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	
20min	Patient with major depressive symptoms/suicide risk and substance misuse; Outcome : planning of future care and involvement of other organisations.
20 min	Patient with newly diagnosed depression and child protection issues; Outcome : 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 ; Outcome : SW contacted and telephone discussion re planned case conference.
30 min	HIV to newly diagnosed palliative care patient; Outcome : met with family and discussed management and DS1500.
25 mins	Planned palliative care discussion at home with patient and carer, non-cancer diagnosis; Outcome : clinical expectations discussed to allay fears over management. Linked with secondary care consultant by phone for agreement with treatment plan.
30 mins	Post hospital discharge visit in elderly lady with multiple co morbidities and polypharmacy; Outcome : medication review and link with social services and ACP planning.
30 min	Planned visit to elderly patient and carer with dementia and new diagnosis of advanced malignancy. Outcome : discussion over diagnosis, to some extent prognosis and palliative treatment. Linked into district nursing and palliative care team. ACP planning with carer.
20 min	Child < 5 years frequent attender to surgery with minor self-limiting symptoms. English poor and requires translator. Planned review to discuss support and education of such illness; Outcome : linked in with Health Visitor for further ongoing support which also involves local third sector agencies. Aim to support mother and reduce attendances at general practice.
20 min	Extended consult in surgery for a patient with complex medical and psychosocial needs; Outcome : management plan and education provided.
30 mins	Middle aged patient who has moved to homeless accommodation. Anhedonia, thoughts of self-harm, lack of self-worth and despondent. Little self-care. Patient whom I have known for many years. Family quarrel and patient feeling excluded. Outcome : discussion, DWP benefits arranged, housing officer appointment. Trial anti-depressant and advice in terms of family contact. Review planned for 1 week.
40 mins (including travel time)	Housebound elderly patient, lives alone with carer support. Highly anxious and had prolonged admission for 2+/12 late 2015. Chest infection and anaemia of uncertain origin; Outcome : reviewed and blood checked. Medication reviewed and amended after discussion. With social support, aim is to 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 frim conclusions from observational data