The Govan SHIP Project

(Social & Health Integration Partnership)

(Formerly, the Govan Integrated Care project)

Report and Evaluation

(with additional commentary placing the SHIP in the context of the 2020 Covid-19 pandemic)

June 2020

Report by:

Vince McGarry, Project Manager

TABLE OF CONTENTS

1. EXECUTIVE SUMMARY 4

1.1 Original Summary 4
1.2 Covid-19 Additional Comments 5

2. INTRODUCTION 6

2.1 Objectives 6
2.2 Delivery 6
2.3 Practice Demographics (Appendix A) 7
2.3.1 Practice Population 7
2.3.2 SHIP Population 8
2.4 Patient Identification 8
2.5 Project Office 8
2.6 Evaluation 8

3. WORK STREAMS 9

3.1 Unscheduled care 9
3.1.1 Out-of-Hours redirection 9
3.1.2 Home Visiting 9
3.2 Frail and Elderly 10
3.2.1 Telephone guidance 10
3.2.2 Acute Presentation 10
3.3 Children & Families 11
3.3.1 Child protection 11
3.3.2 Adverse Childhood Experiences (ACEs) (Appendix B) 11
3.3.3 Third Sector 11
3.4 Information (Appendix C) 11

4. MULTI-DISCIPLINARY TEAM WORKING 13

4.1 External Evaluation (Appendices D, E) 13
4.2 MDT Activity 15
4.3 Participation 16
4.4 Information Sharing 16
4.5 Additions to the MDT 16
4.5.1 External Evaluation 16
4.5.2 Pharmacy (Appendix F) 17
4.5.2.1 Outputs / Outcomes 17
4.5.3 Physiotherapy (Appendix G) 17
4.5.3.1 Demographics 18
4.5.3.2 Referrals 18
4.5.3.3 Outcomes 18
4.5.4 Mental Health (Appendix H) 19
4.6 Scalability 20

5. GP CAPACITY 22

5.1 Utilisation of additional time (Appendix I) 22
5.2 External Evaluation 22
5.3 Recruitment and Retention 23
5.4 Demand 23
5.4.1 Govan vs Comparators 24
5.4.2 SHIP Demand 24

6. SOCIAL WORK 25
6.1 External valuation 25
6.2 Demand 26
7. DEMAND ACROSS HEALTH CARE 27
7.1 Accident & Emergency 27
7.2 Patterns of Healthcare Use (Appendix J) 28
8. POLICY / STRATEGY ALIGNMENT 29
8.1 General Medical Services Contract 29
8.2 Mental Health Strategy 29
9. CONCLUSIONS 31
10. LIST OF APPENDICES 32
11. ACKNOWLEDGEMENTS 33
12. REFERENCES 34

1. EXECUTIVE SUMMARY

1.1 Original Summary

The Govan SHIP project, which was explicitly set in the context of deprivation and the Inverse Care Law[1], was created to explore opportunities for integration and collaboration between General Practice and Health & Care Partnerships.

The original project aims and objectives were to; adopt a person-centred focus based on need and not condition or criteria, develop multi-disciplinary team working and challenge embedded silo approaches, identify opportunities to shift demand through better use of services with colleagues working to the top of their licence, create capacity for GPs to increase their support for more complex patients, and better understand demand across health and care services at GP practice level.

Key components to the delivery of the project involved aligned social (care) workers, structured multi-disciplinary team working with regular monthly meetings ensuring full team engagement and involving a spectrum of colleagues. Additional GP capacity was funded to facilitate extended consultations, case review / planning, facilitating outward facing activity (e.g. child protection hearings), and developing leadership capacity.

Multi-disciplinary team working converted from initially bruising encounters into effective shared care and management of risk. Embedded workers (Pharmacy, Physiotherapy) delivered a shift in demand releasing GP capacity limited only by level of resource and patient complexity requiring on-going GP support.

Addressing unmet need formed the dominant use of additional GP time which dealt with a broad range and complexity of cases, all requiring generalist involvement. Extended consultations provided for better planning and coordination of individual patient care guiding change in local arrangements for integrated care. A proactive approach to home visiting accelerated reduction in demand for reactive, unscheduled responses

The SHIP patient profile showed greater response to the youngest, oldest and younger female working age population. It displayed even higher deprivation and multi-morbidity than observed in the overall practice population, validating the rationale for setting within this context and the need for greater collaboration and integration.

The project succeeded in reducing overall demand when comparing with a similar group of practices. There was a limited impact on A&E presentations within the SHIP population. Limitations of information systems and scale made it difficult to produce meaningful analysis for other patterns of healthcare use at practice population level.

Future efforts to develop multi-disciplinary team working should never underestimate the impact of bringing different organisational cultures together and the role of organisational development in planning for this. The project evidenced the overlap between demand for GP services, social work services and socioeconomic deprivation. This should be a driver for greater integration. Directly creating additional GP capacity may still be required in addition to releasing it through alternative resources to adequately meet patient need in deprived practices.

[1] The inverse care law was first described by Julian Tudor Hart in 1971 (References: #1). It states that "the provision of good medical care tends to vary inversely with the need for it in the population served." Access to services is also affected by the inverse care law. Those who need healthcare least use the services more, and more effectively, than those with the greatest need.

1.2 Covid-19 Additional Comments

The 2020 Covid-19 pandemic has significantly impacted on the delivery of care, which will result in permanent change in many areas as a result. The objectives and aims of the Govan SHIP project remain relevant and could be adapted to align with organisational recovery from this pandemic.

The structured MDT model could readily adapt to distance working and indeed improve effectiveness and efficiency through utilising technology appropriately, affording the opportunity to organise regular practice-based meetings with an even greater number of contributors able to efficiently attend the meeting for as long or as short a period as necessary. The changed relationships with Care Homes and the introduction of Care Home Advanced Nurse Practitioners would also readily fit in with the MDT structure where GPs have responsibilities for particular homes or significant numbers of patients within. The need to develop and sustain relationships and ferment a whole team ethos remains essential however that can be achieved. Administration capacity will potentially be realised through reduced actual patient footfall within practices.

The Govan SHIP model emphasised the holistic need to address health and the social determinants of ill health in deprived communities. The commitment of health and social care therefore remains essential. Pandemic recovery might afford the opportunity to direct primarily health monies to supporting the provision of social workers / social care workers as part of a broader reorganisation of how services are delivered. This would support the forming of the important social / health inter disciplinary relationships identified as one of the keys to the success of SHIP.

The coronavirus pandemic has forced a relaxation of what can be a rigid approach to chronic disease management (CDM) irrespective of actual need (I.e. stable vs. unstable). The SHIP-Pharmacist approach to MDT review linked polypharmacy review and contribution to complex clinical care would support this newer approach and better utilise the skills of the pharmacist working to the top of their licence and breaking out of traditional silos. Capacity could be created through sharing responsibility for more routine tasks with GPs appropriately. Patients requiring ‘shielding' who are at risk of severe illness from coronavirus, irrespective of specific condition effectively become a new category and would also benefit from the SHIP approach as this would be based on need and capture those not necessarily coming within the reach of active CDM.

The involvement of GP trainees in the SHIP project might serve as an example of good practice in the adaption of training programmes under the new environment.

2. INTRODUCTION

The Govan Integrated Care Project (original working title) launched in April 2015 and was funded through the Scottish Government Primary Care Development Fund to explore opportunities for integration and collaboration between General Practice and the newly formed Health & Social Care Partnerships (HSCPs). It was developed with the support of the South Glasgow Community Health Partnership, Social Work, General Practitioners (GPs) at the Deep End[2] and academia from Glasgow University.

The project initially covered the population served by the four GP practices within Govan Health Centre. It was developed specifically within the context of deprivation and the Inverse Care Law. The project ran from Apr 2015 to end Dec 2018.

2.1 Objectives

The original project aims and objectives were to;

- Understand demand across health and care services at GP practice level
- Adopt a person-centred approach based on need and not condition or criteria
- Get extra value from more joined up management and better use of existing health & social care and community resources and services
- Identify opportunities for a shift in existing and emerging demand across and between health & social care with professionals "working to the top of their licence" – ensuring demand is appropriately met by alternative service provision opportunities (other members of team, wider statutory or non-statutory services)
- Understand opportunities to reduce demand in primary, secondary and other care settings through anticipatory care, early intervention, re-direction, and developing effective alternatives
- Create capacity for GPs to support more complex patients and increase access including increased time for consultations for patients with long term and multi morbidities, providing unconditional personalised continuity of care whatever combinations of problems patients may have
- Challenge existing and embedded silo working roles by individuals to shared / integrated working as part of the care team
- Develop an evidence base through qualitative and quantitative evidence

2.2 Delivery

The project would be delivered through;

- Aligned social workers – the project initially started with registered social workers. Learning from year one identified that the role and skill set required for this model of working was more suitable to that of a social care care-worker and change was made in year two.
- Structured multi-disciplinary team (MDT) working - with a core membership of social work, rehabilitation, district nursing, health visiting, GPs, Practice Nurses and practice-based Community Links Workers (if in place). Mental Health nurses engaged with MDTs later in the project. Practice based monthly meetings provided structure to previously informal links between professionals and ensured a holistic understanding of clients/patients' health and social care status and needs

[2] GPs at the Deep End (References: #2) are the group of 100 general practices serving the most socio-economically deprived populations in Scotland.
https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/about/

- Each GP practice was funded for four additional weekly sessions which equated to approximately one extra session per 1,000 patients registered with each practice. This additional GP capacity facilitated (but not exclusively);
  - Extended consultations
  - Polypharmacy reviews
  - Case review / planning
  - Increased outward facing activity – such as child protection hearings, Adults With Incapacity (AWI) and Adult Support & Protection (ASP) procedures.
  - Leadership activities across four main themes;
    - Unscheduled Care
    - Frail & elderly
    - Children & Families
    - Information

The project received additional resource in year three to deliver further tests of change:

- Additional professionals were embedded within practice to test the benefits of working within the SHIP model and within the context of deprivation;
  - MDT Pharmacist – to explicitly support and engage with patients identified through the MDT process as opposed to drug or condition-specific approaches or thresholds identified through traditional data sets such as number of medications, i.e. patients who might otherwise have received little or no pharmacy input
  - MSK Physiotherapist – to add to the learning from a similar project initiated in Inverclyde Health & Social Care Partnership (HSCP) and identify any differences through working within the specific contexts of the SHIP model and deprivation

Patient / Public engagement was admittedly limited. Very little pre-project development work had included patient input. A patient engagement group was however established early post-implementation. Project aims, objectives and methodology received broad support from this group. The group also met early into year two to review a number of case studies and provide their perspective on both process and outcomes. Again, feedback suggested the ethos and efforts of the project were welcomed.

