The Govan SHIP Project
(Social & health Integration Partnership)
(Formerly, the Govan Integrated Care project)

Appendices to the main report
Sept 2020

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APPENDIX A - DEMOGRAPHICS OF THE GOVAN SHIP PROJECT
DEMOGRAPHICS OF THE GOVAN SHIP PROJECT

1. PRACTICE DEMOGRAPHICS

Age and Gender
The age and gender distribution of the practice population is:

![Age and Gender Profile Graph]

Deprivation
The project practices are 29\textsuperscript{th} (Green), 34\textsuperscript{th} (David Elder), 59\textsuperscript{th} (Mair) and 77\textsuperscript{th} (Blue) against the 947 practices in Scotland ranked by the deprivation of the population they serve (ISD, October 2018). The Blue practice is one branch of a larger practice. The ISD Data reflects a larger practice containing Blue as one branch. When measuring branch-only data, Blue would be ranked 11\textsuperscript{th}.

The deprivation profile (as defined by SIMD\textsuperscript{1}) is:

![Deprivation Profile Graph]

Morbidity

\textsuperscript{1} The Scottish Index of Multiple Deprivation (SIMD) identifies small area concentrations of multiple deprivation across all of Scotland
There is no standard definition for morbidity. Appendix xxx describes how this was derived for the SHIP project.

The practice morbidity profile is described below:

![Project Practices Morbidity Profile](image)

*Multi-morbid = 2 or more conditions
Poly-morbid = 4 or more conditions*

2. **SHIP PATIENT DEMOGRAPHICS**

The chart below indicates the number of patients identified to the SHIP on a monthly basis. The increase from Mar 18 partly reflects the introduction of the Mair practice and an end of project focus.

![Monthly additions](image)
The chart below reflects the cumulative identification which equates to approximately 7% of the rolling registered population.

![Cumulative Additions](chart.png)

**Age**
The age profile of the SHIP project indicates that greatest need was identified in the youngest and oldest age groups in comparison with the overall practice baseline.

![Practice vs SHIP Age Profile](chart2.png)

When comparing gender with the practice baseline, the main difference appears in the significantly higher proportion of females aged 25-44.

This reflects an aim of the project to support vulnerable families and the impact of broader social determinants of health on women, and beyond health alone.
Examples include gender based violence, women as carers, child care responsibilities and how these intersect.²

A significantly higher proportion of the SHIP population live in the most deprived quintile when comparing with the practice baseline.

Morbidity

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.
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APPENDIX B - ACES IN THE DEEP END
ACEs in the Deep End
Kim Robertson BSc(Hons)

Coming into medicine from a non-traditional background I have always had an interest in the social and economical determinants of health and well-being, particularly deprivation and inequality. Why do many families continue to have poorer outcomes in terms of educational attainment, healthy living, and life expectancy across multiple generations, while some individuals from similar backgrounds can “escape” poverty and live longer, healthier lives? Inspired by the former Chief Medical Officer for Scotland, Sir Harry Burns, and his discussion of the links between chaotic childhoods, chronic stress, and poor health outcomes in later life; and why this sometimes, but not always, extends through the generations¹, I decided to undertake a research project in childhood adversity across multiple generations within one of the top 100 most deprived communities in Scotland.

Over twenty years ago an obesity study ran by the American health insurance providers Kaiser-Permanente (KP) was experiencing large numbers of participant dropout despite the fact that these individuals were losing weight. In order to understand why KP carried out a survey. The head of their Department of Preventative Medicine, Vincent Felitti, discovered that the majority of the participants he interviewed had experienced childhood sexual abuse. Considering there may be a link between trauma and obesity he, along with Robert Anda from the Centers for Disease Control and Prevention (CDC), surveyed over 17,000 KP patients. This group consisted of predominately white, middle-class individuals, mostly college educated and all in employment². Based on earlier research the participants of this survey were asked about ten types of childhood trauma, subsequently termed Adverse Childhood Experiences, or ACEs:

Table 1: List of Adverse Childhood Experiences (ACEs)

<table>
<thead>
<tr>
<th>Neglect</th>
<th>Abuse</th>
<th>Household Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>emotional</td>
<td>emotional</td>
<td>parent’s divorce/separation</td>
</tr>
<tr>
<td>physical</td>
<td>physical</td>
<td>domestic violence</td>
</tr>
<tr>
<td></td>
<td>sexual</td>
<td>household substance misuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>household mental illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>family member in prison</td>
</tr>
</tbody>
</table>

The study, now known as the ACEs study, found that childhood trauma was incredibly common with around 50% of participants having experienced at least one adverse event in childhood. Around 40% reported 2 or more ACEs and an eighth reported four or more. Additionally it was found that there is a dose-response relationship between the number of ACEs a person has experienced and their future health, social circumstances, and behavioural problems; including so-called “risk taking behaviours” such as smoking, substance misuse, poor sexual health, and obesity².
Since this groundbreaking study there has been extensive research into ACEs and the impact childhood trauma has on the health of individuals in later life. However researchers have only recently began to look further into the multigenerational effects of ACEs despite the fact that evidence that indicates the importance of positive relationships with caregivers has been around for almost fifty years. In 1969 John Bowlby proposed his theory of attachment\textsuperscript{3}; that the relationship a baby has with their primary caregiver, usually their mother, forms their understanding of the world around them, and in turn establishes the child’s response to stress. He stated that if babies receive a consistent response to their cries and had their needs met by their caregiver they would grow up feeling secure and “resilient”; that is, able to cope with stress and trauma. However if a baby receives inconsistent responses from their caregivers, perhaps a loving response on one occasion and an angry one the next, the child will grow up feeling confused and frightened and at greater risk of so-called “toxic stress”\textsuperscript{4}.

Stress is a natural physiological response designed to keep us safe and a level of psychological stress in childhood is normal, for example when a child starts nursery or school. This type of stress has been termed positive stress response. Tolerable stress response can be used to describe more severe challenges in a young person’s life, such as the death of a family member. Toxic stress is used to describe chronic or frequent adversity which has been found to change the development of a child’s brain and impact on other organ systems leading to an increased risk of stress related disease later in life. Toxic stress is linked to neglect, abuse, exposure to violence, parental substance misuse or mental illness; all categories identified by the ACEs study\textsuperscript{2,4}. 

Chart 1: The dose-response relationship of increasing ACEs to poor health outcomes (adapted from\textsuperscript{2})
A parent who has experienced a large number of ACEs in their own childhood may find they lack the coping mechanisms for dealing with the stress of caring for a new baby, which may inadvertently lead to an insecure attachment pattern with their children perpetuating the trauma throughout the generations\textsuperscript{1,5}. Furthermore through the dose-response pattern of ACEs and poor health and social outcomes this parent generation may have their own personal experience of mental illness, substance misuse, violence or prison and as such are exposing the next generation to their own ACEs:

“…maltreatment or neglect at the hands of a caregiver appears to play a significant role in triggering…factors that lead to offending behaviour; low self esteem, poor educational attainment, substance misuse and social exclusion”\textsuperscript{6}

Darren McGarvey

This may explain why many families continue to experience challenges throughout multiple generations which impacts negatively on their physical, emotional and social health and well-being. However this does not explain why some individuals with high numbers of ACEs across multiple previous generations can overcome this adversity and go on to have better educational attainment and better health outcomes than their parents or grandparents. This is thought to be down to the resilience of the individual and attachment theory expert Suzanne Zeedyk, and paediatrician Nadine Burke Harris, amongst others, explain that a strong bond with a caregiver who predictably meets the needs of the child may foster resilience which may make it possible to counteract the effects of childhood adversity\textsuperscript{7,8}. However while this optimistic approach to support relationships that allow individuals to overcome adversity remains positive there has been a recent move towards a “prevention is better than cure” early intervention approach\textsuperscript{9} as:

“Traumatic events of the earliest years of infancy and childhood are not lost but, like a child’s footprints in wet cement, are often preserved lifelong. Time does not heal the wounds that occur in those earliest years; time conceal them. They are not lost; they are embodied”\textsuperscript{10}

Vincent Felitti

Scotland is becoming a more “ACE aware” nation\textsuperscript{9} and government policy is starting to reflect this through initiatives such as the Baby Box scheme which provides a variety of mother and baby essentials such as books, thermometers and maternity pads all packaged in box that newborns can sleep in. This initiative is not only to give all babies born in Scotland, irrespective of family income, the same start, it is also hoped it will reduce infant mortality and promote secure attachment and foster resilience\textsuperscript{11}. Furthermore NHS Health Scotland have established an ACEs Hub in order to raise awareness and influence policy and the decision has made to pilot an Adverse Childhood Experience routine enquiry scheme\textsuperscript{12} to enable healthcare interventions that are targeted towards the causes of ill-health rather than simply treating the symptoms whilst ensuring that practice is trauma-informed. One positive expectation of undertaking ACE enquiry routinely for all patients is that it will help to raise the awareness of and reduce the stigma associated with childhood adversity. However a number of concerns around routine enquiry have been raised such as increasing patient distress through re-traumatisation, and the impact on other services, in particularly mental health services which are already struggling to meet demand. However a similar pilot study in Sunderland has shown that these concerns whilst not unfounded may not come to fruition\textsuperscript{13}.

A number of the general practice surgeries who will be piloting the routine enquiry scheme are part of the Deep End GP group\textsuperscript{14}, a collective of general practitioners working in the most deprived communities in Scotland as defined by the Scottish Index of Multiple Deprivation
The SIMD is a Scottish Government assessment of information across almost 7000 “data zones”: areas of roughly equal population numbers. The SIMD looks at data such as income, school leaver attainment, and number of people living in homes without central heating within these data zones to target funding and policies to attempt to reduce inequality between the most and least deprived areas.

Developed by the Royal College of General Practitioners (RCGP) the Deep End group enables GPs to share knowledge and experience of working in areas of health inequality where patient groups are often socially isolated with complex multi-morbidity health needs and high levels of substance misuse. Not only does this allow Deep End GPs to support each other but enables them to be a strong lobbying voice for their patients to help shape public policy, for example Deep End GPs have advocated for the Scottish Government to introduce minimum unit pricing for alcohol and recently voiced their opposition to a proposed policy of “forced eviction” of asylum seekers in Glasgow.

The city of Glasgow has faced a changing social landscape from the 1950s onwards: industrial decline and including the loss of the Govan shipyards, housing changes from tenements and their widespread sense of community to the socially isolated high rise flats and new towns led to reduced support for families and increased alcohol and other substance misuse to escape the hopelessness that a life of unemployment and poverty entails. In turn this created a generation with increased mortality rates for deaths through suicide, substance misuse and violence which in turn exposed their children to adverse experiences. These socio-economic changes continue to affect the Govan population today and it is now ranked in the top 20% most deprived areas in Scotland, with some parts being ranked in the top 5%. As such this population demographic was selected for a descriptive study of multigenerational Adverse Childhood Experiences.

This mixed methodology study used data from monthly integrated health and social care meetings within the practice. These multidisciplinary meetings are part of the Govan SHIP(Social and Health Integrated Partnership) Project which has been devised as a method to reduce inappropriate accident and emergency presentations through referral back to general practice. The number of patients discussed at these meetings over a twelve month period was collated and their case notes were reviewed and analysed for evidence of childhood adversity. Evidence of multigenerational ACEs; meaning patients who had at least a parent, grandparent, or child registered at the practice with case notes detailing their own adversity in childhood, was then searched for through family member's case notes. The figures for each category of adversity as described in the original ACEs study were collated and the general themes affecting this patient group is discussed further. Additionally a few cases were selected to be described in more detail.

The table below shows a break down of the number of patients discussed at each meeting and the percentage of the SHIP meeting workload that had ACE involvement, on average approximately a quarter of all SHIP workload over the twelve month period involved patients or families with some form of childhood adversity.
Table 2: Vulnerable adults, children, and families discussed at monthly Integrated Health and Social Care MDT (*Note: no meetings took place in months 8 and 9)

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients discussed</th>
<th>Number of patients discussed with ACEs</th>
<th>Number of patients with multigenerational ACEs</th>
<th>Percentage of SHIP meeting workload associated with ACEs (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>50</td>
</tr>
<tr>
<td>2</td>
<td>13</td>
<td>4</td>
<td>4</td>
<td>30.7</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td>4</td>
<td>17</td>
<td>3</td>
<td>3</td>
<td>17.7</td>
</tr>
<tr>
<td>5</td>
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<td>4</td>
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<td>33.3</td>
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<tr>
<td>7</td>
<td>11</td>
<td>2</td>
<td>2</td>
<td>18.2</td>
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<tr>
<td>*8</td>
<td>0</td>
<td></td>
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<tr>
<td>*9</td>
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<td>10</td>
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<tr>
<td>11</td>
<td>12</td>
<td>2</td>
<td>1</td>
<td>16.7</td>
</tr>
<tr>
<td>12</td>
<td>11</td>
<td>2</td>
<td>1</td>
<td>18.2</td>
</tr>
</tbody>
</table>

In total 112 patient or family groups were discussed at ten SHIP meetings across a twelve month period, of these 32 had some form of childhood adversity recorded in their clinical notes. Finding documented evidence of adversity in the clinical notes was not always straightforward and there may be a bias of more detailed records for those patients who had input from mental health services. The nature of the psychiatric or clinical psychologist assessment meant that the documented patient history available for these patients tended to be more in-depth than that taken by other services. Almost every patient who had at least one recorded ACE had evidence of multigenerational adversity and in fact only two patients from the 32 did not have a record in their notes of a parent, grandparent or child who had also experienced a form of adversity.

