

Deep End Report 5

Single-handed general practice

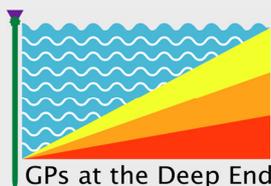
*The fifth meeting of "General
Practitioners at the Deep End"*

07 May 2010

Nine GPs from Glasgow, Dundee and Saltcoats met on Friday 07 May at the Section of General Practice & Primary Care, University of Glasgow, for a workshop on their experience and views of single-handed general practice in very deprived areas.

SUMMARY

- The 100 most deprived general practices in Scotland include 17 single-handed practices serving a combined population of 30,870 patients.
- Single-handed practitioners are passionate about their patients and committed to the personal approach that single-handed practice allows and requires.
- “Small is beautiful” and there are many aspects of single-handed practice, in terms of continuity, immediacy and patient satisfaction, which embody what Government is trying to achieve for patients in the NHS (e.g. as in The Healthcare Quality Strategy for NHS Scotland).
- Single-handed practice is popular with patients, who choose to be registered with a singlehanded practitioner.
- It is paradoxical, therefore, that single-handed practice is a tolerated, rather than an actively supported, way of delivering primary care services.
- The price that single-handed practitioners accept in order to practice in this way includes financial disadvantage (mainly due to diseconomies of scale), being tied to the practice, lack of flexibility, professional isolation and marginalisation by management – all of which could be addressed.
- The combined responsibilities of providing clinical care and running a business can be very stressful.
- Single-handed practice is not attractive to the majority of general practitioners, for a variety of reasons, including personal characteristics, but is a favoured option for some and should be supported, capitalising and learning from the strengths of the approach, while providing support to minimise weaknesses.
- More evidence is needed about the long term effects of single-handed practice e.g. Do the higher levels of continuity and patient satisfaction translate into longer term health outcomes? Is there a trade off between the higher list size to ensure financial stability and the volume and quality of care that can be offered?



GPs at the Deep End

“General Practitioners at the Deep End” work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Royal College of General Practitioners (Scotland), the Scottish Government Health Department, the Glasgow Centre for Population Health, and the Section of General Practice & Primary Care at the University of Glasgow.

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ATTENDING

Name	Location (deprivation ranking of practice)	List size
Karen Davidson	Kyleshill Surgery, Saltcoats (94)	2173
Christine Grieve	Drumchapel Health Centre, Glasgow (14)	2342
Ian Kennedy	Hyndland/Springburn, Glasgow (97)	1122
Susan Langridge	Possilpark Health Centre, Glasgow (15)	2256
Alastair Muir	Woodside Health Centre, Glasgow (65)	2162
Steve Pegg	Whitfield Clinic, Dundee (70)	967
Douglas Robertson	Knightswood, Glasgow (91)	2170
Pierre Tsang	Bridgeton Health Centre, Glasgow (52)	1255
Linda Wright	Glenmore Medical Practice, Glasgow (77)	1403
Yingying Wang	University of Glasgow (Research fellow)	
Graham Watt	University of Glasgow (Meeting facilitator)	

AIM

The meeting aimed to capture the experience and views of single-handed practitioners working in severely deprived areas.

BACKGROUND

SINGLE-HANDED IN THE DEEP END

The 100 general practices in the Deep End include 17 single-handed practices serving a total of 30,870 patients.

Deep End single-handed practices comprise 17% of practices, 7% of patients and 4% of GPs in the Deep End group.

The 17 single-handed practices in the Deep End are situated as follows:

Location	No. of practices
Saltcoats, North Ayrshire CHP	1
Dundee CHP	1
Glasgow South East CHCP	1
Glasgow South West CHCP	1
Glasgow North CHCP	2
Glasgow East CHCP	5
Glasgow West CHCP	6

Participation of the 17 practices in additional practice activities is as follows:

Activity	No. of practices
Undergraduate teaching	3
Postgraduate training	2
Scottish Programme to Improve Clinical effectiveness (SPICE)	5
Scottish Practice Research Network (SPCRN)	8
Keep Well	2
Scottish Primary Care Collaborative (SPCC)	10
GPs at the Deep End (any of 5 meetings)	13

Nine of the 17 GPs attended the first meeting at Erskine, three had attended subsequent meetings and one is a regular member of the Deep End steering group.