2.3 Practice Demographics (Appendix A)

2.3.1 Practice Population

The project practices were; David Elder, Green and Blue practices within Govan Health Centre. The Yellow practice[3] opted out of the project at end of year one, replaced by the Mair practice in November 2017. This afforded the opportunity to test the structured MDT model outside the benefits of co-location within a health centre.

The total practice population across the four current practices is 20,069. All practices are within the Deep End with 71% of the population living in SIMD1[4] (most deprived quintile). 31.5% are multi-morbid (2 or more conditions). 10.7% are poly-morbid (4 or more conditions)

[3] The incomplete data from the Yellow practice has not been utilised as a result.

[4] The Scottish Index of Multiple Deprivation (SIMD) is the Scottish Government's official tool for identifying concentrations of deprivation in Scotland. This link now goes to 2020 data. (see References: #3)

2.3.2 SHIP Population

1,866 people were identified to the SHIP project over the three years with a net of 1,374 still registered at end Sept 2018. This equates to 7% of the rolling population.

The SHIP population exhibited higher levels of deprivation with 80% living in SIMD1.

In comparison with the overall population, the age profile is significantly skewed toward younger and older patients. In terms of gender, the most obvious difference is the focus towards females aged 17-44. This reflects the aims of the project to support vulnerable families and recognises the impact of broader social determinants of health on women, including childcare responsibilities, women as carers, and how these intersect.

When compared with the overall practice baseline, the SHIP population proportionately;

- Reflected even higher levels of deprivation
- Had higher levels of co-morbidity
- Was skewed towards the younger and older age groups
- Was skewed towards women aged 17-44

This profile confirms the broader evidence base describing health inequality in deprived populations and the impact of the Inverse Care Law.

2.4 Patient Identification

A universal approach was adopted, and patients were identified to the project based on perceived need rather than pre-existing criteria.

2.5 Project Office

The SHIP adopted a collaborative leadership approach with a lead GP in a role similar to that of Cluster Quality Lead. There were practice leads and lead GPs for each work stream (Pharmacy, Physiotherapy, Children & Families, Information Management, etc.) These roles were distributed across the GP body to encourage engagement and ownership although some held multiple roles. This structure was supported by a Project Steering Group which included management representation from the HSCP, Social Work Services and the third sector. The project was supported by a project manager with administrative support.

2.6 Evaluation

The project commissioned researchers from the Universities of Stirling and Glasgow early into the second year to explore key components of the model: Social work alignment, extra GP capacity and multi-disciplinary team working. The evaluation would adopt an ethnographic approach, reflecting the differing organisational cultures, customs, habits, and mutual differences of the stakeholders involved.

3. WORK STREAMS

Project objectives were developed across four main themes led by the project manager and a lead GP for each:

- Unscheduled Care
- Frail & Elderly
- Children & Families
- Information

3.1 Unscheduled care

Two specific changes were proposed to address unscheduled care across both acute and primary care sectors;

3.1.1 Out-of-Hours redirection

Early collaboration with emergency departments and out-of-hours services resulted in a protocol on how the practices could respond to out-of-hours redirection applied to patients who did not require treatment then, there, or delivered by an ED/OOH clinician but for whom those clinicians believed follow up would be important.

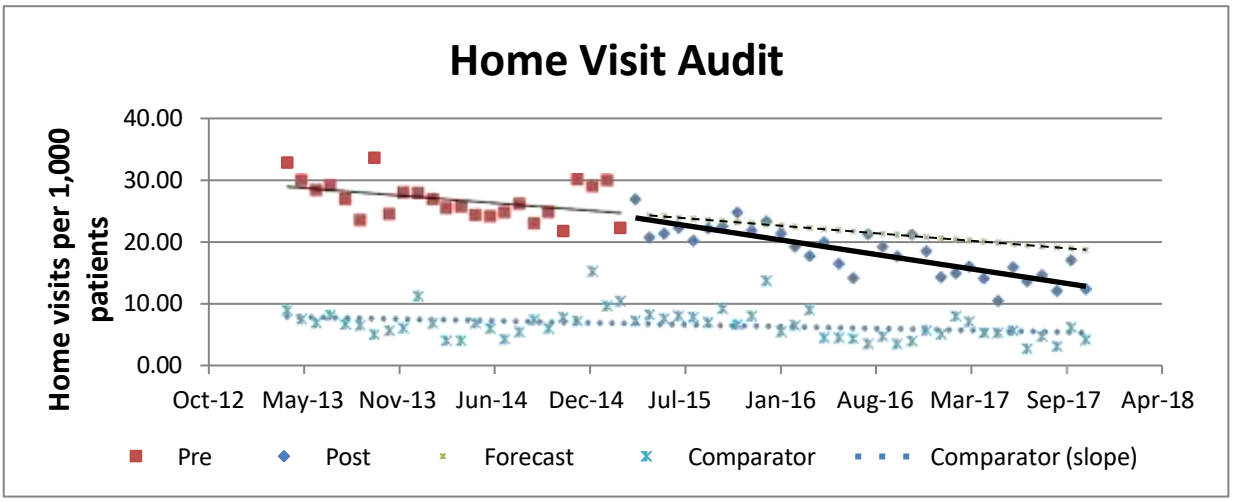
Once informed by electronic communication (e.g. electronic discharge letter) practices would adopt the risk and take responsibility to contact the patient next working day. Appointment systems were modified to accommodate same-day consultations if required and release these if not utilised, ensuring minimal impact on practice workflow.

A desktop review suggested this would be relevant for two to three patients per week per practice. Unfortunately, there was no uptake as the scale of this test of change was too small to show significant benefit. In practical terms the ED found it difficult to isolate Govan patients as part of the overall workflow and A&E clinicians were reluctant to redirect patients if they had made the effort to attend. This work did however demonstrate how redirection could be absorbed by general practice with minimal impact on capacity and that there could be measurable impact if re-tested on a larger scale.

3.1.2 Home Visiting

One of the project objectives was to reduce unscheduled care through developing anticipatory and preventative approaches. Two of the project practices utilised some of the additional GP time to carry out proactive home visits with their housebound population instead of only responding to requests indicating problems had manifested. Home visit data was compared with a third practice (within the project) to assess the benefits of this approach.

The chart below shows the change in trend for home visits:



The starting rates between the subject practices and comparator are different. Both populations show a reduction over time. It is the rate of reduction however that is significant. Projections suggest that, in theory, it would have taken 4 years longer for Govan to reach the comparator median in absence of the SHIP project (i.e. May 2023 vs. Apr 2019).

A conservative estimate would suggest that one home visit equates to three in-surgery or telephone consultations therefore the effect of reducing home visits (theoretically) triples capacity if converted to the other types of consultation. The use of additional GP time in this way meets project objectives to identify ways to support an anticipatory and preventative focus which resulted in significant reduction in unscheduled home visit demand and released GP capacity.

3.2 Frail and Elderly

3.2.1 Telephone guidance

The project developed an escalation policy with Medicine for the Elderly colleagues to reduce or avoid hospital admission. This included a hotline which would provide advice and facilitate rapid access to day hospital. Calls to the hotline were low (two or three per month) but the process was effective when utilised. This has subsequently been expanded and replicated for care homes.

No particular cases were raised through the MDT however the principle was established that elderly medicine consultants might also attend an MDT meeting for complex, difficult to manage cases on an ad hoc basis should the need arise.

3.2.2 Acute Presentation

Other discussions highlighted the need for information in the event of unscheduled presentation to hospital. Elderly Care Assessment Nurses (ECANs) were sometimes required to have the skills of Sherlock Holmes to gather enough relevant information that would sometimes be a factor influencing admission and discharge.

It was agreed that GPs, in addition to clinical conditions and medication, might hold additional and appropriate information, including next of kin, social situation (particularly if not known to social work), continence and diet. The GP electronic Key Information Summary (eKIS) which uploads to the NHS Greater Glasgow and Clyde Clinical Portal was identified as a potential vehicle, being accessible by acute colleagues.

It was agreed that GPs would aim to identify patients for whom hospital admission was foreseeable and complete an eKIS. Guidance was prepared however GP uptake unfortunately remained low.

3.3 Children & Families

3.3.1 Child protection

Very few of the SHIP GPs previously had capacity to attend Child Protection hearings. Some were able to utilise their additional time to participate, offering their expertise on medical and health information relative to a case, resulting in a more informed outcome. MDTs facilitated direct discussions with named social workers if GPs were unavailable for the hearings. Other MDT discussions resulted in joint approaches between Health Visitor and Social Work to attempt to avoid escalation of problems. This was effective in identifying vulnerability and addressing risk which might not have occurred otherwise. These included multiple instances of implementing parental support for issues of mental health.

3.3.2 Adverse Childhood Experiences (ACEs) (Appendix B)

ACEs were not explicitly addressed within the project however a small audit was carried out to determine the degree to which ACEs might be a contributing factor. Data from twelve months of MDT activity in one practice showed that approximately one quarter of patients discussed at MDTs involved patients or families with some form of adverse childhood experience. Finding documented evidence was not always straightforward and there was probably a bias toward those patients receiving mental health support where a more in-depth history was recorded.