Of the 32 patients discussed during the twelve month period 22 had experienced four or more ACEs, and according to the dose-response nature of childhood adversity this is thought to increase the risk of certain health problems. For instance the chances of having liver disease are double that of individuals with no childhood adversity, lung disease and smoking rates are almost three times as high. Alarmingly rates of drug misuse is around eleven times higher in individuals with four or more ACEs and the risk of suicide attempts is around 14 times higher⁶.

Throughout the clinical notes of the individuals and families reviewed there were a number of recurring themes for instance; poor mental health, domestic violence, and separated parents. Behavioural problems were prevalent in the children with many having received input from Child and Adolescent Mental Health Services (CAMHS), a service facing increasing demand with almost 9 in every thousand under 18s having been referred to the NHSGGC service²¹. A number of adult patients had experienced neglect or abuse, although the actual number of clinical notes that had
documented this was quite small and perhaps the routine enquiry pilot will lead to increased recording, particularly of emotional abuse and neglect. A number of adults had either spent time in care or had been looked after by a family member that was not their parent. Additionally there were a number of patients who had subsequently had children of their own who were now in care, a small number of these patients were currently pregnant and as such were likely to need a Pre-Birth Case Conference with Social Workers and other agencies to decide the best way to support the family and protect the child following their birth\textsuperscript{22}. A number of patients had insecure home circumstances either through homelessness, prison or seeking asylum in Scotland as a result of a threat to their safety in their country of origin. Interestingly the original ACEs study does not categorise seeking asylum or having experience of torture or war as an adverse childhood experience\textsuperscript{2} and perhaps this is something that will need to be considered if routine enquiry becomes ubiquitous. Parental separation affected almost every patient and family group discussed at the SHIP meetings over the twelve month period while substance misuse impacted on roughly half.

Multi-agency work is often required for patients with ACEs and their families from statutory services such as social work, educational support, criminal justice and the police to third sector services such as homeless services, Women’s Aid or similar charities, and support services for those seeking asylum. This is in addition to primary and secondary healthcare services such as general practice, accident and emergency services, and mental health and addiction support services. This has a significant financial cost with the CDC estimating the economic impact of child abuse and neglect over the course of one individual’s lifetime to be $210,012. This includes health costs throughout childhood and adulthood, criminal justice costs, and education costs, and losses due to reduced productivity. The cost per death is estimated to be around six times higher at $1,272,900\textsuperscript{23}. Using these US figures it has been estimated that child abuse costs Scotland over £1 billion per year\textsuperscript{24}.

The diagram below shows the number of patients with each category of ACE according to the information available in the clinical notes. Parental separation was by far the most common with over 65% of this patient population affected. Parental mental illness and substance misuse was also prevalent, as was exposure to domestic violence. Only a small number of patients had experience of abuse and neglect documented in their clinical notes which can be taken as a positive, however unfortunately in reality the true figures are likely to be much higher as it is not routine to ask patients if they have experience of abuse and neglect. As such unless they have voluntarily disclosed this trauma there will be no documented evidence of these types of ACEs.
The research was limited by the methodology as it excluded any patients who may have multigenerational ACEs but were not identified by the SHIP project, furthermore any patients who had multigenerational ACEs but did not have that relative registered at the practice were excluded. This study was reliant on the clinical notes of patients and as such only ACEs that were documented were described by this study. As a result a number of ACEs will not have been counted in the figures above. This is perhaps most evident in terms of the figures for patients with emotional neglect and abuse which appear to be relatively low, with only two patients and one affected respectively, however it is likely that in reality the actual figures would be much higher, as physical and sexual abuse can not occur without emotional abuse and neglect occurring simultaneously. A more complete data set could be collected through patient interviews and if this study was to be repeated in the future the planned routine enquiry pilot may enable a more robust data set to collated.
Select cases are described further below in order to give an indication of the types of ACEs seen within families and across multiple generations. Names have been omitted and the ages of the patients have been generalised to protect their anonymity.

Case studies:

Family 1:
Boy aged 4-8 years: History of behavioural problems with CAHMS referrals. Has been violent towards other family members including sibling. He has a history of physical abuse towards him and his father died suddenly (substance misuse).
Mother aged 25-35: She had a poor relationship with her mother and lived with another family member during her childhood until he died. She then became homeless during her adolescence. She has a personal history of domestic violence towards her, poor mental health (post-natal depression, anxiety) and suicidal thoughts.

Family 2:
Girl aged 8-13: Diagnosis of Aspergers with a history of physical neglect. Experiencing suicidal thoughts.
Girl aged 8-13: History of anxiety and behavioural problems.
Father aged 35-45: Personal history of depression and anxiety from adolescence. Separated from the mother of his children.
Paternal grandmother aged 70-80: Elderly and frail, poor physical health. Lives with son and his daughters.
Mother aged 35-45: Estranged from the rest of the family due to her poor mental health. Her father had a history of substance misuse and her brother had a traumatic death. Personal history of post-natal depression with other children who were subsequently taken into care following physical abuse towards them. Personal history of homelessness.

Individual man aged 25-35: History of maternal substance misuse and his father died when patient was a child. Another close male relative died by suicide. He has a personal history of poor school attendance, substance misuse, violence towards him and violent behaviour by him. He has a significant forensic history and a history of homelessness. Poor mental health with suicide attempts and self harm.

Conclusion:

Adverse childhood experiences are common and can contribute to a number of poor health and socio-economic outcomes for the individuals affected by them however evidence shows that strong, secure attachments can foster resilience; that is a better ability to cope with traumatic events, meaning that poor outcomes are not necessarily inevitable. Despite the original ACEs study being twenty years old it is only recently that there has been a drive for trauma-informed practice to become more widespread in Scotland and policy is now reflecting this through innovative early interventions designed to reduce exposure to ACEs. The routine enquiry pilot may help to reduce stigma surrounding childhood adversity but care must be taken not to re-traumatise adults or leave them to cope without appropriate support, particularly as many services face challenges in terms of funding and provision. Collaborative groups such as the Deep End GP group and multidisciplinary working such as that of the SHIP project may be essential in preventing this. The descriptive study showed evidence that multigenerational ACEs are common within this small population but the routine enquiry pilot may give an indication of just how prevalent multigenerational ACEs are in Scotland and as we move towards a more ACE-aware nation perhaps we will see increased numbers of resilient individuals with positive health outcomes, and an end to multigenerational adversity.

(Word count: 3455 excluding references)
References:


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(Social & Health Integration Partnership)

Appendix to the main report

APPENDIX C - INFORMATION MANAGEMENT IN THE GOVAN SHIP PROJECT
INFORMATION MANAGEMENT in the Govan SHIP Project

An early focus for the Govan SHIP project was to develop an information framework that would capture and evidence project objectives, appreciating that failure to collect information prior to the implementation of any systemic change would result in difficulty in measuring the effects (or lack thereof) of that change. There have been subsequent developments at national level (e.g. SPIRE) however, at project commencement, data availability was limited with corporate and national tools in their infancy.

PART ONE – Information Capture, Analysis, Evaluation

GP Demand - GP Practice Management System (EMIS)
There were a number of limitations to extracting data from GP systems. These related to poor search functionality and differing system configurations across the practices. Appointment book data could only be captured manually and would have required an inappropriate level of resource to record throughout the period of the project. It was therefore agreed that GP demand would be defined as all consultation related entries made by a GP as this could be captured more readily.

The strengths and weaknesses of this metric are:
Strengths:
- Captures a broader range of patient related activity including in-practice, telephone and home visit consultations, administration and clinic notes, lab results requiring action and interactions taking place on an impromptu basis or out with standard consulting surgeries
- Removes entry errors associated with each individual entry type
- Could be implemented across all practice with minimal data verification work and capture reliably the same levels of interaction

Weaknesses:
- No weighting with regard to time commitment each takes
- Does not capture granular detail of what form of intervention took place and where this was performed

Corporate Information Systems
Business Intelligence colleagues extracted detailed reports for the participating practices across the following:
- Unscheduled Care (A&E presentations)
- Inpatients
- Outpatients

Data for other practices across Glasgow was extracted in summary format to ensure compliance with data governance requirements. This information could be utilised for comparative evaluation.

Initial work with the data sets highlighted issues resulting in inability to meaningfully analyse and report on inpatient and outpatient with any confidence. It would require an inappropriate resource to unpick these issues:
- Very low and significant (unstable) monthly variation in bed stays and numbers of inpatients
- Policy drivers to substantially reduce delayed discharges limiting any SHIP effect
- Outpatient specialties only recently added to electronic systems impacting on longitudinal analysis
- Historical service changes impacting against which specialty activity might be recorded

Relational Databases
Significant effort went into matching data from these separate systems via relational databases built specifically by and for the project using CHI as the unique identifier.
Comparator Data
The relative merits of comparing with similar practices versus contrasting with those with significantly different demographics were considered. Resource limitations meant that comparison would be limited to a group of GP practices with similar features such as population and deprivation profiles.

Practice populations across NHS GG&C were analysed to determine suitable population groups which were comparable in terms of population size (to ensure adequate homogeneity), deprivation, geography and logistical factors (e.g., health centre locations versus partner-owned premises). Suitable clusters of practices were then approached to determine whether their clinical leadership were happy for data extraction to be undertaken from their practice systems.

Future work under primary care improvement plans might be considered to develop a broader more informed picture and effectiveness of SHIP-like interventions across a broader demographic spectrum. This could include whether interventions work at larger scales (e.g., across clusters or localities), within different populations (e.g., in areas of relative affluence or in more mixed communities) or in areas with different geographic/logistic factors (e.g., increased rurality or reduced population density).

Qualitative Data
Various methods were used to capture qualitative information.

- External evaluation by the Nursing, Midwifery and Allied Health Professions Unit at Stirling University on the key components of the project:
  - Links with Social Work
  - Additional GP capacity
  - Multi-Disciplinary Team Working
- Snapshot diaries of GP utilisation of SHIP sessions (additional capacity)
- Case studies
- Patient engagement / consultation

The scope and depth of qualitative analysis was determined and informed by discussion between the evaluators and the evaluation sub-group who met on a regular basis.

Delivery
This work was primarily developed between one of the lead GPs with Dr Brian Milmore (Lead GP, Information) and Vince McGarry, Project Manager with the support of an information sub-group which reported into the project Steering Group.
PART TWO – Identifying Multi-morbidity

Context
One of the primary aims and objectives of the Govan SHIP project was to shift demand in primary care by grasping opportunities for early intervention. There was therefore a need to be able to identify and target patients for which a preventative or anticipatory care approach might benefit in addition to those with more obvious and easily identifiable conditions. It was logical to assume, based on the background literature, that those with the most chronic conditions had the greatest potential health gain from such interventions.

Barnett et al indicate that “no standard approach for the measurement of multi-morbidity exists, and selection and definition of morbidities to include is inevitably partly subjective and dependent on the data available.”

The SHIP definition of morbidity therefore included patients:
- Who would not necessarily have been defined with a condition under the more explicit parameters of QOF (Quality and Outcomes Framework of targets and indicators)
- For whom the use of prescription data might disguise identification

Outcomes
The morbidity profile of patients involved in the SHIP project was compared to the overall practice baseline (of currently registered patients).

