 free text comments on use and perceived value of additional time

CONTENT AND OUTCOMES OF EXTENDED CONSULTATIONS

Length	Content
20mins	Patient with major depressive symptoms, outside risk and substance misuse. Outcomes: planning of future care and development of other organisations.
20 mins	Patient with severe diagnosed depression and child protection issues. Outcomes: during consultation likely COPD diagnosed referred for spirometry/smoking cessation.
20 min	Pregnant patient - major child protection concerns - background of domestic violence and drug misuse. Outcomes: SW contacted and telephone discussion re planned care conference.
20 mins	2016 newly diagnosed palliative care patient. Outcomes: met with family and discussed management and D11000.
21 mins	Planned palliative care discussion at home with patient and carer, mid-cancer diagnosis. Outcomes: clinical expectations discussed to allow time over management, linked with secondary care consultant by phone for agreement with treatment plan.
20 mins	Post hospital discharge visit to elderly lady with multiple co-morbidities and polypharmacy. Outcomes: medication review and link with social services and ACP planning.
20 mins	Planned visit to elderly patient and carer with dementia and neurological diagnosis. Outcomes: discussed care options, to some extent prognosis and palliative treatment. Linked into district nursing and palliative care team. ACP planning with carer.
20 mins	Child 1.5 years frequent attendee to surgery with minor self-limiting symptoms. English poor and requires translator. Planned review to discuss support and education of both siblings. Outcomes: linked in with Health Visitor for further ongoing support which also involves local third sector agencies. Aim to support mother and reduce attendance at general practice.
20 min	Extended consult in surgery for a patient with complex medical and psychosocial needs. Outcomes: management plan and education provided.
20 mins	Single aged patient who has moved to residential accommodation. Siblings, thoughts of self-harm, link of self-worth and dependent. Little self-care. Patient whom I have known for many years. Family support and patient feeling excluded. Outcomes: discussion, DWP benefits arranged, housing officer appointment. Trial self-depression and advice in terms of family contact. Review planned for 1 week.
20 mins (including travel time)	Homebound elderly patient, lives alone with severe support, highly anxious and had prolonged admission for 2x123 days 2015. Close infection and anxiety of uncertain origin. Outcomes: reviewed and blood checked. Medication reviewed and amended after discussion. With social support, aim to be pre-empt admission if possible. So far managing in community.

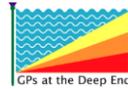
EXTENDED GP CONSULTATIONS

CARE Plus Study findings

- Cost-effective
- Prevent things getting worse

Govan SHIP

- Large number of patients are eligible
- Address unmet need (Inverse Care Law)
- Planning and coordinating care anew
- Driving integrated care from the bottom up
- Complex, varied work requiring clinical generalists, linking to others
- Link Workers involved in only 2 out of 76 cases
- Improve GP morale
- Long term outcomes and implications not known



GPs at the Deep End

Patterns of Health Care Use at Govan Health Centre

B.Sc. Student Project

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SAMPLE STUDIED USING EMIS AND DOCMAN

- 400 patients, alive at the end of 2015 (100 from each practice)
- A third of all patients with 12-26 GP encounters in 2014
- 7-13% of all patients in the practices
- 22-34% of all GP encounters
- Median group aged 45-64 and female
- 50% on an antidepressant
- NHS contact in 2015 : 72% 1y care; 19% 2y, 9% unscheduled
- Two thirds of unscheduled care required no further action
- 85% of 1y care contacts involved GP
- Average of 11 GP encounters in 2015 (?regression to the mean)
- Commonest community contact was with mental health services (21%)

INVOLVEMENT OF FREQUENT ATTENDERS IN SHIP

- 50 (13%) were in SHIP (6% of all SHIP patients)

SHIP INTERVENTIONS

• Extended consultation	7
• Additional house calls	3
• Referrals (social work, HV, voluntary sector)	16
• Social worker contact	9
• Community Link Practitioner contact	15
• MDT meeting	29
• Palliative care review	7

USES OF CARE BY PATIENTS RECEIVING A SHIP INTERVENTION

- 6 (12%) accounted for 54% of unscheduled care (OOH, NHS 24, A&E)
- 4 (8%) accounted for 66% of unscheduled emergency admissions
- Patients with a SHIP extended consultation had on average 2 unscheduled care contacts (compared to 4 without)
- 56% of patients at the two practices with Link Workers, had one or more contacts with them
- 76% of MDTs were for patients receiving palliative care

COMMENTS

- "high attenders" is not a stable category and may not predict future health care use
- Majority of care delivered in Primary Care and by GPs
- Two thirds of unscheduled care required no further action
- Frequent attending was not a major criterion for inclusion in SHIP
- SHIP interventions have the potential to affect the number and outcome of GP consultations and unscheduled care contacts
- Large workload involves small number of SHIP patients – scope for targeted intervention
- Community Link Practitioner contacts, and a practice-based mental health worker have the potential to task shift some GP workload
- Extended consultations and MDTs have the potential to reduce unscheduled care
- Follow up of SHIP patients is needed to answer these questions
- It is difficult to draw firm conclusions from observational data