Scottish policy is reflecting the drive for trauma informed practice. A number of Deep End (including SHIP) practices will participate in the development of routine enquiry. This may help to reduce stigma and learning from multidisciplinary working such as that of the SHIP may be essential in preventing adults being re-traumatised.

3.3.3 Third Sector

Some project resource was also directed toward a 3rd sector organisation to support the wider locality work delivered by Joint Support Teams (Education, health, social work for pre-school children). This added to the overall capacity within the area while facilitating referral from the SHIP project however it would not be an effective use of resource long term at this scale as only a few cases were referred via this route.

3.4 Information (Appendix C)

At the outset, relevant information management system integration remained years away from being realised. This, and to best utilise project resources, led to a pragmatic approach to make best use of existing systems or applications where possible rather than attempt significant development in this area. For example, MDT meeting venues were data enabled allowing colleagues to access their own systems via mobile hardware to facilitate live information sharing. In some circumstances, four or five separate health systems in addition to social work CareFirst6 might be accessed for one patient (GP EMIS, Docman, Community EMIS, NHSGGC Clinical Portal, Rehab EMIS).

Data development work was led by the project manager and a lead GP with expertise in systems and data. This included commissioning the external evaluation. The work was supported by an information group (as subgroup to the steering group), including business intelligence from the Health Board and City Council within its membership.

In addition to the GPs intimate knowledge of their patients, this development work facilitated a mixed approach to patient identification using both qualitative and quantitative information to identify need or risk across a range of problems as opposed to purely numeric models or targets (e.g. QOF).

There were varied challenges, limitations and solutions involved in developing the data framework. These include:

- Some self-reporting as the necessary data was not appropriately captured on the corporate systems
- Inability to link health with social work systems (CareFirst6) due to data sharing limitations and absence of CHI as unique identifier, risking inappropriate matching
- Corporate inpatient and outpatient data sets unsuitable for meaningful analysis at population level due to:
    - Low volume/activity
    - Significant non-patterned variation
    - Change in data capture methods over time

4. MULTI-DISCIPLINARY TEAM WORKING

The SHIP model for multi-disciplinary team working evolved from the Deep End position that with the intrinsic features of contact, continuity, coverage, flexibility, long term relationships and trust, general practices are the natural hubs of local health systems. The 2018 GMS contract subsequently promotes the introduction of practice-attached staff, who will be largely employed by NHS Boards, embedded in practice teams with their day-to-day work co-ordinated by the practice.

Named individuals were initially identified to work with practice specific MDTs. An allocated worker model would not be possible in the longer term due to organisational changes. Over time, colleagues from each professional group deputised for colleagues, effectively creating an aligned worker model and developing small teams which supported continuity and facilitated effective relationships and communications.

4.1 External Evaluation (Appendices D, E)

Key findings indicated this model of working showed promise for addressing the inverse care law with the GPs having additional capacity to plan for and address complex health and social needs, drawing on the expertise of social care and other health colleagues from within the MDT structure.

Patient care was facilitated by the sharing of information between those attending an MDT, each of whom may have had different encounters with the patient. Another benefit of this model of shared care was the positive impact on staff wellbeing and the potential to reduce worry and anxiety about patients;

"You can feel quite isolated and feel that you're the only person feeling that way and when you're round the table and there's other folk round the table that have had the same problems, you know, and ultimately sometimes that's even just a support to hear that."

There was a definite enthusiasm for cluster working and a perception that this would be beneficial for both staff and patients.

MDTs appeared to facilitate anticipatory care planning prior to hospital discharge; Social Work had previously been poor in providing feedback to primary care in relation to hospital discharge. This learning was shared with and addressed by the hospital social work team.

MDTs adapted, revealing the ability of the SHIP project team to respond to learning over time. As the organisation and management of MDTs improved, and with greater involvement of professionals across social work, secondary care and the third sector, the MDT offered a potential platform for integrated working.

Key challenges associated with social work involvement mainly arose from:

- a lack of understanding of the modern-day social work role
- a lack of knowledge about eligibility criteria for access to services via social work
- different perceptions of risk and vulnerability

What constituted risk was a contested category resulting in considerable frustration between health and social care. The social care enablement and rights-based approach regularly conflicted with the health care desire to intervene and prevent a downwards trajectory of a patient that would inevitably lead to hospital admission without such an intervention.

MDT learning resulted in improved quality referrals that were more likely to meet social work criteria and a better understanding of where patient issues might be better served by access to

services within the third sector. This was more obvious in the two practices with community Links workers where they had a specific role to map the local territory for such services.

The SHIP project met challenges known to have affected integration projects elsewhere. There were considerable benefits in gaining the knowledge and understanding crucial to moving forward with the integration agenda. The introduction of social care workers in year two highlighted a positive response to the initially 'bruising' encounter between social workers and GPs as these colleagues were more likely to be able to meet expectations. At that point, work remained to be done to undo negative perceptions, disappointments and frustrations experienced by other staff during the course of integration.

The evaluation only captured initial implementation of the social care workers. The GPs later confirmed this evolution aligned more closely with initial project concepts and offered greater confidence.

The following case studies and involvement of social work give example of how perceptions and frustrations would improve:

Scenario	Older gentleman with diagnosis of Dementia, living alone in privately rented flat. Daughter visiting (as lives abroad) advised flat 'messy' with possible eviction by landlord. Son is main carer and has own health issues. Daughter feels father needs additional support and requires social work input.
Actions Taken	SW visited service user at home, liaised with family and provided information with regard to Eviction Procedures and requested they clean flat. Contacted Local Housing Provider and completed sheltered application forms. Arranged an increase in homecare services to be put in place. Referral made to Carers team for son.
Outcomes	Service user able to remain in own home, service user and family happy with additional supports that had been put in place. Placed on waiting list for sheltered accommodation.
SHIP contribution	MDT structure allowed for concerns to be identified at early stage of possible crisis and a shared management plan which enabled a good outcome for the service user. SW was able to take relevant action quickly.

Scenario	Female patient who is kinship carer for two siblings has multiple adversities in childhood and long history of social work involvement related to parents. Patient becomes pregnant
Actions Taken	Discussion with at MDT on vulnerability re. pregnancy and siblings. GP makes formal referral to social work and informs patient. Specialist from Positive Start team to be involved. Positive Start team disbanded without the knowledge of the GP or aligned health visitor, and this not initially picked up. GP makes GIRFEC referral.
Outcomes	Patient agrees to support from social work. Child protection case discussion plan results in regular health visitor reviews and input from support services (in absence of Positive Start)
SHIP contribution	Co-ordinated approach of SHIP project was able to re-establish and actively contribute to child protection plan following breakdown in initial post-delivery support plans and communications.

MDT Participants had showed development and learning from this experience through a positive change in knowledge, attitudes and behaviours. However, this was mainly restricted to GPs and management. Some staff maintained a negative attitude towards social work and felt disempowered in terms of influence and intervention, over which they had little or no ability to change.

Key recommendations included:

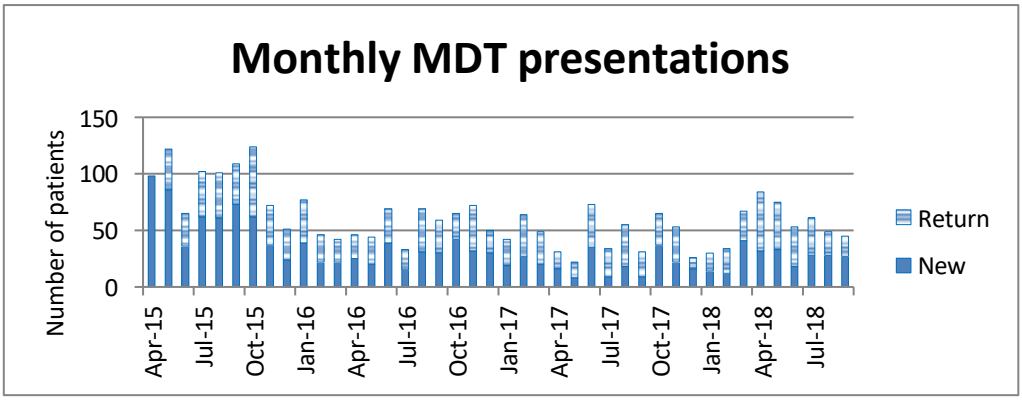
- The integration model would be better served by a wider constituency of professionals involved in planning and development going forward.
- There should have been a stronger focus on planning prior to implementation in order to maximise staff engagement
- Key learning, achievements and successes should be shared with the wider audience

Further recommendations are included. These are presented under the following headings:

- COHERENCE of the SHIP model – initial understanding of aims and objectives
- COGNITIVE PARTICIPATION – investing or engaging in the model at the outset
- COLLECTIVE ACTION – the practical implementation of the model
- REFLEXIVE MONITORING – modifying and embedding the intervention, and future prospects

4.2 MDT Activity

The following data captures the nature and volume of MDT activity[5].



After an initial burst of patient identification up to Oct 15, the average number of cases per MDT was 13. This curve appears to reflect the initial state of addressing unmet need then resolving to a steadier state of managed demand.

	New	Return	Total	%New	%Return
Median Values	28	29	57	49.0%	51.0%

The table above indicates a relatively equal balance between new and return patients. This curve again appears to reflect the initial state of unmet need settling into equilibrium.

Frequency of presentation	**Number of patients**	**% of total**
One or two	1097	81.0%
three to five	211	15.6%
Six or more	47	3.5%
Total	1355*	

** 1,355 is the number of MDT, not all, SHIP patients*

[5] This data excludes the early exit and late entry practices

The table above demonstrates the majority of issues for each patient were discussed and addressed after only one or two discussions. There were a small number of patients who required constant and on-going multi-disciplinary focus throughout the length of the project.