<table>
<thead>
<tr>
<th>Number of conditions</th>
<th>Number of patients in practice (Baseline)</th>
<th>Number of patients in SHIP</th>
<th>Baseline (as % of total)</th>
<th>SHIP (as % of total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>9444</td>
<td>476</td>
<td>47.1%</td>
<td>25.5%</td>
</tr>
<tr>
<td>1</td>
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<td>21.4%</td>
<td>15.3%</td>
</tr>
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<td>2638</td>
<td>264</td>
<td>13.1%</td>
<td>14.1%</td>
</tr>
<tr>
<td>3</td>
<td>1531</td>
<td>210</td>
<td>7.6%</td>
<td>11.3%</td>
</tr>
<tr>
<td>4</td>
<td>983</td>
<td>218</td>
<td>4.9%</td>
<td>11.7%</td>
</tr>
<tr>
<td>5 to 6</td>
<td>856</td>
<td>264</td>
<td>4.3%</td>
<td>14.1%</td>
</tr>
<tr>
<td>7 to 8</td>
<td>257</td>
<td>104</td>
<td>1.3%</td>
<td>5.6%</td>
</tr>
<tr>
<td>9 or more</td>
<td>61</td>
<td>44</td>
<td>0.3%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Multi-morbid (2 or more)</td>
<td>6326</td>
<td>1104</td>
<td>31.5%</td>
<td>59.2%</td>
</tr>
<tr>
<td>Poly-morbid (4 or more)</td>
<td>2157</td>
<td>630</td>
<td>10.7%</td>
<td>33.8%</td>
</tr>
<tr>
<td>Total</td>
<td>20069</td>
<td>1866</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The above data, where multi-morbidity is almost twice and poly-morbidity is three times that of the practice baseline, demonstrates the higher proportion of patients with complex needs involved in the SHIP and how the project achieved its primary objective by providing improved support to such patients and addressing the inverse care law as a result.

**Process**

Read codes and associated code terms, as defined under Scottish Clinical Information in Medical Practice (SCIMP) Group, were extracted directly from the practice (EMIS) patient management systems using customised searches and reports. This data was copied into a customised spreadsheet and filtered allowing for identification of morbidity under selected or generic terms.

These individual morbidity profiles could then be indexed with other data and collated to understand prevalence within specific groups.

This approach was adopted in the absence of national tools available at the onset of the project. Some, such as SPIRE, had not reached the desired maturity or functionality. Other practical considerations such as limited resources and lack of access to other national data sets such as PRISMS (Prescribing Information System for Scotland) drove the definition process. The process was designed in such a way to be exportable across multiple EMIS implementations and configured to allow semi-automated extraction of data by a non-expert user.
<table>
<thead>
<tr>
<th>Condition</th>
<th>Inclusion / Exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>All read codes under G2: Hypertensive disease</td>
</tr>
</tbody>
</table>
| Depression             | Read codes under;  
  • Eu3: Mood-Affective Disorders  
  Read code contains;  
  • Eu340: Cyclothymia, Affective personality disorder, Cycloid personality, Cyclothymic personality  
  Read code terms contain the text  
  • “depress”, “dysthymia”  
  Exclude  
  • Read code term containing the text “manic depress”                                                                 | |
| Chronic Pain           | Read code is 8H69: Refer to Pain Clinic                                                                                                                                                                                                                     |
| Asthma                 | Read codes under H33: Asthma                                                                                                                                                                                                                                   |
| Coronary Heart Disease | Read codes under G3: Ischaemic Heart Disease, Excluding G375: Atrial Fibrillation and Flutter                                                                                                                                                                |
| Dyspepsia              | Read codes under;  
  • J1: Oesophageal, Stomach and Duodenal diseases.  
  • J34: Diaphragmatic hernia  
  Read code equals EMISNQAN4: Angiodysplasia of stomach                                                                                                                                              |
| Diabetes               | Read codes under;  
  • C10E: Type 1 Diabetes Mellitus  
  • C10F: Type 2 Diabetes Mellitus                                                                                                                                                                           |
| Thyroid                | Read codes under C0: Disorders of Thyroid gland  
  Read code equals EMISNQSE16: Secondary Hypothyroidism                                                                                                                                                  |
| Rheumatoid             | Read codes under;  
  • N0: Arthropathies and related disorders  
  • M160: Psioratic Arthropathy                                                                                                                                                                               |
| Psoriasis              | Read codes under M16: Psoriasis and similar disorders  
  Read code equals EMISNQCH31: Chronic Large plaque psoriasis  
  Exclude read codes under M160: Psioratic Arthropathy                                                                                                                                                 |
| Hearing                | Read codes under F59: Hearing loss                                                                                                                                                                                                                           |
| COPD                   | Read codes under H3: Chronic obstructive pulmonary disease  
  Exclude read codes under;  
  • H33: Asthma  
  • H34: Bronchiectasis                                                                                                                                                                                  |
| Anxiety, etc           | Read codes under;  
  • E20: Neurotic disorders  
  • Eu4: Neurotic, stress-related or somatoform disorders  
  Exclude read codes under  
  • E204: Neurotic depression reactive type                                                                                                                                                             |
| Irritable Bowel Syndrome | Read codes under J52: Functional gastrointestinal tract disorders NEC  
  Read code equals EMISNQCH56: Chronic constipation  
  *(NEC - Not Elsewhere Classified)*  
  *(NEC - Not Elsewhere Classified)*                                                                                                                                                                       |
| Alcohol                | Clinical Code term contains the text "alcohol"  
  Exclude read codes and codes under;  
  • J615: Cirrhosis – non alcoholic  
  • J615z: Non-alcoholic cirrhosis NOS  
  • J61y: Other non-alcoholic chronic liver disease  
  • J61y1: Non-alcoholic fatty liver  
  • J61y8: Non-alcoholic steatohepatitis  
  • E040: Non-alcoholic amnestic syndrome                                                                                                   |
<table>
<thead>
<tr>
<th>Condition</th>
<th>Read Codes Under</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drugs</strong></td>
<td>- E24: Drug dependence</td>
</tr>
<tr>
<td></td>
<td>- E25: Nondependent abuse of drugs</td>
</tr>
<tr>
<td></td>
<td><strong>Exclude read codes under</strong></td>
</tr>
<tr>
<td></td>
<td>- E250: Nondependent alcohol abuse</td>
</tr>
<tr>
<td><strong>Stroke</strong></td>
<td>Read codes under G6: Cerebrovascular disease</td>
</tr>
<tr>
<td><strong>Chronic Kidney Disease</strong></td>
<td>Read codes under;</td>
</tr>
<tr>
<td></td>
<td>- 1Z1: Chronic renal impairment</td>
</tr>
<tr>
<td></td>
<td>- K05: Chronic renal failure</td>
</tr>
<tr>
<td><strong>Diverticulosis</strong></td>
<td>Read codes under J51: Diverticula of Intestine</td>
</tr>
<tr>
<td><strong>Atrial Fibrillation</strong></td>
<td>Read code is G573: Atrial fibrillation and flutter</td>
</tr>
<tr>
<td><strong>Peripheral Vascular Disease</strong></td>
<td>Read codes under G73: Other peripheral vascular disease</td>
</tr>
<tr>
<td><strong>Heart Failure</strong></td>
<td>Read codes under G58: Heart Failure</td>
</tr>
<tr>
<td><strong>Epilepsy</strong></td>
<td>Read codes under F25: Epilepsy</td>
</tr>
<tr>
<td><strong>Dementia</strong></td>
<td>Read codes under;</td>
</tr>
<tr>
<td></td>
<td>- E00: Senile and pre senile organic psychotic conditions</td>
</tr>
<tr>
<td></td>
<td>- F11: Other cerebral degenerations</td>
</tr>
<tr>
<td></td>
<td>- Eu0: Organic, including symptomatic, mental disorders</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>Read codes under;</td>
</tr>
<tr>
<td></td>
<td>- E1: Non-organic psychoses</td>
</tr>
<tr>
<td></td>
<td>- Eu2: Schizophrenia, schizotypal and delusional disorders</td>
</tr>
<tr>
<td></td>
<td>- Eu30: Manic episode</td>
</tr>
<tr>
<td></td>
<td>- Eu31: Bipolar affective disorder</td>
</tr>
<tr>
<td></td>
<td><strong>Exclude read codes under</strong></td>
</tr>
<tr>
<td></td>
<td>- E112: Single major depressive episode</td>
</tr>
<tr>
<td></td>
<td>- E113: Recurrent major depressive episode</td>
</tr>
<tr>
<td></td>
<td>- E135: Agitated depression</td>
</tr>
<tr>
<td><strong>Inflammatory Bowel Disease</strong></td>
<td>Read codes under J4: Non infective enteritis and colitis</td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td>Read codes under;</td>
</tr>
<tr>
<td></td>
<td>- F49: Blindness and low vision</td>
</tr>
<tr>
<td></td>
<td><strong>Read code equals</strong></td>
</tr>
<tr>
<td></td>
<td>- 6688: Registered partially sighted</td>
</tr>
<tr>
<td></td>
<td>- 6689: Registered blind</td>
</tr>
<tr>
<td><strong>Learning Disability</strong></td>
<td>Read codes under;</td>
</tr>
<tr>
<td></td>
<td>- E3: Mental retardation</td>
</tr>
<tr>
<td></td>
<td>- Eu7: Mental retardation</td>
</tr>
<tr>
<td></td>
<td>- Eu8: Disorders of psychological development</td>
</tr>
<tr>
<td></td>
<td><strong>Read code equals</strong></td>
</tr>
<tr>
<td></td>
<td>- 918e: On learning disability register</td>
</tr>
<tr>
<td><strong>Eating Disorder</strong></td>
<td>Read codes under;</td>
</tr>
<tr>
<td></td>
<td>- Eu50: Eating disorders</td>
</tr>
<tr>
<td></td>
<td><strong>Read codes equal</strong></td>
</tr>
<tr>
<td></td>
<td>- E271: Anorexia Nervosa</td>
</tr>
<tr>
<td></td>
<td>- E2751: Bulimia</td>
</tr>
<tr>
<td></td>
<td>- E2751-1: Compulsive eating disorder</td>
</tr>
<tr>
<td><strong>Bronchiectasis</strong></td>
<td>Read codes under H34: Bronchiectasis</td>
</tr>
<tr>
<td><strong>Parkinson’s</strong></td>
<td>Read codes under F12: Parkinson’s Disease</td>
</tr>
</tbody>
</table>
### Exclusions

Several conditions were not included in the Govan SHIP data set. These and the reasons for omission are listed below:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Rationale for exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treated constipation</td>
<td>No standardised code set. Hard to search for medications due to wide overlap</td>
</tr>
<tr>
<td>Prostate disorders</td>
<td>Range of codes. Often single episodes of care to definitive Rx</td>
</tr>
<tr>
<td>Migraine</td>
<td>Wide variation in coding and of Rx initiated without coding, wide Rx overlap</td>
</tr>
<tr>
<td>Chronic sinusitis</td>
<td>Poorly coded, not practical to search for drugs due to wide overlap</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>Little control over referrals, etc. and many chronically managed by other service provider (optician, etc.). Under-recording is likely</td>
</tr>
</tbody>
</table>
The Govan SHIP Project
(Social & Health Integration Partnership)

Appendix to the main report

APPENDIX D - A QUALITATIVE EVALUATION OF THE GOVAN SHIP
EXECUTIVE SUMMARY
A Qualitative Evaluation of the Govan SHIP: A Social and Health Integration Partnership Project

A report prepared by researchers from the Universities of Stirling and Glasgow.

Fiona M. Harris, Julia McGregor & Margaret Maxwell
University of Stirling

Stewart Mercer
University of Glasgow

25/08/2017
Executive Summary

Background
The SHIP project was developed in order to respond to the needs of patients with complex health and social needs living in the most deprived general practices in Scotland. The ongoing pilot/demonstration project is being implemented within Govan Health Centre, with the key aims of addressing the inverse care law via an integration model. This evaluation explores the key components of this model: linked social work (SW) and social care workers (SCWs), GP extra time and multidisciplinary team working (MDTs).

Methods
This evaluation took an ethnographic approach, informed by realist evaluation theory. Data collection consisted of unstructured (n=10) and semi-structured (n=21) interviews and non-participant observation at MDT meetings. The analysis drew on an interpretive approach and normalisation process theory (NPT) was used to frame the discussion. This evaluation explored implementation processes and experiences. An outcomes-based evaluation is the focus of a separate study.

Key Findings
MDT working, SW, SCW involvement and the additional time allocated to GPs worked in synergy to create an integrated model of working that shows promise for addressing the inverse care law. The extra time allows GPs to plan and address complex health and social needs, also drawing on the expertise of colleagues from other sectors within MDT meetings. The SW involvement in GHC met with key challenges that mainly arose from a lack of understanding of the current social work role, different perceptions of risk and vulnerability as well as a lack of knowledge about the eligibility criteria for access to services referred via SW. However, practice staff benefited from learning about these issues, resulting in GPs providing more incisively written referral requests that were more likely to meet SW criteria, as well as gaining an understanding of what patient issues might be better served by access to services within the third sector.

SCWs linked to GHC are a recent innovation that shows promise. There have already been examples of joint/collaborative working with practice/community-based staff that highlight the benefit to patients of working in an integrated way to prevent crises before they occur. The MDTs have also been adapted over time, revealing the propensity for the SHIP project team to learn and adapt the model over time. As the organisation and management of MDTs improves in efficiency, and with greater involvement of professionals across social work, secondary care and the third sector, the MDT offers a potential platform for integrated working.