PRESENT COMPANY

The nine general practitioners taking part in this meeting serve a total population of 15850 patients, ranging from 967 to 2342 patients. 5 practitioners have list sizes of more than 2000. The group included “the last single-handed GP in Dundee”. There were four women and five men. Two of the group had not attended a previous Deep End meeting.

The period of time spent as a single-handed practitioner ranged from two to 24 years, with a total of 118 years and an average of 13 years.

EVIDENCE ABOUT SINGLE-HANDED PRACTICE

The meeting began with a presentation from Dr Yingying Wang presenting the results of her PhD thesis on single-handed general practice in urban areas, including 20 qualitative interviews with single-handed GPs and a published research analysis of routine data. (Wang, O'Donnell, Mackay and Watt. Practice size and quality attainment under the new GMS contract. *British Journal of General Practice* 2006;**56**:830–835.)

Her study focused on single-handed general practice in urban areas, because unlike single-handed practice in remote and rural areas, urban single-handed practice is a matter of choice, and is not determined by geography or demography.

In 2002, there were 85 urban single-handed GPs in Scotland, who were more likely to be male, older, qualified in South-East Asia and with a larger list size than other GPs working in urban areas.

By 2009 there were 73 single-handed practices in urban areas in Scotland, serving 155,875 patients, including 17 in the 100 most deprived practices, serving 30,870 patients.

Dr Wang's interviews included seven single-handed GPs from the Deep End, including five attending the present meeting.

Single-handed GPs come to this position by a variety of routes including a planned career move, responding to the opportunity of a vacant practice or splitting from unsatisfactory partnerships.

In general, single handed practices have achieved similar median numbers of QOF points for clinical and organisational domains as small, medium and large practices in each year of the Quality and Outcomes Framework, but with a wider distribution and longer tail. A small number of single-handed practices achieve significantly fewer points than average.

It was pointed out that practices may lose points by deciding not to carry out parts of the QOF which are considered unduly onerous. Small practices are also unable to achieve points for conditions with zero prevalence within the practice.

THE NEW GMS CONTRACT

Where single-handed practitioners are most disadvantaged by the new GMS contract is in the employment of staff. The basic requirements of practice manager, receptionist and practice nurse support cannot be reduced and are a proportionally greater expense for single-handed practitioners than for group practices, with their ability to make economies of scale. In some areas, it is not safe to have a single member of support staff on duty at one time. The cost of employing two staff for safety reasons is an added expense for single-handed practitioners. As the global sum has been capped, and staff costs have gone up (with cost of living rises), single-handed practitioners have been particularly disadvantaged.

With a small list, and little prospect of increasing income via the contract, practitioners with smaller lists may boost their income with extra-practice activities, but this depends on cross-cover, good professional relationships and geography.

PATIENT SATISFACTION

Single-handed practices achieve high patient satisfaction scores, compared with group practices, which supports the view of single-handed practitioners that they are better able to provide both a personal service and an efficient service based on continuity of contact and knowledge of individual patients (“offering a bespoke service in contrast to the “MacDonalds” approach of large practices”). These aspects of practice are not incentivised or rewarded by the QOF.

PRESSURES OF SINGLE-HANDED PRACTICE

Single-handed practitioners cannot afford to prevaricate or delay in dealing with problems, which otherwise build up, causing mounting pressure and stress. Poor outcomes often increase workload. It was said that SH practitioners very quickly learn that they have to look after themselves, with efficient management of their own time and energy to survive the pressures of single handed practice.

Holidays are vital for re-charging, but dependent on the availability and reliability of locum cover and have to be cancelled at short notice if locum cover falls through. In general, single-handed practitioners do not have the flexibility of mutual back-up and cover that is available within group practices. One GP reported having to return to work three days after an operation for this reason.

The most stressful aspect of single-handed practice was said to be the pressure of running a business in addition to carrying out clinical work. It takes only a few problems for a smooth running practice to become suddenly very stressful.

A particular stress that was mentioned is the problem of dealing with patients with whom the GP has had some disagreement, when there is no possibility of the

patient seeing a partner for a second opinion, or to give the relationship a rest, without leaving the practice.