Even where no action would be taken or where issues could not be influenced through a SHIP connection or intervention, value remained through highlighting awareness and issues of risk regarding a patient's situation to the whole MDT.

4.3 Participation

This model of MDT working also facilitated wider participation on a case-by-case basis. Other patient representatives included Prince & Princess of Wales Hospice nurses, housing officers, Community Mental Health Team, Occupational Therapist. The principle of having colleagues from the acute sector was also established although this did not materialise (see section on Frail & Elderly).

4.4 Information Sharing

The ethos for information sharing within the SHIP project was to apply the legacy from high profile cases where "*the issue of inadequate information sharing and ineffective work with colleagues and other agencies"* had been identified and "*The knowledge held by an individual practitioner or agency may not, on its own, appear worrying but when collated the overall picture may indicate a more significant level of concern and risk"*[6].

At its simplest level, the discovery process of the MDT would identify contact details of allocated social workers and GPs allowing for appropriate and timeous (email for non-urgent issues) contact, avoiding system blockages or bottlenecks. One GP suggested that this could sometimes save up to 2 hours per week.

Information sharing arrangements were developed in alignment with the protocol agreed between NHS Greater Glasgow & Clyde and Glasgow City Council and guidance from the Board's information governance manager. Posters in each GP practice explained the nature of the project, facilitating opt-out for patients. Information would only be shared to address concerns or perceived risks regarding the welfare of the individual or others (i.e. vulnerability). Staff used their professional judgement to share information in a proportionate manner relative to the reason for discussion. The GDPR 2018 (General Data Protection Regulations) subsequently confirmed the lawful basis for sharing information within the project as being based on legitimate interests as part of service provision.

The local Research Ethics Committee (REC) indicated that formal clearance was not required as the study was an evaluation of service.

4.5 Additions to the MDT

4.5.1 External Evaluation

The expanded MDT membership (Pharmacy, Physiotherapy and Mental Health) evolved towards the end of year two and were therefore not included in the earlier external evaluation.

[6] GPs and primary healthcare teams: learning from case reviews - Summary of risk factors and learning for improved practice for the health sector, https://learning.nspcc.org.uk/media/1338/learning-from-case-reviews_gps-and-primary-healthcare-teams.pdf. (This link no longer works, see References; #4 for an updated source)

4.5.2 Pharmacy (Appendix F)

The SHIP Pharmacist was introduced in the third year of the project. They would operate beyond the traditional role of prescribing support pharmacist and integrate with the model of structured MDT working, facilitating further shifts in demand, releasing GP capacity, improving patient outcomes, and educating a change in practice across the system.

The SHIP pharmacist screened all MDT patients where high risk and vulnerability were identified. They would further review those who were on medication and follow up through telephone or face to face consultation where appropriate. They also conducted home visits which would be relatively unusual for pharmacists. This universal approach resulted in the identification of undiagnosed conditions, even for those not on medications. Home visiting identified issues likely overlooked by a GP such as medication storage and social care packages involving medication.

The pharmacist attended all MDTs for full meetings. If scaling up, it might be appropriate to plan and utilise time more effectively however at this stage it was important for them to be present where their input could resolve immediate queries and save time. Colleagues valued the SHIP pharmacist participation, sometimes resulting in cross referrals 'that otherwise may have been missed". One practice, in particular, made effective use in the direct contact between pharmacist and MSK physiotherapist in addressing pain management.

4.5.2.1 Outputs / Outcomes

A key priority was to develop relationships between the practices and local community pharmacies. The SHIP pharmacist facilitated improved awareness, improved communication channels and changes which would improve patient safety as a result. For example, lack of information when changes were made to dosette boxes was identified as a common theme.

The SHIP pharmacist identified an average of 2.64 interventions per patient reviewed, demonstrating there are pharmaceutical interventions to be made for almost every patient on medication irrespective of condition ranging from medication optimisation to changes in high-risk medications in order to improve patient care.

In summary, Pharmacy involvement beyond the traditional role of prescribing support provided significant benefit and successfully contributed to overall project objectives.

The 2018 General Medical Services Contract[7] proposes the introduction of a new pharmacotherapy service. The SHIP pharmacist role was effectively a precursor, and their input equates to level three. The lead project GP proposed this should be considered 'core' instead of acute prescriptions, coding and immediate discharge letters (level 1) as it will make greatest contribution to 'manageable workload', make more effective use of their combined resources and support working to the top of the licence.

4.5.3 Physiotherapy (Appendix G)

The role of Advanced Physiotherapy Practitioner (APP) was also introduced into the project in its third year. The APP would function as an alternative first point of contact, addressing musculoskeletal (MSK) issues with the aim of releasing GP capacity, improving patient outcomes, and educating a change in practice across the system to support a shift in line with national policy. Beyond the SHIP project, this would also complement work previously started in Inverclyde.

[7] The 2018 General Medical Services Contract in Scotland, (References: #5

Aims specific to SHIP were:

- To test the introduction of an MSK physiotherapist in an area of high deprivation (as opposed to a mixed economy)
- To test the dynamics of integrating this role with the existing structured MDT model of working

Capacity modelling had directed that the APP should work across a maximum of three practices. This was easy to allocate as one of the four practices self-excluded due to lack of consulting space.

Only 49 of 1,722 SHIP patients were also referred to the APP suggesting little need for participation with the structured element of MDT working while remaining accessible to the other MDT professionals out with the structured element as required.

4.5.3.1 Demographics

The physiotherapy data suggests that, unlike other SHIP patients, the deprivation profile of people attending the MSK APP was no different from the overall practice profile. However, a much higher proportion of patients referred to the APP were multi or poly morbid (18% and 7% higher than baseline respectively). This suggests the impact of deprivation is less apparent for MSK physiotherapy in an already deprived population. However, the influence of deprivation on multi-morbidity is well known[8] therefore there may still be a differential in need when compared with a more affluent population. It will be important to review as the APP role is scaled up and when aiming to addressing inequalities.

4.5.3.2 Referrals

An average of 32% of referrals (across the three practices) came directly from reception. While this was lower compared to the 60% target in Inverclyde it remains significant and achieved the project objective of shifting demand and releasing GP capacity. A number of factors influenced this;

- Challenges for reception staff to facilitate direct referral, particularly at busy times (which were addressed as the project progressed)
- High levels of multi or poly morbidity and complexity necessitating initial presentation to the GP

Again, comparison with different practices and demographics would be required support this hypothesis.

The detailed report profiles utilisation, including rationales for slow growth and decline toward the end of the project. Taking these into account, the average utilisation rate was 89% (weeks 17 to 44). There is no reason to doubt that this will have been sustained or improved with the post being made permanent and weekly timetable adjusted to better manage and respond to need and demand across all three practices.

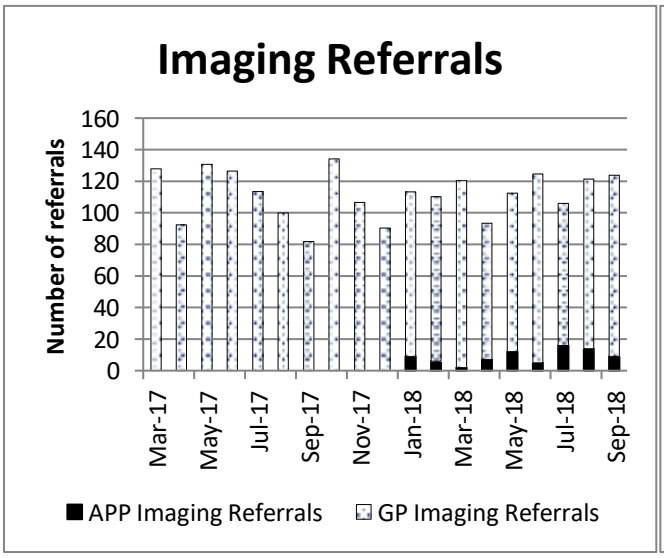
4.5.3.3 Outcomes

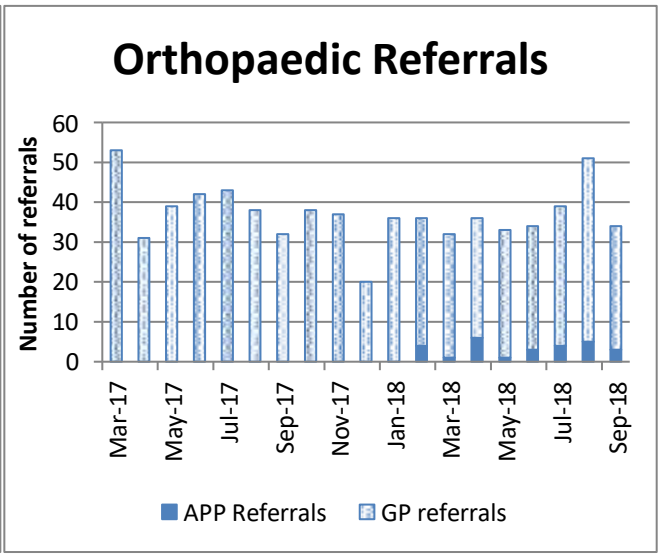
The vast majority of APP patients were given advice and recommended home exercise programmes to help manage their condition (72%). A pre-APP baseline audit suggested GPs would have offered resources to only 12% of MSK suitable patients.

[8] The influence of socioeconomic deprivation on multimorbidity at different ages: a cross-sectional study (2014), G. McLean et al. (References: #6)

The variability in the (limited) monthly data makes it difficult to determine if there has been a reduction in practice-wide imaging and orthopaedic referrals (for all reasons). This is also unsurprising given the limited capacity of the APP in relation to GP and overall practice capacity (three APP sessions against between 19 and 30 GP clinical sessions per week).