Conclusions & Recommendations
The SHIP project met with challenges known to have affected integration projects elsewhere, namely, issues related to bringing together two formerly distinct sectors. However, there have been considerable benefits in gaining the knowledge and understanding crucial to moving forward with the integration agenda. As the SHIP project continues to evolve there are some key recommendations arising from this report that are worthy of consideration:
• The integration model would be better served by a wider constituency of professionals involved in planning and development going forward. Representation should go beyond GPs and SWs to include SCWs, nursing and key third sector organisations.

• There needs to be a stronger focus on planning prior to implementation in order to maximise staff engagement

• Key learning, achievements and successes should be shared with all associated staff

The tables below provide further detail of the learning gained from all stages of the project informed by Normalisation Process Theory, which is a theoretical framework that lends itself to presenting the lessons learned from complex interventions, from planning through to looking back at lessons learned from implementation. Following this approach, the recommendations are presented under the following headings:

• COHERENCE of the SHIP intervention model – initial understanding of aims and objectives

• COGNITIVE PARTICIPATION – investing or engaging in the intervention at the outset

• COLLECTIVE ACTION – the practical implementation of the model

• REFLEXIVE MONITORING – modifying and embedding the intervention and future prospects
### Coherence of the SHIP aims and goals

<table>
<thead>
<tr>
<th>SHIP Aims and goals</th>
<th>Understanding</th>
<th>Strategies for promoting coherence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic level aims:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To promote integrated health and social care services via the GHC pilot; reduce hospital admissions and demands on GP time spent on social needs, anticipatory care.</td>
<td>Differential understanding: GPs, SWs and stakeholders have full understanding; other practice and community staff focusing on integration of social work and general practice.</td>
<td>Involve all staff categories in planning, intervention development and pre-implementation activity.</td>
</tr>
<tr>
<td>Values</td>
<td>Although the core values and goals were agreed, the lack of consultation and involvement across all professional groups led to a variable understanding of what SHIP meant and how it would be implemented. Stakeholders and GPs use this language but the ethos of targeting care at those of most need also understood/valued by other staff.</td>
<td>Intervention planning should include matching goals to actions. Establish an intervention framework at the outset, matching elements of the intervention to how values/aims will be achieved.</td>
</tr>
<tr>
<td>Addressing the inverse care law; Addressing the complex and health and social needs of GHC population; Better working relationships, better understanding.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Intervention level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SW linked to primary care</td>
<td>All practice staff: expected rapid referrals/access to SW services; expected governance of SWs SW: advice, education re eligibility criteria; accountable to SW line management. Conflicting understanding at the outset undermined the potential to achieve shared goals.</td>
<td>Example: Planning how the MDT would work in practice. Consult staff from other disciplines to see what works in other sector MDTs such as community nursing, secondary care professionals.</td>
</tr>
<tr>
<td><strong>SHIP time (GP extra time for extended consultations, case management, leadership and development)</strong></td>
<td>Differential understanding: Addressing inverse care law; complex care planning for patient benefit (GPs and some other practice staff); some staff regard as exclusive GP benefit; variable equity of time distribution between GPs.</td>
<td></td>
</tr>
<tr>
<td>MDT</td>
<td>Differential understanding: GPs: to achieve integrated working SW and other staff: adding to what already in place either formally or through informal networks</td>
<td></td>
</tr>
</tbody>
</table>
Cognitive Participation: establishing engagement and buy in to the intervention

<table>
<thead>
<tr>
<th>Mechanisms</th>
<th>Outcomes</th>
<th>Strategies for promoting cognitive participation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initiation</strong></td>
<td>Are key personnel working together to drive the initiative forward?</td>
<td></td>
</tr>
<tr>
<td><strong>Enrolment</strong></td>
<td>Has engagement been achieved with key personnel?</td>
<td></td>
</tr>
<tr>
<td><strong>Legitimation</strong></td>
<td>Is engagement such that others believe that they can contribute?</td>
<td></td>
</tr>
<tr>
<td><strong>Activation</strong></td>
<td>Is engagement in the project maintained?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All key personnel from senior stakeholders (SW, HSCP) through to frontline SWs, GPs, nursing and AHP staff are on board at the outset.</td>
<td>Shared goals and values ensure that all personnel are engaged from the outset.</td>
</tr>
<tr>
<td></td>
<td>Initial enthusiasm for SHIP from all staff until they realise that they had misunderstood what would happen in practice.</td>
<td>Consensus building &amp; ownership of shared values, understandings &amp; outcomes is essential at all stages.</td>
</tr>
<tr>
<td></td>
<td>Differential legitimation: GPs are fully invested and are driving the steering group. Project manager from HSCP has referent authority to manage change. However other categories of practice and community staff are not consulted/involved. SWs are initially involved in the steering group led by the GHC GPs. Engagement and planning at too high a level to prepare for implementation.</td>
<td>Interprofessional training &amp; professional development is required to address poor understanding of others’ roles.</td>
</tr>
<tr>
<td></td>
<td>Senior stakeholders and GPs continue to be engaged. SWs linked to GHC are removed from the steering group (perhaps a sign of deteriorating relationships). There is a change in project manager who has potential to act as boundary spanner but change is driven by GP led steering group. Increasing resentment from nursing as initiatives (e.g. MDT) regarded as a time burden with little perceived benefit.</td>
<td>Top-down, policy-driven change may result in resentment and unwillingness to share tacit knowledge; need to involve all constituents in driving implementation at every stage.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Networking between historically hostile professional groups may help to build relationships.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Boundary spanner’ (neutral to professional interests) needed to drive change; has the ability to understand different cultures of working and facilitate positive relationships and networks.</td>
</tr>
</tbody>
</table>
### Mechanisms

<table>
<thead>
<tr>
<th>Mechanisms</th>
<th>Impacts</th>
<th>Strategies for promoting collective action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shared goals and expectations about the form of work, what is a legitimate object of work, roles of participants, rules of conduct, beliefs about meaning of work, shared expectations about outcomes</strong></td>
<td><strong>Different expectations</strong> about the form of social work (attachment/liaison)&lt;br&gt;<strong>Varying goals</strong> - social workers aimed to clarify, share info and advise, GPs wanted them to react by accessing services or providing assessments, community nurses wanted a closer working relationship with social workers, joint planning etc.&lt;br&gt;<strong>Different philosophies of care</strong>: social workers feel their role is to identify strengths and promote independence (partic in adult work) whilst HPs believed SW role is to prevent risk&lt;br&gt;<strong>Different expectations of behaviour</strong> – HPs and practice staff expected SWs to actively engage with them and become part of the practice; SWs expected to attend MDTs and that practice or NHS staff would consult them if necessary&lt;br&gt;<strong>Different beliefs about legitimacy of MDT</strong> – GPs feel they are essential focus for anticipatory planning; nurses felt they were generally not relevant to their practice&lt;br&gt;<strong>Different meanings of SW priorities between SW practitioners and senior mgmt.</strong> – values &amp; practice issues vs ‘budgets and boundaries’&lt;br&gt;SCWs seem to share HP expectations about early intervention, direct support, active navigation of SW system, patient focus, direct referral. Also seem to share beliefs about what are legitimate referrals&lt;br&gt;SWs/team leaders disagreed that their role should include joint working, felt this was a luxury; SCWs felt joint working with DNs and HV was essential&lt;br&gt;GP, PNs, PMs unaware of SW knowledge or expertise or how they were using it. Lack of mutual respect between SWs and HPs for assessment of risk and vulnerability.&lt;br&gt;SW dept felt the project required very experienced qualified workers who could use their experience to articulate and educate re SW roles, practices wanted workers who could navigate and explain the system, address vulnerabilities not yet eligible for SW intervention, say ‘how can we help?‘&lt;br&gt;SCW knowledge and contribution fits this expectation much more closely.&lt;br&gt;Over time, (and increasingly) MDTs appear to demonstrate agreement about the expertise and usefulness of participants, accept practice as valid and create a collegiate environment (although not the case earlier)</td>
<td><strong>Attention to joint CPD/shared learning would help to ensure all share realistic expectations of what can be achieved.</strong>&lt;br&gt;Joint learning must emphasise different philosophies of care; achieve a shared understanding of risk, vulnerability and capacity; limitations on service access and eligibility criteria for SW referrals.&lt;br&gt;Mutual respect is vital to effective integration, this may be fostered by joint learning sessions where all contributors are equally valued.&lt;br&gt;SWs/SCWs require more autonomy to deliver ‘enabling’ social work practice.&lt;br&gt;MDTs require careful planning and organisation in order to reduce time burden, demonstrate relevance and ensure that engagement is maintained across all roles/sectors.</td>
</tr>
<tr>
<td>Mechanisms</td>
<td>Impacts</td>
<td>Strategies for promoting collective action</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Agreement about knowledge required, expertise and contribution of participants, what practice is valid, useful, authoritative | Agreement was reached pre-project but without clear understanding  
No agreement between GPs, SWs and other HPs about either nature of SW tasks or whether these could/should be allocated by MDTs, taken on by SWs at MDTs or allocation reserved to SW managers. | SWs/SCWs can demonstrate collegiality and willingness to help by advising on the information necessary to achieve relevant referrals. |
| Agreement about allocation of tasks and resources, hierarchies, definition of skill sets, autonomy of agents, quality of skills | Different levels of autonomy between participants; SWs and nurses have insufficient autonomy to be full partners.  
SCWs seem to have more autonomy than SWs.  
Skill sets of SWs/SCWs not understood by other professionals.  
Skills/expertise (eg around workstreams, MDT working) not recognised or shared.  
Project manager not given due authority to act as boundary spanner and drive change. | Shared information across sectors can also reduce staff anxiety and improve relationships. |
| Allocation of resource, distribution of risk, who has power, how work will be evaluated, who will be advantaged | Resources seen (by nurses particularly) to be allocated mainly to GP partners  
Different sources of authority – GPs, SW managers, community health managers  
Disagreement about who should have control. Project manager had only referent authority.  
SW dept/SWs had greater risk as more exposed to public scrutiny/misunderstanding, less well resourced, more uncertain about place in integrated services.  
Little advantage to SW dept  
Nurses felt little advantage to them  
GPs seen as main beneficiaries; some HP acknowledgement of patient benefit. | Leadership should be driven by an individual without vested interest in either professional group/sector where possible.  
The ‘boundary spanner’ should be given the power to drive implementation processes.  
Care should be taken to demonstrate benefit for both key sectors and to all personnel.  
Patient-centred care should be emphasised as a shared value and goal at every opportunity. |
Reflexive Monitoring: looking back at the experience of implementation

GPs and stakeholders within the HSCP, academic general practice and the social work department show development and learning from this experience:

- a positive change in knowledge, attitudes and behaviours
- benefit restricted to GPs and senior management with capacity to maintain cross sector networks. Unfortunately, many of the other staff within the GHC adhere to negative attitudes towards SW and feel increasingly frustrated and disempowered by an intervention that affected them as individuals but over which they had little or no ability to change. Team leaders in SW are the exception to this, as they appear to have maintained a commitment and positive attitude towards the project and continue to play an important role in generating improved relationships.

Reconfiguration

This aspect of SHIP demonstrates the dynamic nature of the remaining SWs involved and the GPs in three of the four practices who remained engaged in the intervention. Adaptations have been made to MDTs to reduce the time burden on attendees and there are indications that they may eventually become more collaborative in organisation and leadership rather than remaining solely GP led. This may help to maintain or revitalise engagement across all professional groups. The introduction of SCWs also highlights a positive response to an initially ‘bruising’ encounter between SW and general practice and there are early indications that many of the initial (misguided) expectations of SWs may now be met by SCWs. The caveat remains that access to services will still require meeting eligibility criteria, although it is clear that GPs at least now understand the pressure on services and the thresholds for access to these. Shared learning has also taken place to ensure improved quality of information provided in SW referral requests and time will, it is hoped, no longer be wasted by poor information provision or a lack of understanding of risk thresholds. Unfortunately, it appears that this learning has not been shared more widely, and although there have indeed been some positive examples of collaborative working between SWs/SCWs and other HPs within GHC, nevertheless work remains to be done to undo negative perceptions, disappointments and frustrations experienced by other staff during the course of SW integration.

Strategies for promoting reflective monitoring

Shared learning events and dissemination (highlighted in several sections above) may help to address remaining tensions and negative experiences.

Efforts should be made to involve all categories of staff in consultations and planning going forward in order to maximise learning from other professional, integrated networks such as those pre-existing among nursing staff and SW/SCWs.
The Govan SHIP Project
(Social & Health Integration Partnership)

Appendix to the main report

APPENDIX E - A QUALITATIVE EVALUATION OF THE GOVAN SHIP
FULL REPORT
A Qualitative Evaluation of the Govan SHIP: A Social and Health Integration Partnership Project

An interim report prepared by researchers from the Universities of Stirling and Glasgow.

