Patterns of Health Care Use of Frequent Attenders at Very Deprived General Practices in Glasgow

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- Glasgow has stark health inequities, both within the city and compared to other cities with similar deprivation; so called the “Glasgow Effect” [1]. The rates of multimorbidity are increasing and occur 10-15 years earlier in deprived areas [2].

- The Deep End Project was set up to consider what general practitioners, working in the 100 most deprived areas in Scotland, can do to address health inequalities [3]. The Govan Social and Health Integrated Partnership (SHIP) is a Deep End Project, set up on 1st April 2015 at four General Practices which serve the 16th, 28th, 30th and 32nd most deprived practice populations in Scotland [4]. The integration is with social care and also includes hospitals and other stakeholders, such as the third sector. Patients are offered targeted interventions (table 1).

Aims
1. To describe the health care contacts, in one year, of a representative sample of patients who are frequent users of health care at each of the four Govan Health Care Practices; including the balance of primary/ secondary and scheduled/ unscheduled care.
2. To describe the allocation of SHIP project interventions to these frequent users.
3. To assess the potential impact of SHIP interventions on health care use.

Methods
- 400 patients were sampled, comprising a representative third of those who consulted the GP 12-16 times in 2014 and were alive for the whole of 2015.
- Data from 1st January 2015 to 31st December 2015 were collected.
- Data were collected, on patient demographics, primary care contacts and extra workload and SHIP involvement, from primary care records (EMIS).
- Data were collected on scheduled secondary care, unscheduled care and community care from the secondary care records (Docman).

Results
- 40% of patients were aged 45-64 years old and 66% females.
- 50% of patients were prescribed an antidepressant.
- 72% of health care contacts were primary care, 19% secondary care and 9% unscheduled care.
- 85% of primary care contacts (n=5,462) were with GPs.
- There were on average 11 GP consultations, at the practice or home, per patient in 2015, lower than 2014 (15).
- Two thirds of unscheduled care required no further action.
- Separate IT systems for community care prevents information sharing about the frequency of contacts. The most common community contact was mental health services (21% patients).
- 50 sample patients (13%) were in SHIP, (6% of all SHIP patients).
- 43 SHIP patients (86%) had between 1-3 SHIP interventions.
- 6 SHIP patients (12%) had 54% of SHIP unscheduled OOH, NHS 24 and A & E care.
- 4 SHIP patients (8%) had 66% of SHIP unscheduled emergency admissions.
- Patients who had SHIP extended consultations had less unscheduled care (2 contacts per patient) than those who did not (4).
- 2 practices had a SHIP Community Link Practitioner and 56% SHIP patients in those practices had 1 or more CLP contact.
- 76% of SHIP MDTs were for patients also receiving palliative care.

<table>
<thead>
<tr>
<th>SHIP Intervention</th>
<th>Number of patients (n= 50) (% of all SHIP patients)</th>
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<tbody>
<tr>
<td>Extended consultation</td>
<td>7 (6)</td>
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<tr>
<td>Additional house calls</td>
<td>3 (6)</td>
</tr>
<tr>
<td>Referrals (to social work, health visitor or voluntary service)</td>
<td>10 (10)</td>
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<tr>
<td>Social worker contact</td>
<td>9 (8)</td>
</tr>
<tr>
<td>Community link practitioner contact (social prescribing: improve links between practices and community resources)</td>
<td>15 (611 contacts)</td>
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<tr>
<td>Multidisciplinary team meeting (MDT) (with social worker)</td>
<td>29 (102 meetings) (6)</td>
</tr>
<tr>
<td>Palliative care review</td>
<td>7 (17 meetings) (30)</td>
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</tbody>
</table>

Conclusions
- GP frequent attenders were most often middle-aged females with a high number taking antidepressants.
- “High attenders” is not a stable definition for all patients and does not predict future health care use.
- Majority of care was scheduled and delivered in primary care and by GPs.
- A small percent of these “frequent attenders” were in SHIP, demonstrating this is not the main criteria for SHIP inclusion and the importance of local knowledge of vulnerabilities.
- SHIP interventions have potential to affect the outcome of GP consultation rates and unscheduled care.
- Large workload by small number of SHIP patients, particularly unscheduled care; showing scope for targeted interventions.
- Community Link Practitioner contacts and the introduction of a practice based mental health worker have the potential to “task shift” [5] some GP workload.
- Extended consultations and MDTs have the scope to decrease unscheduled care.
- To assess the effect of SHIP, further study of these patients over time will be necessary.
- This study highlights the difficulty of drawing clear conclusions from observational data.

References