It is clear however that APP referrals now form a significant proportion of the overall totals (from a previous baseline of zero) and have therefore reduced GP demand in this aspect (imaging median = 7.5%, orthopaedic median = 8.8%).





A number of metrics were difficult to capture quantitatively however qualitatively, practice staff believed that the practice embedded APP:

- reduced the time that patients were in pain following an acute injury
- reduced the number of repeat appointments
- reduced the likelihood of climbing an analgesia ladder while on waiting list for other services
- provided support so quickly as to avoid acute injuries turning into chronic problems
- reduced the length of time people might need to be off work for this type of problem

Both patient and staff experience indicated high satisfaction with the introduction of the APP.

4.5.4 Mental Health (Appendix H)

The project person centred approach was based on need and not on any particular condition. Early learning around the nature of patient engagement, the practical experience of GPs, and wider evidence[9] suggested there was a need to give greater recognition to mental health. A mental health specific sub project was established in year three and dedicated lead recruited.

Consultation with a broad range of stakeholders identified:

- a consensus around high levels of need
- a shared perception that support services are often not readily available or easily accessible
- a lack of shared understanding about the nature of mental health need or how pervasive it was

[9] Deep End Report 22: Mental health issues in the Deep End. (References: #7)

Analysis of mental health need was undertaken through two pieces of work:

- A review of GP consultations which had mental health as the presenting or a significant issue
- An audit of referral outcomes to mental health services

The GP consultation review showed the majority of mental health presentations exhibited symptoms relating to depression, anxiety, low mood or stress. Many individuals were on medication. Most were not linked with support but had been referred to or engaged with treatment previously. The audit of referral outcomes showed less than 20% of referrals to primary care or community mental health teams went on to engage with treatment.

Other learning points were:

- Mental health concerns are responded to differently by different practitioners
- There is not a shared understanding about who should be responding to different needs
- There is not a shared understanding of how mental health needs are defined
- Current support services can be challenging to negotiate for both those referring and those being referred

As a result, simplified guidance for GPs for mental health referrals was developed in consultation with local service leads. Unfortunately, this was not implemented due to the sub project lead leaving post towards the end of the project. In addition to this test, and based on project learning, the sub project lead identified several strands for future work:

- Easily accessible referral guidance for GPs (as described above)
- Further analysis of referrals with specific focus on rejections and redirections
- Patient engagement
- Mental health input to the development of the community link worker role

4.6 Scalability

Variation to the SHIP MDT model may be appropriate subject to context if considering replication and expansion however SHIP experience dictates several essential components for effective multi-disciplinary team working:

Essential components for effective collaborative working include:

- Building relationships and communications - team formation and discovery phase
- Mutual respect alongside a willingness to challenge silo working towards shared/collaborative as part of a wider care team
- A readiness to accept working with uncertainty and adapt during the infancy of process as it and relationships develop.
- Minimise bureaucracy and process to avoid time burdens and adding to colleague's workload.
- Evaluate on an on-going basis, perhaps through issues and learning logs as well as more formal events.

Shared learning in advance of developing multi-disciplinary team working it is important to ensure effective understanding and communication. This should incorporate:

- Person centred focus
- Roles - in relation to direct care and as service liaison/advocate
- Responsibilities
- Expectations
- Accountability and line management

- Retention of autonomy – alignment not attachment
- Collaborative leadership and ownership – no ‘one’ is in charge
- Contextual understanding – there are several ‘right ways’ so there is need to adapt, not just adopt
- Perceptions of risk
- Eligibility criteria and resource limitations – where can thresholds lower or referrals improve
- Other formal and informal dynamics (such as use of language and word association – e.g. a balance between enablement and dependency)

Structured engagement (meetings) between all of the members of the multi-disciplinary team should at least initially be required to develop the relationships and network of communications across the team however the on-going commitment from each professional group / service will be variable and this will be subject to local need and provision.

5. GP CAPACITY

GPs were funded for locum backfill at a rate of approximately one session per 1,000 patients registered with the practice to reflect Deep End recommendations.

"There have been occasions where the additional time has provided enough cognitive space to 'realise' where a problem might lie and I get those, for want of a better term, 'Eureka!' moments. Without this ability to hold longer consultations, one is under immense time pressure and has to 'shut down' consultations rather than expanding."

5.1 Utilisation of additional time (Appendix I)

A short study was carried out to describe and quantify utilisation of additional GP capacity in Feb 2106. This was a review of administrative data covering all patient contacts over 4 weeks and 2-week diaries submitted by 15 GPs describing their use of protected sessions afforded by the project:

In 25 protected GP sessions, 13 GP partners reported 136 activities, including 76 extended consultations with the patient present and 14 sessions viewing 25 case records with the patient absent (average approx. 4 cases reviewed per GP per week).

The content of extended consultations displayed the nature, severity, and complexity of physical, psychological and social problems within families and households, typical of patients in very deprived areas. Detailed descriptions of the extended consultations are captured in the report which recommends reading by all who are unfamiliar with the nature of general practice in very deprived areas.

The study also showed that:

- The range and complexity of cases all required generalist involvement.
- Addressing unmet need formed the dominant use of additional GP time.
- Extended consultations provided for better planning and coordination of individual patient care which supported previous research on extended consultations in a high-deprivation practice.[10] They also provided a basis for driving change through local arrangements for integrated care, based on the needs of patients.

5.2 External Evaluation

Key findings from the external evaluation indicated this model of working showed promise for addressing the inverse care law with the GPs having additional capacity to plan for and address complex health and social needs, drawing on the expertise of social care and other health colleagues from within the MDT structure.

Staff believed that patients valued the extended consultations and the perceived response suggests that the extra time allowed GPs to behave more empathically with patients, which has been shown to improve patient outcomes.

This extra capacity facilitated GP attendance at external case conferences or child protection hearings where their input made valuable contribution to the hearing. Prior to SHIP, they often were only able to contribute comments via letter, email or telephone and sometimes missed the short deadlines for responding because of other time pressures.

[10] More time for complex consultations in a high-deprivation practice is associated with increased patient enablement, S. Mercer at al. (References: #8)

Clear benefits to GPs and patients were

- Addresses the inverse care law by providing additional health care to those with most need
- Facilitates complex care planning (and complements MDT working)
- Allows GP attendance or more incisive engagement in external/multi-sector case conferences or hearings
- Reduces GP stress

5.3 Recruitment and Retention

An unanticipated benefit of the extra time for GPs is that reduced work-related stress and could help to mitigate the high 'burn out' in GPs working in areas of high deprivation (Mercer et al. 2016). *"I feel that I'm probably under less pressure and feel that you're actually getting things finished rather than... there always seems to be things that you're never quite, you know, finishing or are getting to."* The positive environment of SHIP project contributed to four locums/trainees and an experienced GP taking up vacant partnerships within these practices with at least two of the senior GPs delaying retirement.

While not an explicit objective, the SHIP approach has resulted in the situation where there are no GP vacancies within the practices connected with the project. This bucks the national trend. Evidence suggests the potential retirement profile is most severe in GPs working with deprived populations and therefore will be proportionally high in Glasgow City.[11]

Additional GP resourcing has clearly played its part as also evidenced by the GP Pioneer project however improved collaboration, communications and relationships with other services have been confirmed as making significant contribution to this.

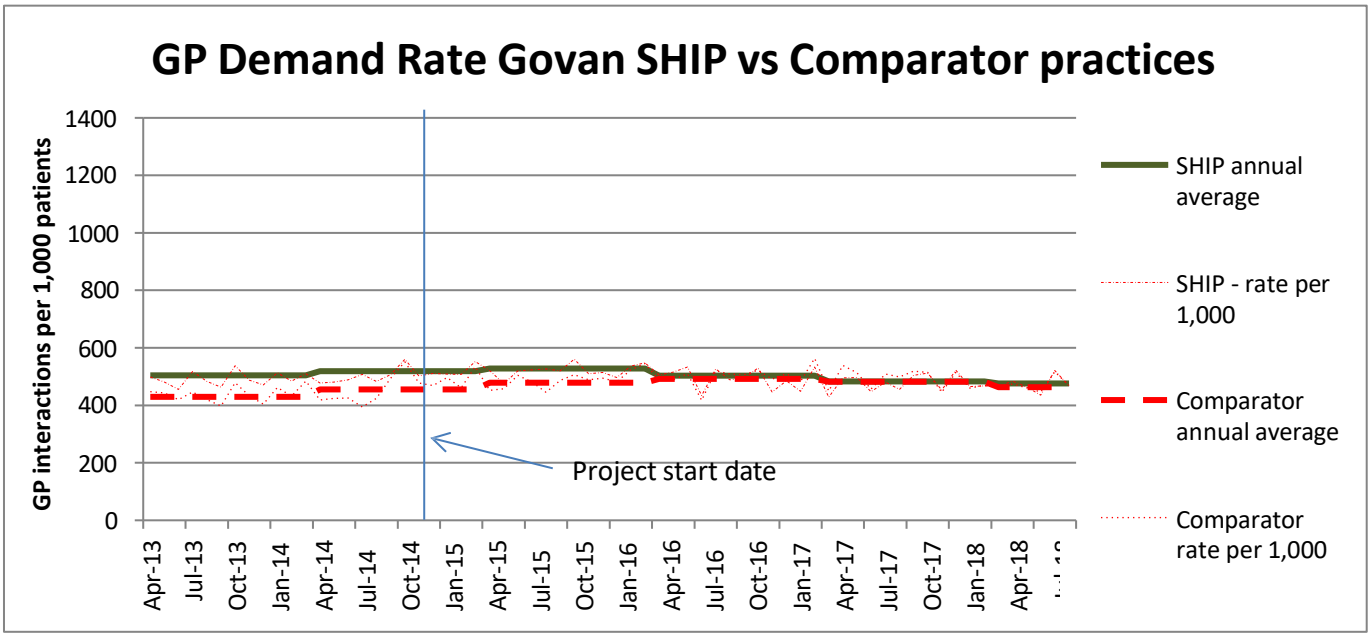
5.4 Demand[12]