Fiona M. Harris, Julia McGregor & Margaret Maxwell
University of Stirling

Stewart Mercer
University of Glasgow

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Disclaimer

This report should be considered as a working document reporting on a study in progress. The final report (due March 2017) will include further interviews with professionals as well as include patients’ views and experiences.
Executive Summary

Background
The SHIP project was developed in order to respond to the needs of patients with complex health and social needs living in the most deprived general practices in Scotland. The ongoing pilot/demonstration project is being implemented within Govan Health Centre, with the key aims of addressing the inverse care law via an integration model. This evaluation explores the key components of this model: linked social work (SW) and social care workers (SCWs), GP extra time and multidisciplinary team working (MDTs).

Methods
This evaluation took an ethnographic approach, informed by realist evaluation theory. Data collection consisted of unstructured (n=10) and semi-structured (n=20) interviews and non-participant observation at MDT meetings. The analysis drew on an interpretive approach and normalisation process theory (NPT) was used to frame the discussion.

Key Findings
MDT working, SW, SCW involvement and the additional time allocated to GPs worked in synergy to create an integrated model of working that shows promise for addressing the inverse care law. The extra time allows GPs to plan and address complex health and social needs, also drawing on the expertise of colleagues from other sectors within MDT meetings.

The SW involvement in GHC met with key challenges that mainly arose from a lack of understanding of the current social work role, different perceptions of risk and vulnerability as well as a lack of knowledge about the eligibility criteria for access to services referred via SW.

However, practice staff benefited from learning about these issues, resulting in GPs providing more incisively written referral requests that were more likely to meet SW criteria, as well as gaining an understanding of what patient issues might be better served by access to services within the third sector.

SCWs linked to GHC are a recent innovation that shows promise. There have already been examples of joint/collaborative working with practice/community-based staff that highlight the benefit to patients of working in an integrated way to prevent crises before they occur.

The MDTs have also been adapted over time, revealing the propensity for the SHIP project team to learn and adapt the model over time. As the organisation and management of MDTs improves in efficiency, and with greater involvement of professionals across social work, secondary care and the third sector, the MDT offers the potential platform for integrated working.

Conclusions & Recommendations
The SHIP project met with challenges known to have affected integration projects elsewhere, namely, issues related to bringing together two formerly distinct sectors. However, there have been considerable benefits in gaining the knowledge and understanding crucial to moving forward with the integration agenda. As the SHIP project continues to evolve there are some key recommendations arising from this report that are worthy of consideration:
- The integration model would be better served by a wider constituency of professionals involved in planning and development going forward. Representation should go beyond GP and SWs to include SCWs, nursing and key third sector organisations.
- There needs to be a stronger focus on planning prior to implementation in order to maximise staff engagement.
- Key learning, achievements and successes should be shared with all associated staff.
Introduction
This report presents the results of the qualitative evaluation of the Govan Social and Health Integration Partnership (SHIP) project implemented within the Govan Health Centre, Glasgow. The overarching aim of the project was to facilitate integrated working between health and social care sectors, via the implementation of a multi component intervention. The main components of this intervention were linking social workers into the Govan Health Centre (GHC), initiating multidisciplinary teams (MDTs) and buying in GP locums in order to provide extra GP time for SHIP-related activities.

The Health and Social Care Partnership (HSCP) commissioned the research team to undertake this evaluation between April 2016-March 2017. What follows is an account of qualitative research completed to November 2016.

The evidence gathered to date includes a synthesis of relevant documentary and policy sources, a literature review, two phases of interviews with health and social care professionals and observations made during attendance at MDTs.

Background to the Govan SHIP
Chronic physical and psychological morbidity account for 80% of all GP consultations (Scottish Government 2009), and in combination can lead to significantly poorer health outcomes and low quality of life (Naylor et al 2012). Recent primary care research finds increasing incidence and earlier onset of multiple morbidity in deprived areas (Barnett et al 2012), and GPs and Nurses working in deprived practices report that complex social need on top of these difficulties is a significant barrier to effective treatment and self-management of disease (O’Brien et al 2011).

GPs from the 100 most deprived practices in Scotland (GPs at the Deep End: http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/) identified areas of concern affecting Primary Care practitioners and patients in deprived communities (the 100 most deprived postcodes according to the Scottish Index of Multiple Deprivation (SIMD)). GPs at the Deep End have continued to investigate these areas and from 2009, have been developing ideas and proposals to try to address identified problems.

National and local policy context
The Govan SHIP initiative is taking place, and developing, in a dynamic policy environment as reforms, restructuring and new legislation take effect and policymakers look for evidence of cost effective new ways of working.

The Healthcare Quality Strategy for NHS Scotland (2010) aims to change the focus of healthcare provision to person-centred, partnership working between NHS Scotland, Local Authorities, Third Sector and independent contractors, and to realise the overarching strategic narrative of the Scottish Government’s 2020 Vision. Recognition of the impact of multiple long term conditions, poor mental health and an increase in the ageing population, in an environment of diminishing resources and increasing demand for both medical and social care, is one of the drivers for the vision. This narrative of longer healthier lives and the achievement of sustainable, quality health and social care through prevention, anticipatory care and supported self-
management; treatment in a homely setting, person centred decision making and integrated health and social care informs the policy context of the project.

The 2020 vision also encompasses a move towards major change in the delivery of primary care services, in particular the expansion of general practice, multidisciplinary working and workforce planning to ensure the “right people, in the right numbers in the right jobs” (Healthier Scotland 2013). While the 2020 vision appears to endorse the Deepend ‘approach’ and states an intention to target resources into the most deprived areas of Scotland, to date only 11 of the 100 most deprived practices have been provided with additional clinical capacity to address the needs of their patients (Deepend Report 30 www.gla.ac.uk/deepend). Co-location of social services and third sector providers with primary care teams where possible, and a wider range of professionals integrated with the practice-based structure of primary care, are among the aims of the National Clinical Strategy (2016). A new GP contract for Scotland, operational from April 2017, includes significant change to the GP role with a new focus on Complexity, Undifferentiated Presentations and Clinical Leadership. Practices will be expected to work as Clusters from April 2017 and Clusters will have responsibility together with integrated authorities for the quality of all health and social care services in their locality (Audit Scotland 2014). Initiatives to release GP capacity for these new roles, and develop multidisciplinary working models are in development.

The Scottish Government’s reform and integration of health and social care services (the Public Bodies (Joint Working) (Scotland) Act 2016) became operational on 1st April 2016, as NHS and local authority care services merged the management of resources and became jointly responsible, as Health and Social Care Partnerships (HSCP), for the health and care needs of their local populations under the new Act. HSCPs are expected to work closely with GPs to ‘shift the balance of care’ from acute to community and primary care; policy aims include reduced hospital admissions and delayed discharges.

The Social Work (Scotland) Act (1968), requiring local authorities to provide services for people in need, is the foundation of social care provision in Scotland. Amendment of this Act by the NHS and Community Care (Scotland) Act (1990) transferred the responsibility for community care to local authorities. The resulting huge resource transfer created tensions between the NHS and social care departments, exacerbated by pressure on health boards to free hospital beds and on councils to manage accommodation with insufficient resources (Freeman & Moore 2008). This legislation also introduced compulsory competitive tendering, whilst councils were not given the power to ring-fence social care budgets. Current public services legislation includes a requirement to constantly seek cost efficiencies.

The 21st Century Social Work Review by the Scottish Government in 2006 refocused professional roles towards statutory duties or high risk/high complexity cases. This perhaps echoes the current legislative requirement to work to the ‘top of the licence’ in health services, delegating ‘lower level’ support tasks and maximising professional expertise.

The national social policy direction towards personalisation, independence, rights and self-determination, together with a strategy of shifting to anticipatory care and prevention, fits closely with Social Work (and council) values, and is echoed in Glasgow City Council’s strategy of providing social care ‘in line with a vision of promoting independence’. It is also compatible with the need to manage services with dwindling resources and staff (In Glasgow, FTE social worker posts have reduced by 25% since 2008).

The changes in health and social care are driven by national strategies designed to address an ageing population, increased demand for service and reduced resources, however the systems remain largely separate. The short-lived Community Health and Care Partnerships, a previous ‘top-down’ attempt at
integration, failed to address incompatible recording systems, issues of consent and information sharing, or
the organisational and professional tensions between social care and health, and between social work
management and staff who feared a ‘health takeover’ (Freeman & Moore 2008). Joint working initiatives
maintained separate management and governance arrangements. CHPs and CHCPs failed to engage with
GPs in many areas; and the relationship in Glasgow has been described as ‘poisonous’ by some of our
interviewees.

Budget disparities, a longstanding cause of tension, remain. The final report by Glasgow City Shadow
Integration Joint Board in January 2016 pointed to continuing budget disparities on the eve of integration,
with Social Work having a budget deficit due to overspend in Children and Families which would have to be
recovered from spending on Adult Services. This was the political, strategic and financial landscape that was
in place when the next phase in health and social care integration was launched with the Health and Social
Care Partnerships.

Glasgow City Council (GCC) and NHS Greater Glasgow and Clyde (NHS GGC) became Glasgow City Health
and Social Care Partnership on April 1st. The body responsible for managing the integration scheme, the
Integration Joint Board, produced a Strategic Plan for 2016-2019, as required by the new legislation, to
ensure delivery of the functions of the new Partnership and to measure progress. Integration of health and
social care services will be measured against the nine statutory National Health and Wellbeing Outcomes.
Eleven Strategic Planning groups have been identified to direct and measure performance for 11 ‘care
groups’ - including older people, mental health, children and families, addictions and carers - and to link
local operational indicators for each ‘care group’ to the national outcomes. Locally, there will be Partnership
management teams for adult services, children’s services, older peoples’ services and health improvement, and
care group planning groups. However, there is no ‘care group’ for complex need/multimorbidity. Furthermore,
while addressing the ‘inverse care law’ is a core principle that lies at the heart of the Deepend philosophy, it is
surprising that this is not highlighted as an aim of the integration agenda within the HSCP.

Among the initial priorities for the South Glasgow locality is

*Taking forward the Govan integrated care project with four GP practices testing new forms of integrated
service delivery with community health, social care and the third sector to support and prolong independent
living in the community harnessing all available resources.* (Glasgow City Integration Joint Board Strategic

The Govan Social and Health Integrated Partnership (SHIP), initially known as the Govan Integrated Care
Project, developed from a series of meetings and consultations, between the CHP Director, the Director of
Social Work and the Govan GPs. As the Scottish Government began to show interest, academic GPs
associated with the Deep End began to contribute to the development of a proposal. As this progressed,
the Director of the CHP encouraged further development of the SHIP proposal to go beyond the SW
initiative to bring the Deepend ‘agenda’ to the fore with other aspects of care.

The Govan SHIP initiative, involving a cluster of the four practices based at Govan Health Centre, is an
integrated care model designed to address a number of concerns within primary care. Emphases differ
depending on the perspective from which the project is viewed. From a policy and planning perspective the
aims are expressed as, variously: *to manage demand* (NHS GGC website 2015), *to reduce demand on acute and
residential care* (Audit Scotland 2016), *to reduce the rates of unscheduled care at emergency departments
and cut delayed discharge* (NHSGGC, newsletter August 2015), *to support and prolong independent living in*
the community (Glasgow City HSCP Strategic Plan 2016-2019). From a medical or clinical perspective, the project aims to draw up care packages for patients before they reach a crisis (NHSGGC, newsletter August 2015), devise appropriate anticipatory care plans (Healthier Scotland 2016) and improve chronic disease management (Audit Scotland 2016). The Deep End perspective encompasses these aims but also places emphasis on developing capacity to address social need and health inequalities at practice population level. Within this perspective, it is also essential that integrated practice aims to address the Inverse Care Law (the availability of good medical care tends to vary inversely with the need for it in the population served) by targeting care, including anticipatory care, where it is most needed (GPs at the Deep End 2012, 2013).

Three groups of patients were identified as those with the greatest vulnerability, and who could benefit from preventive action and additional support - vulnerable children and families where childrens’ health and development may be at risk, frail elderly people who are at risk of hospital or care home admission without intervention and adults with multiple and complex medical and social conditions who attend A&E frequently or have a high level of unscheduled care episodes.

Four subgroups (workstreams) were created to focus the development of the project: Vulnerable Children and Families, Frail Elderly, Unscheduled Care and an IT group to ensure collection of relevant data for evaluation.