It was recognised that patients in deprived areas could be less demanding than patients in affluent areas, who could be better informed and wishing more time to discuss their options with the GP, but it was pointed out that demands are not the same as needs, and that patients in deprived areas could benefit from additional time for genuine health needs.

There was discussion about the “draining effect” of continually giving health messages which patients might not understand or act upon. In general it was felt that this could be emotionally, rather than intellectually, draining. Patients are often intelligent, but lack information, resources and a belief that change is possible.

MAKING BEST USE OF RESOURCES

Concerning the additional needs of patients in deprived areas, practitioners reported that they had seen no re-distribution of resource to address such needs. One practitioner had taken the initiative in addressing this issue by making his practice available for counsellor training.

Several practitioners are based in health centres, and reported the advantage of this situation, mainly in relation to the proximity of colleagues for professional and social contact. There was also some sharing of services.

Another sharing arrangement was described where three small practices worked in sufficient proximity to allow sharing of receptionist and other staff (e.g. for phlebotomy), but such proximity and sharing arrangements are rare.

JOINT WORKING

Challenged with the assertion that the main challenge facing general practice, building on its intrinsic strengths of knowledge, contact, continuity, coverage and trust, is the leadership required to improve co-ordination across a range of fronts, it was said that single-handed practice is largely about leadership (“out of necessity”), on behalf of patients, without the problems of leadership within a partnership, and developing external relationships as and when required. It was felt that single-handed practitioners do not have a problem in engaging with the wider body of primary care.

Successful cross-cover arrangements depend on practitioners having strong local relationships with other practitioners.

PROFESSIONAL ISOLATION

Professional isolation was acknowledged as an issue, with negative effects if practitioners fell ill, or were under particular stress or were not keeping up to date.

It was recognised that many developments in professional practice, such as evidence-based medicine, could happen more quickly in a collegiate environment. The general lack of dedicated continuing professional development activities had weakened this aspect of practice.

The Family Doctors Association was described as a valuable source of advice and support for single-handed practices, but was said to have few Scottish members. In the past there had been a Glasgow Small Practices Association but there was doubt as to whether this group is still active.

WHAT CAN SINGLE-HANDED GENERAL PRACTICE ACHIEVE IN DEPRIVED AREAS?

The group discussed whether the role of general practice is to support patients through their lives as they encounter problems (“the power of the kind word”), or if practice can also make a difference, by improving health and self management, and preventing, delaying or ameliorating future problems. Although single-handed practice seems best placed to make a difference in this way (as pioneered by Julian Tudor Hart), based on continuity of contact between practitioners and patients who know each other well, it was not known whether or to what extent single-handed practice achieved such effects.

The ghost of Harold Shipman was mentioned as an example of a single-handed GP who had reportedly been loved by many of his patients, while murdering many of them.

In summary it was felt that the role of the GP is to deliver the best technical and modern care, while helping patients through the complexities of their lives (adding to their natural ability) and developing facilities for various types of support within local communities. The third of these is most difficult, partly because of lack of time but also because there are so many agencies (“there are more services than I know about”), often disconnected between themselves, which are charged with such functions, and which tend not to recognise or value the role that GPs can play.

With their knowledge and contact with patients, GPs are well placed to provide the continuity and co-ordination required to avoid the increasing fragmentation of services and of care. The group was careful not to suggest that GPs are the whole solution, but they are an important part of the solution. They also have levels of legal responsibility and accountability for their decisions which are quite different from those of most professionals working with patients. GPs are the only category of staff in primary care whose replacement is mandatory should a vacancy arise.

It was felt that referrals from deprived practices sometimes merited higher priority than allocated by secondary care, when the GP knew the detailed social circumstances of the case, but these were not appreciated or known by colleagues in secondary care. In general it was felt that relationships and joint working between secondary and primary care could be improved.

There was general agreement that health care is less important than more fundamental determinants of health in deprived areas, such as housing and employment. One practitioner described the cathartic effect on some patients on a scheme "taking themselves out of themselves" (e.g. by a trip to Loch Lomond). It was suggested that general practitioners might also benefit in this way.