Key project objectives included identifying opportunities to shift demand within primary care and more specifically to reduce GP Demand. GP demand was measured internally comparing those recruited to the SHIP against the practice baseline and also against a group of comparator practices with a similar demographic pro

[11] Distribution of GPs in Scotland by age, gender and deprivation (2015), Blane D et al. (References: #9)

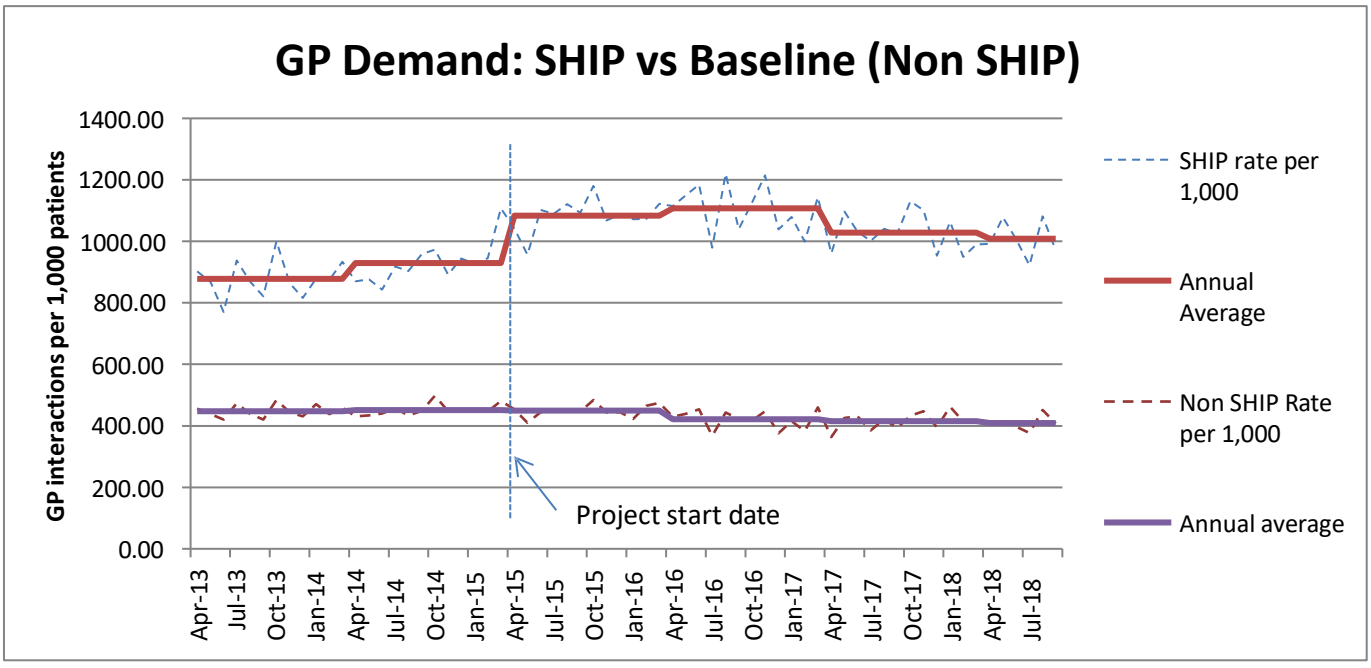
[12] **Definition -** project GP demand was defined as any consultation related data entered by the GP into the practice patient management system (EMIS) and more than consultations alone.
Strengths: This captures a broader range of patient related activity over and above in-surgery consultations including administration notes, data entry, lab tests requests, home visit notes and telephone consultations. 98% of GP entries are captured via this definition
Weakness: No weighting in terms of time commitments of each

5.4.1 Govan vs Comparators



The above chart demonstrates GP demand across the SHIP practices improved in relation to the comparator practices over the length of the project. In an interrupted time series analysis, a significant reduction of -1.48 (-2.87, -0.09) GP interactions per 1000 patients per month was observed following onset of SHIP (Levin, McGarry & Crighton, 2019[13]). By March 2018 this was equivalent to and an absolute reduction of 37 GP interactions per 1000 and a relative reduction of 7.2%.

5.4.2 SHIP Demand



The chart above suggests that SHIP patients historically place higher demand on GPs. This trend continued during the first two years of the project before a decline was observed.

[13] Measuring the impact of the Govan social and health integration partnership (SHIP) project on emergency admissions to hospital and GP interactions: a controlled interrupted time series analysis. (References: #10)

6. SOCIAL WORK

6.1 External valuation

The external evaluation found that the SHIP initially experienced many of the challenges found in the literature on social work and health integration projects. These include:

- Little understanding or appreciation of the other's role on either side
- GPs have little confidence in the social care system and expect to be 'stonewalled' by indifferent officials
- GPs sceptical about quality of SW assessment & have little knowledge of SW training or skills
- Negative stereotypes persist, reinforced by lack of meaningful communication: SWs see GPs as controlling, arrogant, disrespectful & intent on enforcing the 'medical model' whilst GPs see SWs as incompetent, unavailable, 'lefty tree-hugging do-gooders' & 'all about box-ticking'

Pre-implementation presentations from social work to the steering group explaining what they could expect from social work engagement appear not to have been understood or accepted. It seemed they were destined to fail to meet expectations engaging in the role of liaison social workers, while the others expected attached workers (working directly with their patients). High thresholds that had to be met for eligibility led to resentment on the part of health care staff and negative behaviour towards the social workers.

These difficult early encounters were however replaced by positive relationships and working together, demonstrating that with time to reflect, lessons had been learned and there had been a shift in attitudes. Indeed, in crisis situations, social workers were reported to act swiftly, professionally, collaboratively and their efforts were highly valued.

"Because we had been working with the social workers and they had been working alongside us and we'd been sort of working towards this crisis so when it happened at five o'clock at night we were able to … we have the confidence in each other to just go and sort it out."

Social work colleagues contributed to the learning and developmental aspects of MDT working, promoting enablement and advising in relation to the regulatory and legislative framework around care. This included why social work could not intervene without a person's consent even if there was a collective view that this would bring benefit. For example, this might relate to person having capacity or not meeting entry criteria for a particular service or support.

Qualified social workers were replaced in year two as the nature of patient need became clearer. Social care workers were expected and more able to engage with patients to do the kind of 'social work' that had been a feature of generalist social working in the past. They would also be able to continue accessing social work information systems and share information as well as carry out assessments and make referrals.

"We didn't realise just how specialised that [social workers] had become, but also how separate they'd become from third sector, voluntary sector, homecare type services. So as the project has evolved it became clear to us that it wasn't fully qualified social workers that we actually needed, but what we needed was social work care workers who could give us access to the social work system."

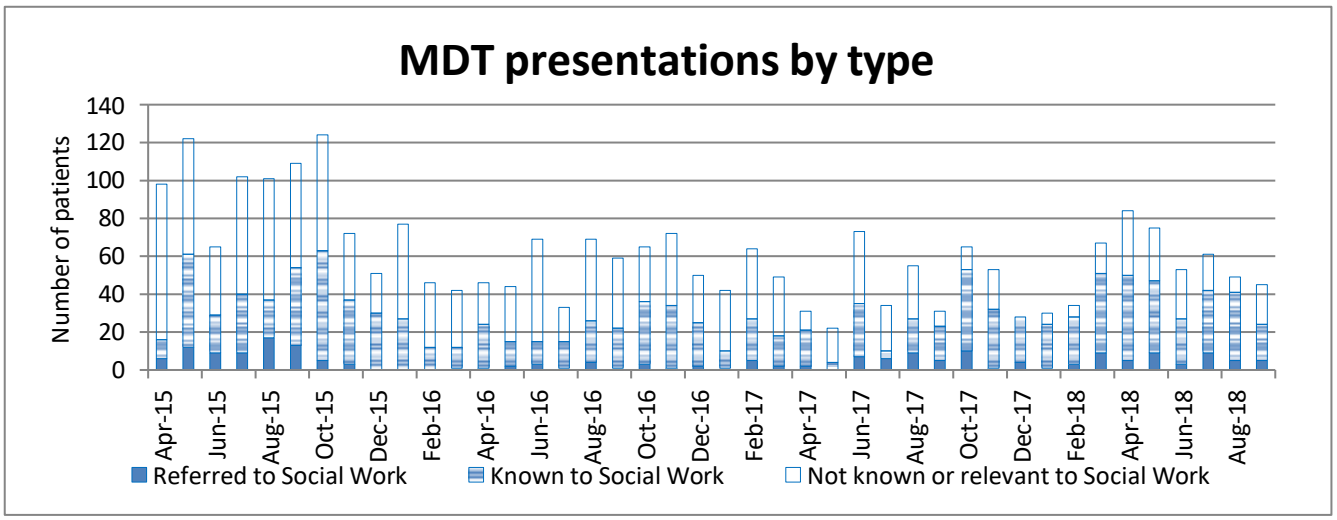
The participation of social work was essential with regard to information sharing and effective management of cases being referred to, or currently engaged with, social work services.

"A lot of parents' vulnerabilities affect kids but it won't be known to Social Work. Also, In A&E, when kids are taken to hospital, A&E contact the GP. Frequent contacts about kids being taken to A&E may be indicative of something else going on, maybe just ignorance of health and safety, maybe some other risk. If I find out about that at the MDT, I can go to see them, offer support, again its preventative. […] If we can intervene and offer support, it might prevent a child protection situation and show people Social Work has a support side as well."