New models of care being piloted to address identified vulnerabilities and increase clinical capacity include co-location of 2 social workers at the health centre, one for vulnerable children and families and one for adults, to work across the four practices (latterly replaced by 2 social care workers); monthly multidisciplinary team meetings in each practice; additional GP capacity facilitated by the addition of GP locums to allow senior GPs to offer extended consultations, attend case conferences or participate in other project-related activities.
Evaluation Approach & Research Methods

The approach to the evaluation

The research team conducted a qualitative process evaluation of Govan SHIP. This focused on exploring the following areas:

- identifying the barriers, facilitators and potential solutions to social work integration
- exploring the benefits and challenges of health and social care integration
- lessons and recommendations for future integrated working

The evaluation takes an ethnographic approach informed by realist evaluation (Pawson & Tilley 1997). Ethnography is an approach suited to understanding complex settings and interventions, and aims to explore a research question or the implementation of an intervention within its ‘natural setting’ (Hammersley & Atkinson 1995). Thus, rather than simply seeking answers to pre-determined questions about what participants say that they do, an ethnographer seeks to explore what people actually do in practice (O’Reilly 2005). The realist approach to evaluation marries well with an ethnographic study design, given its focus on implementation contexts and the mechanisms by which outcomes are achieved. This evaluation is thus informed by the central realist question: ‘What works, for whom and in what circumstances?’

Research Methods

The study involved two phases: a context mapping phase drawing on observations and unstructured interviews, followed by semi-structured interviews and continued observations.

Sampling and Recruitment

A purposive sample of staff working within/linked to the GHC and stakeholders with involvement in the integration agenda were identified. This included social workers, social care workers, practice and community-based nurses, GPs from each of the four practices, Community Links Practitioners (CLPs) and higher level stakeholders from health care management, social work and academic primary care. Table 2 illustrates the professional roles of those recruited.
Table 1: Sample by professional role

<table>
<thead>
<tr>
<th>Professional Roles</th>
<th>Phase 1</th>
<th>Phase 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Social Workers</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Social Care Worker</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>District Nurse</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Practice Manager</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>CLP</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Stakeholders (HSCP, SW managers, Primary Care/Univ)</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total Staff Interviewed (n=32)</strong></td>
<td><strong>11</strong></td>
<td><strong>21</strong></td>
</tr>
</tbody>
</table>

All potential participants received by email: a letter of invitation to participate; an information sheet about the evaluation; and a consent form. The email was followed by a phone call and, if willing, a convenient time and date to be interviewed was arranged with the research fellow (JMcG). Written consent was obtained after participants had been given the opportunity to ask any questions about the study. Five potential participants declined to be interviewed, primarily on the grounds of lack of availability or time to take part or because they felt that they had not been involved in SHIP-related activity.

Data collection and analysis

An initial scoping exercise was conducted in order to develop an ‘intervention map’ within the four GP practices that constitute Govan SHIP. This involved unstructured interviews (n=10) with staff from the four practices as well as relevant social work professionals. Interviews were supplemented by observations at MDTs hosted in three of the four practices, which took place during both phases of data collection. When an understanding of what was being implemented (or not) in the four practices were established, semi-structured interviews (n=20) were undertaken with health and social care professionals in a second phase of data collection. Table 2 illustrates data collection to date.

Table 2: Data Collection

<table>
<thead>
<tr>
<th>Data Collection</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unstructured interviews (phase 1)</td>
<td>10</td>
</tr>
<tr>
<td>Semi-structured interviews (phase 2)</td>
<td>20</td>
</tr>
<tr>
<td>MDT observations (Fieldnotes)</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total data collection: 30 interviews &amp; 6 MDT observations</strong></td>
<td></td>
</tr>
</tbody>
</table>

Unstructured interviews (in the first phase of data collection) aimed to target key health and social care professionals linked to the SHIP project in order to establish what the components of the intervention were and how they were being implemented in each practice. These (face-to-face) interviews were recorded as

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1 Two interviews were conducted as paired interviews therefore there were a total of 30 interviews that included 32 individuals.
fieldnotes and analysis focused on mapping the contexts of the SHIP project, including variations in implementation across the four practices. As only three of the four practices had implemented MDTs, observations were made in those three practices. These too were recorded via fieldnotes, concentrating on noting the range of health and social care professionals in attendance, multidisciplinary and cross sector working and the nature of interactions within these meetings. These observations have been incorporated into the semi-structured interview data related to MDTs.

Semi-structured interviews (either face to face (n=16) or by telephone (n=4)) were conducted in the second phase of data collection. These interviews ranged in duration from 30-80 minutes, with an average of 50 minutes. The interviews followed an iterative approach, pursuing further detail on themes as they emerged from initial analysis. Semi-structured interviews were digitally recorded, transcribed verbatim and analysed using QSR NVivo (v11) software. The analysis followed the technique of constant comparison (checking experiences against those of others in the sample), to ensure that the themes represented a range of perspectives (Mason 2202, Miles & Huberman 1994, Pope & Zeibland 2011). Any contradicting or variable views were also explored in order to lend depth and variation to the analysis (Strauss & Corbin 1990). Unanticipated themes were also included (Pope & Zeibland 2011).

Ethical issues

The study adhered to ethical guidelines for good practice in research (BSA 2002). Ethical approval was awarded by the Research Ethics Committee of the Faculty of Health Sciences and Sport, University of Stirling. Additionally, advice was sought from the Research Ethics Committee of NHS Greater Glasgow and Clyde (GG&C) and formal clearance was not required on the grounds that this study was an evaluation. GG&C Research and Development office also advised that an honorary contract and letter of access was not required for this study.

Informed consent was sought and gained prior to the interviews. While we assured participants that confidentiality would be maintained, in this study anonymity could not be guaranteed given the small numbers of key professionals interviewed. However, where possible, we have tried to ensure that quotes or views were not attributable to individuals, although in a study of this nature this too is not always possible. Although this evaluation was initially designed to follow a case study approach, with each of the four GP practices representing a unit of analysis, we made the decision to abandon this in reporting the results of semi-structured interviews in order to protect the identity of those who gave important but potentially contentious views that were associated with particular roles. If we had linked these views to particular practices there was a high risk of making these participants identifiable. While we understand that much of what is reported here may have been already openly discussed among colleagues, nevertheless we approach reporting of potentially contentious views with caution.

The study data were only available to the University researchers. In this way we strove to maintain confidentiality as well as retain independence for the evaluation.

Data protection

The study will comply with the terms of the Data Protection Act 1998. Participants were assigned a non-identifiable code and identifiable data (e.g. contact details) were held separately. This data will not be used for any further purpose apart from contacting participants who indicated an interest in receiving a summary of the study results.
Study data will be held securely on a single password protected university computer for a period of five years from the end of this study to facilitate any further dissemination of study results. This will then be destroyed. Any paper records (apart from consent forms) will be destroyed at the end of the study using University of Stirling confidential waste disposal.
Results

Initial unstructured interviews and observations were used to establish the intervention contexts. This is presented in tabular form in Appendix 1. All data sources were drawn on to inform the following results, with verbatim quotes from semi-structured interviews used where appropriate. We present an account of each of the major components of the SHIP project in turn: SHIP extra time, Social Work and Social Care Worker involvement, MDT working and finally, wider issues related to SHIP and the health and social care integration agenda.

Ship Extra Time

[T]here isn't enough time to do what you want to do. I don't think there's even enough time to do what you need to do which is slightly worse again...(Int 7, GP).

The above quote refers to the pressure on health care staff working within Deepend General Practice settings.

Figure 1: Deepend General Practice Contexts

- Complexity and multimorbidity are the norm, and are more severe, in very deprived areas (GPs at the Deep End 2012; Mercer & Watt 2007)
- Unmet need in deprived areas is significant, increasing demand and pressure on general practice (GPs at the Deep End 2009); and patients wait longer to access the care that they need and have lower levels of satisfaction (Mercer & Watt 2007)
- Mental health and psychosocial problems are more than twice as prevalent in deprived areas than affluent areas (GPs at the Deep End,2014) and yet clinical consultations is generally shorter (Mercer & Watt 2007)
- GPs in very deprived areas have insufficient time to address range & depth of patient problems (GPs at the Deep End 2009; Mercer & Watt 2007)
- GP stress is higher in deprived practices (Mercer & Watt 2007) and empathy with patients is lower, affecting patient outcomes (Mercer et al. 2016)
- Patients from deprived areas more likely to lack confidence in making health decisions and managing their illness and treatment (Chief Medical Officer’s Annual Report 2014-15; Mercer et al. 2016)

A recent report on the GP extra time at GHC (Watt nd.) explored the numbers and content of GP consultations arising from the ‘extra time’ initiative included within the SHIP project. This consisted of recruiting two locums to be shared within the four practices. This provided each of the 15 GP partners with time amounting to one session per week to be used as they saw fit. The majority of this additional time has been used to address the unmet needs associated with complex care. This has included, for instance, time for case review (in some cases within the MDT), extended consultations and time to attend case conferences (Watt nd.). There is an evident attention to addressing the inverse care law, by targeting additional capacity at those most in need of help. What follows represents some supporting data from qualitative interviews.

SHIP sessions (as many healthcare staff refer to the additional time) allow the time to focus on complex care planning. This enables GPs to explore both the health and social situations of patients and enables anticipatory care planning. One GP also referred to how the additional time enhanced patient centred care and shared decision making. This may well have also enhanced the doctor-patient relationship, allowing the GP to demonstrate enhanced empathy for the patient with more time to explore their issues.
But it’s also been great to be able to say ‘well I’m going to take extra time to find out more about your problem to understand the social situation better, to make plans with you’ [...]. It’s been nicer to be able to do an anticipatory care plan that actually looks at not just the doctor’s agenda [...] but actually what the patient’s priorities are, you know. The patient’s main concerns at the moment might not be my worries about their critical diagnosis, it might be other stuff and being able to dig down that layer deeper has been great (Int 6, GP).

Two GPs stated that addressing the ‘inverse care law’ (Tudor-Hart 1971) was one of the major aims of SHIP, which was facilitated by the extra GP time: I’d rank the inequality and inverse care higher than integration because I think I can actually deliver a lot of that by giving... I can give you more time now as an individual patient due to SHIP (Int 10, GP). Staff also perceived that patients valued the extended consultations and that this made a big difference to them: ‘patients really are aware they’re having that little bit extra time’ (Int12 Practice Nurse). Again the perceived patient response suggests that the extra time allowed GPs to behave more empathically with patients, which (as noted in the literature above) has been shown to improve patient outcomes.

GPs spoke about using SHIP time to attend external case conferences or child protection hearings, where the person’s medical history or that of family members made a 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. Interviewees, revealed that other professionals valued this input and patients appreciated the supportive presence of their GP at these hearings.

Others spoke about how SHIP time was of wider benefit to practice staff simply because the extended consultation time either within surgeries or during house calls meant that a GP could tackle the range of health and social issues presented by a patient with multiple and complex needs, enabling a more incisive problem solving, thus:

It’s taken a bit of pressure off the receptionists from that point of view, it’s taken a bit of pressure off I think all the other GPs in the practice and potentially the trainees as well even though they don’t have SHIP sessions because I’m more free to go and do that extended house call and actually address all the patient’s problems rather than the patient phoning up two or three times a week because they still have an unmet need (Int 6 GP).

Similarly, some staff felt that the additional time spent in case review or in extended consultations had the potential to reduce A&E attendance as they had extra consultation slots to offer if a patient phoned with an injury.

Perhaps an unanticipated benefit of the extra time for GPs is that this may well reduce work-related stress and could help to mitigate the high ‘burn out’ in GPs working in areas of high deprivation (Mercer et al. 2016).

So there’s an element of you feel now that you’re in control to a certain extent of the workload which just felt completely chaotic before. There was absolutely no control of what happened to you during the day at all. Now I think for a profession to move forward and survive like general practice that’s really, really important (Int 2, GP).

A usual day for a full time GP in GHC would begin at 8.30 in the morning and end at 7.30 or 8.00 pm in the evening with little or no time for breaks in between. Although the SHIP time didn’t necessarily reduce the
time GPs spent at work, it appeared to have an impact on wellbeing. As one GP put it, *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* (Int 9, GP).

Indeed a Practice Manager was eloquent in her praise of the additional time for GPs. She felt that it reduced GP stress and enabled reports, referrals and telephone calls to be done during surgery time rather than extending the working day. She perceived the combined value of this to have led to an increase in social prescribing, with an increase in contact with external agencies. Thus, cross sector working was facilitated (Unstructured interview PM).

There is some evidence that the ethos of targeting additional care at the most vulnerable in order to address the inverse care law has also motivated related activity within nursing staff (albeit without the benefit of SHIP time). For instance, one practice nurse talked about her work with the addictions group, explaining how she decided to give extra time to these patients in order to encourage them to accept treatment for Hepatitis C. She felt that the extra time had contributed to take up of treatment, *‘it’s all about trust and relationships and people don’t get that, you’ve got to build it up and it takes time. You can’t do it overnight’* (Int 12, Practice Nurse). However the extra time devoted by the practice nurse above was not related to SHIP time, but instead was time that she decided to prioritise within her existing workload.