RELATIONSHIPS WITH HEALTH BOARDS AND COMMUNITY HEALTH PARTNERSHIPS

It was felt that health boards, and now community health partnerships (which have replaced boards as the point of contact for general practices) are not supportive of single-handed practice, often because they are considered too small to bother about.

Single-handed practitioners can be less visible, because of their greater difficulty in participating or in being represented at meetings

In general, practitioners did not want to complain, or to have closer relationships with CHPs, preferring to "get on with the job", but when external relationships were dysfunctional, they felt in a weak position to solve problems.

For example, when staff are attached to more than one practice in an area, the tendency is often for such staff to base themselves in larger practices, where there may be more space and other staff contact. It was felt that there should be a mechanism for ensuring a fairer distribution of hours worked between practices sharing attached staff.

Single-handed practitioners also report that they can be allocated poorer quality staff, whom other practices know and do not want. "We are a dumping ground for poor staff". Single-handed practitioners feel in a weak position in addressing this type of problem. It was said that complaints by single-handed practitioners were less likely to be heard and that, in general, the views of single-handed practitioners carry less weight than the views of larger practices.

NEW INITIATIVES

The plethora of initiatives in primary care is considered a continuing problem, as is the marginalisation of GPs within policy and management.

Several practitioners reported having been involved in new initiatives, based on short term funding, which if considered successful had been rolled out on an area

basis, without commensurate resources, thus diluting the successful effect. It was felt that if the possibility of sustainability was not built in at the beginning, even successful initiatives were unlikely to survive.

THE FUTURE

In view of the declining numbers of single-handed practices, there was discussion about the future of this type of practice. In general, if a single-handed practice becomes vacant, boards consider the “vibrancy” of the practice, making it available as a continuing single-handed practice if vibrant, and incorporating the practice list in a nearby group practice if not. Single-handed practitioners often also take on a partner in the final months of their time in practice, which can ensure a single-handed succession.

WHAT COULD MAKE A DIFFERENCE?

Where practicable, the sharing of practice resources, especially staff and administration, can provide much-needed economies of scale and flexibility on such issues as cross cover. Other forms of practical business support could make it easier for single-handed practitioners to concentrate on the personalised patient care which is considered the main strength of single-handed practice.

Professional support has been provided in the past by the Family Doctors Association and the Glasgow Small Practices Association, but the former is largely an English organisation and the latter has fallen into abeyance. There is a need to re-establish this type of support. It was suggested a buddy system could provide part of the support that is required.

Increasing the stability of single-handed practices would help address board’s perceived major concern about single-handed practices, namely their responsibility to take over should the practice go “belly up”.

Most issues concerning practice in very deprived areas were considered no different from those faced by all practices in such areas. An endemic issue is that patients frequently lack the information and life skills to make what professionals consider “better choices”, but addressing this is a long term task requiring education and counselling. Attaching additional staff to practices makes it more likely that patients will attend and continue to attend.

Single-handed practices could receive better value from attached staff if there were a mechanism to ensure a fairer distribution of time between the practices to which staff are attached.

CONCLUSIONS

Single-handed practitioners are passionate about their patients and committed to the personal approach that single-handed practice allows and requires.

“Small is beautiful” and there are many aspects of single-handed practice, in terms of continuity, immediacy and patient satisfaction, which embody what Government is trying to achieve for patients in the NHS (e.g. The Healthcare Quality Strategy for NHSScotland).

Single-handed practice is popular with those patients who choose to be registered with a singlehanded practitioner.

It is paradoxical, therefore, that single-handed practice is a tolerated, rather than an actively supported, way of delivering primary care services.

The price that single-handed practitioners accept in order to practice in this way includes financial disadvantage (mainly due to diseconomies of scale), being tied to the practice, lack of flexibility, professional isolation and marginalisation by management – all of which could be addressed.

Single-handed practice is not attractive to the majority of general practitioners, for a variety of reasons, including personal characteristics, but is a favoured option for some and should be supported, capitalising and learning from the strengths of the approach, while providing support to minimise weaknesses.

More evidence is needed about the long terms effects of single-handed practice e.g. Do the higher levels of continuity and patient satisfaction translate into longer term health outcomes? Is there a trade off between the higher list size to ensure financial stability and the volume and quality of care that can be offered?