The project objective to lower thresholds and increase horizontal referral to social work proved to be more difficult. Involvement of the 3rd sector and community organisations becomes more important in these circumstances however the complexity of this territory prevents referrers (mainly GPs) from easily identifying accessing an appropriate service or support. Community links workers were embedded in two of the practices and their participation facilitated such engagement more effectively[14].

6.2 Demand

Social work contribution was observed most strongly through MDT working:



	Referred to Social Work	Known to Social Work	Not known or relevant to Social Work
Median	5.9%	42.3%	50.2%

The 5.9% of referrals were of higher quality and more likely to meet social work criteria as a result of MDT working and discussion. The relationship between demand for social work services and deprivation[15] runs parallel to that of deprivation and health. The data above confirms the logic for strengthening the relationship between social work and GP practice and that the SHIP provided an effective vehicle for this. GPs and Social Workers: Partners for Better Care (2014)[16] echoes the need for greater integration between social work and general practice and provides other case studies describing benefits to this approach.

[14] National Links Worker programme review of 2018. (References: #11)

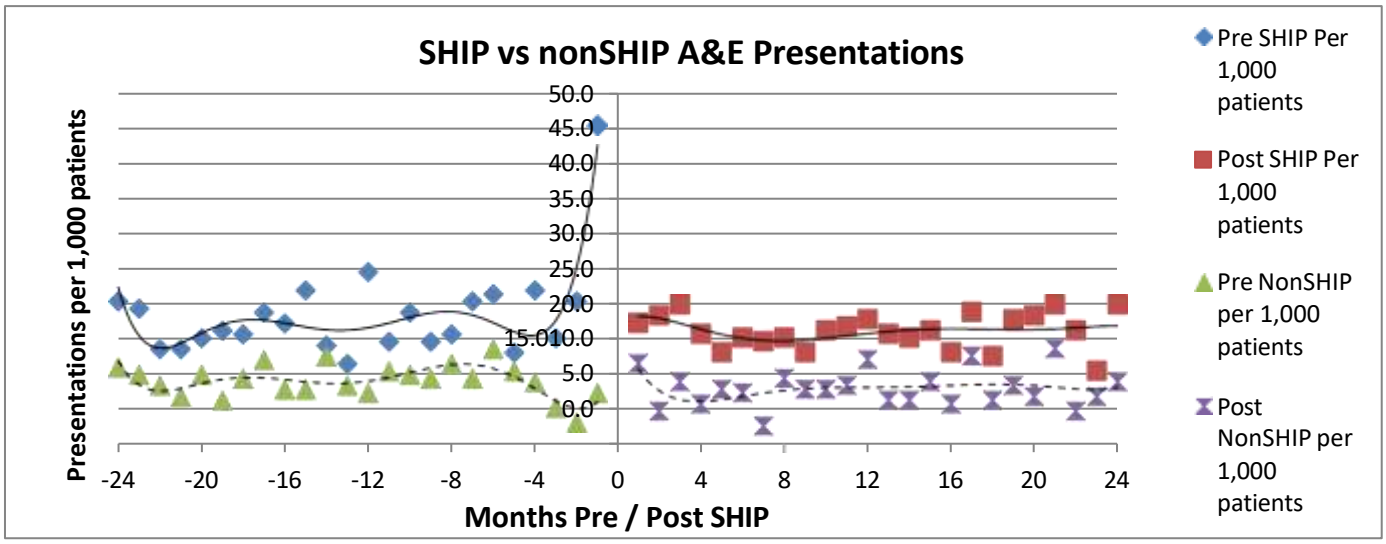
[15] 63% of Glasgow City social work client population living within the 15% most deprived datazones in Scotland - Social Work Area Demographics, June 2011, pages 43-46, Glasgow City Council, https://www.glasgow.gov.uk/CHttpHandler.ashx?id=8286&p=0 (this link no longer works, see References: #12 for more details)

[16] GPs and Social Workers: Partners for Better Care (2014), http://www.primarycareone.wales.nhs.uk/sitesplus/documents/1191/Partners-for-Better-Care-2014%5B1%5D.pdf (this link no longer works, see Reference: #13 for more details)

7. DEMAND ACROSS HEALTH CARE

7.1 Accident & Emergency

SHIP patients were 'paired'[17] and compared with similar non-project patients and who were all registered throughout to understand changes in A&E demand in the two years pre and post 1st SHIP date. 523 pairs were identified for analysis.



This data suggests that, again, patients identified to the SHIP placed higher demand on other services. The increase in the months prior to SHIP intervention suggests this became a significant indicator for inclusion in the project however there was no overall impact and the post intervention drop is more likely to be associated with regression to the mean (i.e. drop in attendance would have occurred naturally)

There are however individual cases where SHIP and multi-disciplinary team working has shifted demand and where this has included at least some involvement with accident & emergency;

Scenario	Patient with known personality disorder and anxiety illness. High frequency presentations to A&E over several years (178 in two years prior to SHIP intervention). Multiple agency involvement.
Actions Taken	Additional capacity facilitated GP attendance at Care Programme Approach (CPA) meetings along with planned extended consultations with a named practice GP and other planned support from CMHT.
Outcome	Over threefold reduction in A&E presentations (56 over following two years)
SHIP Contribution	Additional GP capacity facilitated extended consultations and CPA meeting attendance

[17] Pairing criteria:

- Continually registered between April 2013 and Sept 2018
- 1st SHIP Date between 1st April 2015 and 30th Sept 2016 to ensure capture of 2 full years of activity pre and post 1st SHIP date
- Gender
- Age band (divided into 5-year age groups)
- Multi-Morbidity – two or more conditions

Scenario	Patient with long term mental health problems. Normally only presented when in crisis. Poor insight into condition and poor compliance with medication resulting in build-up of medications and subsequent overdose during crisis. Result was a number of contacts with OOH and A&E. Patient has no social network and very little family support. Patient wanted to change accommodation and frustrated with lack of response.
Actions Taken	*(MDT pharmacist)* Medication review and given medication advice. Supply changed to weekly dispense to limit build-up of medications and better compliance. Blood pressure (BP) very high and booked in for further BP checks. Subsequently confirmed hypertensive. Medication started. Social worker contacted, confirming housing application pending. Liaison CPN for update on mental health involvement.
Outcome	Improved medications compliance. Hypertension diagnosed and managed. Better insight into mental health and importance of healthy lifestyle. Patient referred to links worker. Patient awareness: Next CPN appointment reducing risk of failure to attend Housing application process and time spans, reducing anxiety 3rd sector mental health services (Breathing Space, etc.) Community pharmacy for minor ailments. Reduced OOH & A&E input.
SHIP Contribution	Due to the link between the SHIP MDT it was easy to contact services such as links and social work and other services involved in patients care. Normally it would be difficult and time consuming to ascertain who the other HC professionals are involved in patients care. Concentration of A&E episodes identified as indicator for MDT referral. High BP (and secondary effects resulting in multi-morbidity) may have been missed as this patient normally only presented in crisis without SHIP intervention (GP capacity, MDT Pharmacy)

7.2 Patterns of Healthcare Use (Appendix J)

A sample of 400 patients was selected from those that had consulted a GP between 12-26 times in 2014, for which demand was neither high nor low, were analysed for their broader pattern of health care utilisation. The purpose was to understand broader population demand, avoiding the smaller numbers of high demand patients.

Summary findings include:

- 62% were referred to outpatients in the study year with a 16% DNA rate
- 12% required elective admissions – with an average of 4 elective admissions each
- The characteristics of frequent GP consulters were similar across the practices, with a high proportion of middle-age female patients
- Over half were taking anti-depressants. 21% of patients had been referred to mental health
- A very small number of patients accounted for two thirds of unscheduled emergency admissions
- Identifying frequent users of GP consultations as a potential indicator of unscheduled care use and as a marker for intervention with regard to this is inefficient.
- Initiatives to reduce use of unscheduled care should target frequent users of unscheduled care directly
- Patients who had extended consultations as part of the SHIP had low rates of unscheduled care
- In general, it appeared that referral to the SHIP was based on urgency of current problems rather than patterns of frequent use of GP encounters

8. POLICY/STRATEGY ALIGNMENT

8.1 General Medical Services Contract

The Govan SHIP project was, in many aspects, a precursor to 2018 GMS contract. Many elements have been adopted from early experience of the SHIP and other nationally funded projects. These include multi-disciplinary team working, the need for social care involvement and other measures to release and create additional GP capacity.

This chapter reflects how learning from the SHIP could educate delivery:

Alignment with Social Work: The contract seeks the development of expanded teams of clinical and non-clinical professionals working in practices and localities. It recommends the inclusion of several health care professions and non-clinical support workers (e.g. links workers). There is however little mention of statutory social work services. The experience of SHIP suggests there is an explicit requirement for the involvement of social work, particularly in practices serving highly deprived populations, given the significant overlap in populations.

Multi-Disciplinary Teams: 'How' multi-disciplinary working should be delivered is to be addressed downstream through primary care implementation plans and other vehicles. SHIP learning highlights the benefits of periodical structured engagement involving the whole team and the need for organisational development prior to implementation in order to break down potential barriers and develop the necessary relationships and communications that are essential for effective multi-disciplinary team working, shared decision making (at minimum between professionals), managing workload and sharing risk.

Additional GP Capacity: A significant aim of the contract is to reduce GP and GP practice workload. The contract does not quantify expectations. SHIP learning and feedback from project GPs suggests that each element will offer varying return and that a universal approach to rollout will fail to address inequalities. Proportionate universalism[18] should be considered, particularly in the current climate of limited resources, when allocating resources to ensure that relative benefits match the relative need of the local population.