Some practice staff perceived SHIP time as an exclusive benefit. While one GP argued that the benefits of being able to properly review a complex patient reduced the burden on other staff, some felt that the extra time made no difference to their daily work, which suggests the need to elicit patients’ views and experiences of extended consultations (to be explored in future interviews). However, there is little doubt that the benefits for GPs are considerable and by exploring the extra time alongside other initiatives (such as the MDT), it is reasonable to assume that the additional time was also of considerable benefit to patients.

### Key Learning from SHIP time

A clear benefit to GPs and patients:

- Addresses the inverse care law by providing additional health care to those with most need
- Facilitates complex care planning (also see use of time for MDT meetings)
- Allows GP attendance or more incisive engagement in external/multi-sector case conferences or hearings
- Reduces GP stress

Because there is less obvious direct benefit to other practice staff – examples of benefit to patients should be shared/celebrated with all practice staff
Linked Social Workers

Bringing two social workers (one specialising in adults and the other in children and families) into the GHC to work across the four practices was core to achieving the aim of integrating health and social care. The original idea of social work integration reportedly (Int 20 Stakeholder) arose with one of the Govan GPs. Subsequently the local GP committee (including seven Govan GPs) approached the Scottish Government who were receptive to supporting a social work and health integration project. However, despite planning and discussions between primary care, the social work department and the Scottish Government that can be traced back several years, integrated working began with mismatched expectations coming from both social work and health care professionals. Initial experiences were charged with negative emotions, disappointment and ultimately, issues of mutual respect became a significant barrier to finding solutions to integrated working. Many of the issues reported by interviewees have been reported elsewhere, therefore summaries of this evidence will precede each of the major themes in this section.

A search of the literature on social work and primary care integration projects (from 1974-present) revealed that many of the papers discussed implementation or outcomes of social worker liaison or attachment schemes, or compared these models. Table 2 illustrates the comparison between these two models of integrated working. Appendix 1 provides key summary points from the literature search, some of which is also reported below.

Table 3: Comparison of Attachment and Liaison Models of Social Work in Primary Care, 1974 - 2015

<table>
<thead>
<tr>
<th>Model</th>
<th>Attachment</th>
<th>Liaison</th>
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<tbody>
<tr>
<td>Location</td>
<td>Medical Social Work Model</td>
<td>Social Services Model</td>
</tr>
<tr>
<td>Team</td>
<td>General Practice</td>
<td>Social Work office</td>
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<tr>
<td></td>
<td>Primary Care team</td>
<td>Social Work team</td>
</tr>
<tr>
<td>Contact</td>
<td>Daily face to face contact with GPs,</td>
<td>Contact mainly by phone or email</td>
</tr>
<tr>
<td>frequency &amp;</td>
<td>Nurses &amp; Practice staff</td>
<td>May attend formal meetings</td>
</tr>
<tr>
<td>nature</td>
<td>Regular formal meetings</td>
<td>Less contact with nurses</td>
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<tr>
<td></td>
<td>Opportunistic informal meetings or</td>
<td>Little face to face contact with</td>
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<tr>
<td></td>
<td>‘chats’</td>
<td>practice staff</td>
</tr>
<tr>
<td>Referrals</td>
<td>Direct from Practice staff</td>
<td>Via usual Social Care referral</td>
</tr>
<tr>
<td>Main role</td>
<td>Generalist</td>
<td>channels</td>
</tr>
<tr>
<td>Practice focus</td>
<td>Practice population - patients</td>
<td>Specific care group eg elderly.</td>
</tr>
<tr>
<td></td>
<td>identified by Practice staff</td>
<td>May have continuing non-practice</td>
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<tr>
<td></td>
<td>Focus on casework</td>
<td>commitments eg caseload/duty rota.</td>
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<tr>
<td></td>
<td></td>
<td>May or may not see Practice</td>
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<td></td>
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<td>patients. May facilitate</td>
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<td></td>
<td></td>
<td>Practice referrals to other</td>
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<td></td>
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<td>workers/teams or to screening</td>
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<td>centre Focus on statutory work or</td>
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<tr>
<td></td>
<td></td>
<td>departmental priorities</td>
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<tr>
<td>Access</td>
<td>Universal; worker prioritises cases</td>
<td>Eligibility criteria; departmental</td>
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<tr>
<td></td>
<td></td>
<td>constraints</td>
</tr>
<tr>
<td>Autonomy</td>
<td>Worker controls caseload &amp; decides</td>
<td>Worker carries specified caseload,</td>
</tr>
<tr>
<td></td>
<td>which approaches to use</td>
<td>usually carrying out standardised</td>
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<td></td>
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<td>procedures under managerial</td>
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<td></td>
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<td>direction</td>
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<tr>
<td>Nature of</td>
<td>Complex, psychosocial issues in</td>
<td>Practical or resource issues only</td>
</tr>
<tr>
<td>referrals</td>
<td>addition to resource and practical</td>
<td>for direct work; may pass on</td>
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<td></td>
<td>needs</td>
<td>complex referrals to appropriate</td>
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<tr>
<td>Tensions</td>
<td>Tensions between Social Workers &amp;</td>
<td>Tensions between Social Workers</td>
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<td></td>
<td>Primary Care professionals may be</td>
<td>and Primary Care professionals</td>
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<tr>
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<td>may be</td>
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Sources: Corney 1985, Cameron & Lart 2003, Kharicha et al 2004
In 1978, half of UK Local Authorities were involved in such schemes (Williams & Clare 1979, Corney 1985) and this continued until the 1990s (Cameron & Lart 2003).

Attachment was consistently preferred by GPs, nurses and social workers. Social workers reported more autonomy to work to professional ideals (Hudson 2002, Kharicha et al 2004); and GPs and social workers reported learning and changing practice positively (Lymbery 2006), even when the positive change had resulted from initial conflict. However, these schemes tended not to improve GP communications with Social Work Departments. GPs preferred to work with their known, named social worker and it has been suggested that fundholding GPs bought in social workers specifically to avoid dealing with the Departments (Lewis 2001). In turn, Departments were fearful that attached Social Workers would start to put Primary Care priorities above Departmental ones.

GPs and Primary Care staff generally perceived the liaison model as being less effective and more negative; with more conflict and communication problems. Liaison social work also involved simple practical/resource referrals rather than dealing with complex, psychosocial issues (Corney 1985). However, Social Work Departments appeared to prefer liaison schemes as these allowed them to retain managerial control (Cameron et al 2014).

Lymbery (1998) identified key actions in planning a successful attachment:

- review previous collaborations
- ensure the attached SW has more autonomy than in the Social Services Department
- develop referral methods that work for both the practice and the SW
- accept that LA eligibility criteria will limit the SW’s ability to get funded resources
- ensure sufficient organisational development such that roles and responsibilities are clear from the outset

The SHIP model of SW integration

From both unstructured and semi-structured interviews it appears that SHIP adopted the liaison model of social work involvement in the GHC. Although initially the two social workers were purported to have had their posts ‘backfilled’ via funding from the SHIP project, nevertheless the picture of their involvement in the GHC appears to be one where they remained isolated from the health care ‘community’ and were perceived by practice staff as, on the whole, inaccessible. Referrals initially came from practice staff, but these came with unrealistic expectations and/or a lack of understanding of the social workers’ roles, which then led to refusals to take action. It appeared that a perceived ‘failure’ to meet practice staff expectations swiftly degenerated into negative attitudes and relationships between the social workers and practice staff.
Eventually the social workers scaled back involvement to two days per week each and their activity linked to the GHC became even less visible apart from their attendance at MDT meetings (reported further below).

One of the social workers noted: ‘It was very clear I wouldn’t be an attached social worker, I would be the link for social work and I think actually that fundamental part wasn’t very clear to everybody and that’s where lots of things for me went wrong’ (Int 1 SW). It seems that although there were presentations from social work to the steering group to explain what they could expect from the SW initiative, nevertheless there appears to have been either a lack of acceptance or a lack of understanding of what this would mean. While the literature cited above highlights clear definitions and role distinctions between attached and liaison models of SW, it is unsurprising that these terms may well have held no meaning for non-SW professionals. From the outset then, it seemed that the social workers were destined to fail to meet expectations as they entered GHC acting in the role of liaison social workers, while the GHC staff expected attached workers.

> I realised that the two social workers would not be the people who were seeing the patients, they would be passing on messages to the people who would be seeing the patients and at a stroke the whole thing just collapsed in front of me because what I wanted, which was a relationship with the people who were working with the same people as me, wasn’t going to happen (Int 7 GP).

This initial misunderstanding was at the root of the eventual breakdown in relationships that was to follow. The SHIP initiative experienced many of the challenges found in the literature on social work and health integration projects and evidence pertinent to understanding SHIP implementation is summarised in a series of Boxes, beginning with Figure 2 below.

**Figure 2: General Practice - Social Work Attitudes and Understanding of Roles**

- Little understanding or appreciation of the other’s role on either side, & no change in this position over 40 years (Ratoff 1974, Cameron & Lart 2003)
- GPs have little confidence in the social care system and expect to be ‘stonewalled’ by indifferent officials (Mangan et al 2014, 2015, Hubbard & Themessl-Huber 2005)
- GPs sceptical about quality of SW assessment & have little knowledge of SW training or skills (Glasby & Miller 2015, Xyrichis & Lowton 2008, Mangan et al 2015)
- 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’ (Abramson & Mizrahi 1996, Griffiths & Glasby 2015, Hudson 2015, Mangan et al 2015)
- Relationship characterised by impatience, frustration, ‘hostility & antagonism’; ‘distrust and even contempt’ (Williams & Clare 1979, Corney 1985, Cameron et al 2014)
- SWs felt GPs do not recognise they have established professional networks already – with Health Visitors, District Nurses, Midwives etc (Hudson et al 1997, Mangan et al 2015)
- GPs see SW role as accessing resources; SWs in 1980s described their role as therapeutic, by 2000 SWs reporting role as ‘assessment’ (Hudson et al 1997, 2002, Bliss et al 2000)
- SWs & GPs in successful schemes reported reciprocity and good relationships based on informal contact & discussion, ‘despite the system’ (Williams & Clare 1979, Hudson et al 1997, Lotinga 2015)

_Initial expectations_
It became clear that both the social workers as well as practice staff began their relationship without having a clear idea about what integration would mean and how it would actually be implemented. Indeed as one interviewee noted, ‘it was woolly for everybody’. Some staff based their initial expectations of the social workers on previous, extremely positive experiences of having a generalist social worker attached to GHC many years previously. Practice staff shared the belief that the social workers would take referrals and speed up the current access to services. Unfortunately, as the social workers explained, access to services is beyond the control of individual social workers as services are controlled centrally. Furthermore, as social work becomes increasingly specialised, referrals are passed to specialist teams so that, for instance, the children and families social worker would immediately refer on to a criminal justice team where appropriate rather than take any responsibility for those falling into this category.

Another issue that immediately soured relationships was the fact that the adult social workers were constrained by their departmental eligibility criteria for referrals, imposed as a result of dwindling resources. Whilst the children and families social workers had some scope for preventive work, this was also limited by resource requirements. Early interviews with practice staff revealed the perception that the social workers held up their eligibility criteria ‘like a shield’, that acted as a barrier to taking action. Again, the lack of understanding of how referral processes worked and the 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. As time went on negative perceptions became entrenched and a social work team leader began attending meetings in the place of the adult social worker, who experienced the most negative reactions, partly due to the higher risk threshold and even less access to referrals than within children and families.

Governance and disciplinary boundaries also may have played an important part in skewing initial expectations (see Figure 3).

Figure 3: Status and autonomy

- GPs’ professional status established & unchallenged. SWs’ professional status threatened due to managerial control; lack of autonomy reduces the ability to develop new networks & ways of working (Hudson et al 2002, Johnson et al 2003, Kharicha et al 2005, Lymbery 2006)
- SWs’ low status attributed to working with poor & socially excluded groups (Lewis 2001)
- GPs seen as ‘drivers of spend’ – essential partners in integration– so continue to have high status and power but nevertheless feel under attack and overworked (Leutz 2006, Hutchison 2015)
- GPs see themselves as leaders & are seen that way by others; Nurses felt less able to speak up, particularly when employed in Practices (Elston & Holloway 2001, Xyrichis & Lowton 2008)
As one senior manager explained:

[T]he GPs... and this is putting it at its crudest, I mean, were basically looking to direct the social workers and it was clear that wasn’t going to happen in the sense that the social workers still had a line management back in social work and... what that led to was the service manager having to participate in the MDTs and always some negotiation taking place and clarification taking place about what social work... the social work staff who were going to be regularly present could and couldn’t do (Int 18 Stakeholder).

Indeed there was a serious clash in both culture and power, as with the integration effort, two powerful partners were brought together.