8.2 Mental Health Strategy

There are a number of learning points from the mental health element of the project that relate to and are reflected in strategy, including; variation in response, the high drop-off rate between referral and engagement with mental health services, the relationship of mental health to the link worker role, lack of shared understanding on how mental health needs are defined and how they should be responded to;

National Mental health Strategy: 2017 - 2027[19]

- Action 15. Increase the workforce to give access to dedicated mental health professionals to*…(including)...*GP practices
- Action 24. Fund work to improve provision of psychological therapy services and help meet set treatment targets
- Action 25. Develop more accessible psychological self-help resources and support national rollout of computerised CBT

[18] http://www.healthscotland.com/uploads/documents/24296-ProportionateUniversalismBriefing.pdf (this link no longer works, see References: #14 for more details)

[19] National Mental Health Strategy 2017 - 2027 (References: #15

A Five-year Strategy for Adult Mental Health Services in Greater Glasgow & Clyde: 2018-23[20]

Make the most of community-based resources to offer early support

- Consider the development of non-clinical responses to distress and suicidal behaviour
- Align service user expectations with available help to facilitate straightforward access to the right kind of help and maximise the opportunities for self-management
- Supporting services users and carers to navigate the service options and improve 'signposting'
- Where appropriate, move away from traditional clinical models of referral and discharge from services, towards self-directed care, open access and brief and low-intensity interventions - 'easy in, easy out'
- A commitment to simplifying access routes (e.g. self-referral to PCMHTs) with the use of link workers and "choice" appointments to help work out how best to respond to more complex difficulties.

[20] https://glasgowcity.hscp.scot/search?keys=mental+health+strategy (this link no longer works, see References: #16 for details)

9. CONCLUSIONS

The Govan SHIP project sought to deliver against an ambitious and broad range of aims and objectives.

The aspiration to deliver a person-centred approach, responding to need rather than condition or criteria, was broadly met. The aim for unconditional personalised continuity of care whatever combinations of problems patients encountered remained sometimes compromised by barriers to entry criteria for services. Certain groups appeared to benefit even though there were no set selection criteria and entry was universal. These were; vulnerable families and in particular women aged 17-44, recent and significant presentation to A&E, existing and increasing GP demand. Higher deprivation and higher multi-morbidity were also common features of the SHIP population.

The SHIP model of multi-disciplinary working demonstrated extra value from more joined up management, better use of resources and services, shifting demand between health & social care professionals working to the top of their licence. The structured approach ensured whole team involvement and input on a regular but not necessarily frequent basis, ensuring shared management and approach to risk. Better planning would have ensured alignment of aspiration and understanding across the teams, avoiding the conflict that ensued. The learning from this however led to improved collaboration existing and the breaking of embedded silo working roles into shared / integrated working as part of the care team.

The various project work streams identified (though not always implemented) opportunities to reduce demand in primary, secondary, and other care settings through anticipatory care, early intervention and re-direction. Some demonstrated the principles however did not have the required critical mass or wider system support to demonstrate effectiveness.

Direct funding afforded additional GP capacity and support to more complex patients, increasing access and time for consultations for patients with long term and multi morbidities. This funding also ensured significant GP contribution to project and work stream development. Shifting demand across social work, pharmacist, physiotherapist, and other professionals through the MDT also released capacity however GP demand remained high because of the complexity of many patients. Further work will be required to quantify and evidence that the aims of the new GMS contract will release similar capacity, particularly in practices serving deprived populations with the associated complexity requiring continued high levels of GP input.

Quantitative analysis confirms a reduction in overall GP demand. It also confirms need for a significant relationship with, and demand for, social work services. The impact on unscheduled care, while significant for a relatively small number of individuals and the practices involved, was marginal at system level. The work on information management and evaluation demonstrated how an understanding of demand across health and care services at GP practice level could be developed and created the evidence base through qualitative and quantitative evidence on potential areas for focus, input and investment. The availability of quality and relevant information / performance management at practice level remains challenging. Development of SPIRE (Scottish Primary Care Information Resource), Rollout of LIST (Local Intelligence Support Teams) teams and development of cluster and practice quality reports will go some way to improving this.

Learning from the Govan SHIP could and should contribute to developments under the GMS contract and other policy / strategic directives.

10. LIST OF APPENDICES

A. Demographics of the Govan SHIP Project
B. ACEs in the Deep End
C. Information Management in the SHIP Project
D. A Qualitative Evaluation of the Govan SHIP – Update of Executive Summary, August 2017
E. A Qualitative Evaluation of the Govan SHIP - Full Report, November 2016
F. Evaluation of the impact of pharmacist polypharmacy reviews within the Govan Social and Healthcare Integration Partnership (SHIP) project
G. Improving Primary Care Access by Introducing an Advanced Physiotherapy Practitioner (APP) into 3 Deep End GP Practices – Govan SHIP Project
H. Mental Health in the Govan SHIP Project
I. GP use of additional time at Govan Health Centre as part of the SHIP project
J. Patterns of health care use at Govan Health Centre

11. ACKNOWLEDGEMENTS

I would like to thank all the colleagues who provided their time, wisdom, insight and expertise that greatly contributed to the development, implementation and outcomes from the project.

Thanks go to the operational colleagues, managers, MDT participants & members and practice staff. Particular credit is due to Margaret Anne Dale who was the key link to social work and who deserves special thanks for her perseverance in ensuring on-going collaboration, despite initial difficulties.

This report was prepared with the support of a broad range of contributors;

Project Lead GP
Dr John Montgomery

Practice & Work Stream Lead GPs
Dr Anne Mullin
Dr Brian Milmore
Dr Niall Cameron
Dr Ewan Gray
Dr Amanda Connelly
Dr Gillian MacKenzie
Dr Adrian Petrie

Academic Colleagues
Professor Graham Watt
Professor Stewart Mercer

Report Contributors
Rizwan Din - Pharmacy
Margo Pratt, Caroline Horn, Eden Keiler, Ewan Gray - Physiotherapy
Kim Robertson (BSc student) - ACEs
Prof. Graham Watt - GP use of additional time
Alice Harry (BSc student) - Patterns of Healthcare Use
Associate Prof. Fiona M. Harris, Julia McGregor, Prof. Margaret Maxwell (University of Stirling) and Prof. Stewart Mercer (University of Glasgow) – External Qualitative Evaluation
Dr Brian Milmore - Information management & Identifying Morbidity
Gillian Neal - Mental Health in the Govan SHIP project

HSCP Senior Management
David Walker, Assistant Chief Officer

And, Alan Gilmour, Planning and Line manager - for his support and direction throughout.

12. REFERENCES

1. Hart, JT (1971), The Inverse Care Law, The Lancet, https://doi.org/10.1016/S0140-6736(71)92410-X (back to text)
2. The Scottish Deep End Project: https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/about/ (back to text)
3. The Scottish Index of Multiple Deprivation (SIMD) – link (https://www2.gov.scot/Topics/Statistics/SIMD) now goes to 2020 data. 2016 data can be seen on a map here https://jamestrimble.github.io/imdmaps/simd2016/ (back to text)
4. NSPCC (2015), GPs and primary healthcare teams: learning from case reviews, https://learning.nspcc.org.uk/media/1338/learning-from-case-reviews_gps-and-primary-healthcare-teams.pdf (original source moved or removed so link has been removed, document can be found at this alternative source) (back to text)
5. The 2018 General Medical Services Contract in Scotland, https://www.gov.scot/publications/gms-contract-scotland/ (back to text)
6. G. McLean et al. (2014), The influence of socioeconomic deprivation on multimorbidity at different ages: a cross-sectional study, British Journal of General Practice, https://bjgp.org/content/64/624/e440 (back to text)
7. Deep End Report 22: Mental health issues in the Deep End, https://www.gla.ac.uk/media/media_327432_en.pdf (back to text)
8. Stewart W Mercer, Bridie Fitzpatrick, Glen Gourlay, Gaby Vojt, Alex McConnachie and Graham CM Watt (2007), British Journal of General Practice, More time for complex consultations in a high-deprivation practice is associated with increased patient enablement, https://bjgp.org/content/57/545/960/tab-pdf (back to text)
9. David N Blane, Gary McLean and Graham Watt (2015), Scottish Medical Journal, Distribution of GPs in Scotland by age, gender and deprivation, https://journals.sagepub.com/doi/10.1177/0036933015606592 (back to text)
10. Measuring the impact of the Govan social and health integration partnership (SHIP) project on emergency admissions to hospital and GP interactions: a controlled interrupted time series analysis, https://jech.bmj.com/content/73/Suppl_1/A86.2 (back to text)
11. National Links Worker programme review of 2018, https://www.alliance-scotland.org.uk/blog/news/national-links-worker-programme-review-of-2018/ (back to text)
12. Jason T. Mokrovich (2011), Glasgow City Council, Social Work Area Demographics, https://www.glasgow.gov.uk/CHttpHandler.ashx?id=8286&p=0 (original source moved or removed so link has been removed, some relevant information may be available in this document) (back to text)
13. The Royal College of General Practitioners and The College of Social Work (2014), GPs and Social Workers: Partners for Better Care, http://www.primarycareone.wales.nhs.uk/sitesplus/documents/1191/Partners-for-Better-Care-2014%5B1%5D.pdf (original source moved or removed so link has been removed, the report is referred to in this article,"Closer working by GPs and social workers could save £1.6bn a year" which is available by logging in to BMJ. However, the link to the original report doesn't work in the article either) (back to text).
14. NHS Health Scotland, Proportionate Universalism and Health Inequalities, http://www.healthscotland.com/uploads/documents/24296-ProportionateUniversalismBriefing.pdf (original source moved or removed so link has been removed, more information about proportionate universalism can be found in this report. (back to text)
15. The Scottish Government (2017), Mental Health Strategy 2017-2027, https://www.gov.scot/publications/mental-health-strategy-2017-2027/ (back to text)
16. Glasgow City Joint Integration Board (2018), A Five-Year Strategy for Adult Mental Health Services in Greater Glasgow and Clyde 2018-23 (Draft): https://glasgowcity.hscp.scot/search?keys=mental+health+strategy (original source moved or removed so link has been removed, this appears to be the new link to the report). (back to text)