I think there are definite cultural differences and that Govan has exposed some of those and exposed, if you like, the lack of understanding that exists between different services about how they operate and the constraints around them, and I think that’s come to be much better appreciated. I think it’s also tested maybe the extent to which... professionals across multidisciplinary working actually work in an environment of mutual respect, and I don’t think that’s what Govan started from, I think it’s moved towards that but it’s been a tough battle and a bruising one (Int 18 Stakeholder).

Philosophies of care

One of the areas of ‘culture clash’ between health and social work was in the perception of risk and individual choice, which was ultimately derived from different philosophies of care (see Figure 4).

Figure 4: Philosophies of Care

- Rescue v empowerment: very different attitudes to risk and urgency. GPs tend to seek immediate response & elimination of risk (eg residential care for a frail patient); SWs tend to aim for management of an acceptable level of risk in order to facilitate patient choice (eg remaining at home in a less than ideal environment) (Kharicha et al 2004, 2005, Hubbard & Themessl-Huber 2005)
- Language use - the same word (eg ‘enablement’) may be interpreted very differently by GPs, Nurses & SWs (Lymbery 1998, Bliss et al 2000).

One of the contentious areas was in the ways in which needs were perceived. As in the literature (above) the social workers spoke of an ‘enablement’ and a ‘rights-based’ approach to addressing need. There were many instances where social workers refused to take action when health care staff had identified risk and vulnerability. What constitutes ‘risk’ was a contested category, and considerable frustrations were expressed on both sides. For instance, one patient was referred to a social worker because they thought
the person didn’t have the capacity to take care of themselves. However, on investigating, the social worker found that despite learning difficulties, this person had supportive neighbours and in fact did not meet a threshold for incapacity that would warrant social work referral. In another example, an interviewee spoke of the way that their judgements were undermined and although there were real benefits of working together, this could have been obscured within tense relationships.

‘the social worker’s not done this, the man needs a service’ and ‘social work aren’t doing their job’ and you’re like ‘has he got capacity, you know, that’s not my role’ but you’re like ‘he’s got capacity, yes it’s a shame he’s choosing to live his life like that but it is his life and we can’t intervene’ and interestingly enough that was the one that ended up removing the children and you think ‘that’s not come to my attention yet, but you’re bringing up about…’ (Int 2 SW).

However, there were understandable concerns expressed by nurses, health visitors and GPs that they could predict a downwards trajectory of a patient that would inevitably lead to repeated hospital admissions unless some form of preventive action were taken. As one practice manager stated in one of our early interviews, “sometimes people in very deprived areas don’t fit into boxes, so how can they make an assessment based on general criteria?” Unfortunately, with management and budgetary constraints such as they are, there was little that social workers were able to offer in terms of preventive care.

Another issue was that of prior consent to intervene. This also highlighted a different approach to the delivery of care. Whereas health professionals would routinely make decisions about what a patient needed and advise them accordingly, social workers (unless circumstances such as adult or child protection were involved) require potential clients to consent to engage in social work processes and cannot ‘force’ people to accept services that they do not agree to. As one senior stakeholder elaborated: ‘a social worker does not have the right to come in and take over and control someone’s life’ (Int 11 Stakeholder).

Enablement was also a term used by social workers to contrast their practices with health care colleagues. I think sometimes it was about they were wanting us to do things for people instead of we would say ‘no, they can do that themselves, what reason is it they can’t do that themselves?’ (Int 1 SW). They gave examples of a perceived ethos of care that in some cases promoted dependency on health professionals, such as doing things for patients rather than supporting them to do things themselves. However, the language of enablement appeared to be one that was not always demonstrated in practice, as there was (particularly in terms of adult social work) little evidence of supportive and enabling social work on the ground. Indeed one of the CLPs pointed out (in an unstructured interview) that signposting to services does not work with this population, “If you give them a leaflet and tell them to go to such and such a service, they won’t do it. There are too many barriers and they would just give up.” Nevertheless it is important to understand this point within the context of the constraints on current models of social work and possibly the impact of degenerating relationships.

Comparison with Links worker

One feature of the social work involvement was the unfavourable comparison made between the social workers and the Community Links Practitioner (CLP), otherwise known as the Links worker. There were two Links workers based in two of the four GHC practices. The Links workers were an external initiative running alongside the SHIP project and there had been considerable pre-implementation planning, as well as careful attention to recruitment and training of the CLPs. Mostly recruited from community development backgrounds, the CLPs had the training and experience to do what, unfortunately, GHC staff hoped the social workers would do. The one major difference would be that they expected a gold plated service: someone who would work within the community with complex patients, but also be able to undertake...
social work assessments and referrals. This comparison, alongside the misguided expectations, contributed further to negative relationships with the social workers.

The CLPs were universally highly regarded and there was some evidence of boundary maintenance work between the two professions from the outset, with tensions developing around roles and expectations of what collaborations might mean. Furthermore, the CLPs also understood risk and vulnerability very differently to the social workers and this too caused tensions in their relationships. However, there were examples of some positive joint working between the CLPs and social workers. For instance, one family required social work intervention but did not like/mistrusted social workers. Since the CLP already had a good relationship with the family, they accompanied the social worker on a visit and together they managed to achieve a resolution.

_There’d been some other issues that had presented that were flagged up by the police, so the social worker was able to come to me and say ‘look, we’ve got this extra report in, we need to go back out, will you come with me?’_ (Int 4 CLP)

**Benefits of social work involvement**

Although the history of social work involvement in the GHC experienced challenges, nevertheless there were benefits and many lessons were learned (on both sides) over the time that the two social workers were in place. As the initial social workers returned to their previous posts, social work team leaders stood in, providing a fresh start and a more positive environment prior to bringing in two social care workers to replace the social workers. The tone of staff responses changed dramatically from early interviews to those conducted more recently, demonstrating that with time to reflect, lessons had been learned and there had been a shift in attitudes. This meant that interviewees were able to see the positive aspects of social work involvement that may initially have been obscured by the negative relationships.

In crisis situations (particularly where there was a statutory role involved), the social workers were reported to act swiftly, professionally, collaboratively and their efforts were highly valued. These situations were also ones where the social workers may have repaired some relationships.

_But equally the health visitor in [practice name] was excellent and I would say we’d done a good piece of work with a referral that had come that would've went to social care direct for a notification of concern, [...] that came on my desk on the Monday, so very quickly I'd got that, whereas [...] that would've went through to social care direct, there would've been a delay before I got, well whoever got that to follow that up, but myself and the health visitor were able to act on that immediately and she was, I've got a lot of respect for this particular health visitor, so I have had positive [experiences] and it's really important to highlight that_ (Int 2 SW).

And from a GP perspective there were also acknowledgements of the value of the collaboration with social workers:

_So I think that whole process probably worked a little bit better because we knew the social workers and they had been working alongside us and we'd been sort of working towards this kind of 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 out and sort it out_ (Int 9 GP).
Hospital discharge planning was also facilitated by relationships between social workers, GHC staff and the hospital-based team, although there also were examples of some tensions around perceived needs on discharge.

Social work presence at MDT meetings improved information sharing between the health and social work systems, which is explored further in the section below. However, this was an area of mutual learning that could inform future practice.

*I do think there’s faults on both sides and I think one of the things as well is that it was obvious is we don’t actually feedback to primary care, you know, the referral comes in and they don’t know what happens with it in social care direct, there’s no feedback, we’re not the best at that I think* (Int 1 SW).

Some of the GPs acknowledged gaining an understanding of the eligibility criteria and working with the social workers to learn more about how to make referrals and the level of detail required was of significant benefit. It led to improved information provision to social work, which in turn was more likely to achieve a positive result for the patient. Furthermore, as one GP noted:

*So I suppose there’s a positive to it both in terms of [...] you know, making a better referral but also knowing that a referral’s not going to be accepted means that I don’t have to waste energy trying to have it accepted and I can divert that energy into looking for other solutions for the patient* (Int 6 GP).

Finally, while there were also improvements in understanding of SW roles and eligibility criteria, after a ‘bruising’ start, ultimately it appeared that relationships were also improved with the social work department.

*I think probably eventually better relationships between general practice and the social work department and I think a better understanding from our side of what can be expected and what they can offer, and maybe better signposting to other organisations that might be able to help* (Int 9 GP).

**Social Care Worker Initiative**

By November 2016 the two social workers had returned to their previous roles and team leaders attended MDTs in their place. The learning from the social work involvement led to the understanding that what would better fit the needs of GHC and patients was a social care worker (SCW) model, where the worker was expected and able to engage with patients to do the kind of ‘social work’ that had been a feature of generalist social working in the past. However, they would also be able to access social work information systems and share information as well as do 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* (Int 5 GP).
At time of writing the SCWs were only recently in post, although one of them had attended MDTs some months previously in order to provide some SW input when the adult SW left GHC. Thus, she was able to make initial observations that cast light on the change over time:

*I think the approach from everyone’s completely different from before, so I don’t know what came around or what happened or whether higher management decided ‘this is what needs to be done’, and I suppose at the very beginning it was a learning curve, everybody... you know, although you’re going forward with something it’s all new to everyone, so it’s about, you know, and mistakes we’ll be making and maybe you know, people’s attitudes change or whatever* (Int 14 SCW).

**Implementation and inception issues**

It appears that the implementation of the new SCW initiative has happened with little notification or involvement for the GHC staff. For instance, two health visitors (HV) were unaware that a SCW had attended the MDT, pointing to the need for more pro-active engagement and information sharing both on the part of SCWs as well as senior GHC staff. As one of the HVs noted:

*The problem is when you go to these meetings there’s no introductions so I don’t know who half of them are, honestly...* (Int 13 HV).

There appears to have been little information provision to practice nurses (PNs), HVs or District Nurses (DNs) as well as to a member of the Rehabilitation Team that was interviewed. Given the previous history with social work, it would appear essential that the way forwards is prepared for collaborative working and encouraging the development of relationships. As one DN said, ‘*Well they’ve not came to see me and I’ve not gone to see them, so again maybe that’s something that I should make the effort to do*’ (Int 15 DN).

Another issue worth highlighting is that there appears to be a lack of clarity around accountability and governance of the SCW. While the SCW clearly understands that they will continue to be line managed by the social work department, because they are employed via SHIP project funding, this may not be clear to others. For instance, a SCW mentioned that on an early visit to GHC she was asked to do photocopying for a member of staff, which she promptly refused to do. While this was not reported with bad feeling, it is important to establish issues of accountability at the outset to avoid the potential for misunderstandings to occur. As one GP admitted, *I think... you see they’re employed by the project but I think it’s through the HSCP they’re employed – I don’t know, I don’t actually know the contract, I’m not sure...* (Int 2 GP).

**The social care worker role**

The SCWs communicated a great deal of enthusiasm for their new roles and talked about their hopes and expectations of what they could do going forward. One highlighted the importance of joint working and information sharing thus:

*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* (Int 16 SCW).
GPs also expressed expectations that the social care workers would be able to engage with patients in a way that was not appropriate for social workers, while also maintaining access to social work information systems and referrals.

*Well I think that we learned from the year that we've already had that they understand their*

<table>
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<tr>
<th>Key Learning from Social Worker and Social Care Worker Initiative:</th>
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<td>Social work attachment and generalist rather than specialist social work better fits the needs of primary care. Social care workers are potentially a more appropriate way to meet the needs of complex patients.</td>
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<tr>
<td>Social workers are constrained by budgetary imperatives, managerial control and have to work within scarce resources.</td>
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<tr>
<td>Eligibility criteria for referrals are non-negotiable, but working with social workers helps to establish higher quality referrals that have a greater likelihood of a positive outcome.</td>
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<tr>
<td>Mutual respect and understanding with clear shared goals are key to successful integrated working.</td>
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<td>Accountability and line management needs to be clearly defined and agreed between sectors at the outset.</td>
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<td>Nursing and allied health professionals routinely work closely with social work and third sector organisations therefore should be involved in planning and actively engaged in implementation in order to facilitate understanding and improved communication.</td>
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*role, that they're able to work autonomously, and when I mean autonomously I mean they're able to work beyond specific criteria and protocols that they can take referrals and they can because they're a sort of generic practitioner (Int 2 GP)*.

**Potential benefits**

There is evidence that SCWs are already working with patients to find solutions to complex problems. An example was given of a SCW working collaboratively with nursing staff to address the needs of a frail elderly patient in a way that would not have been possible or appropriate for a qualified social worker.

*I linked in with his housing officer, she got a deep clean carried out in the house, got it all... we were able to get furniture, we were able to get different things, you know, he accepted homecare, got him into a daycare centre, a wee gentleman who was 91 who told me it was true, daycare centres were all full of old people [laugh] but he agreed to go once a week and we got him a befriender and that was a great working (Int 14 SCW).*
Multidisciplinary Team Working (MDT)

There was much support for MDT working and for MDT meetings, although there were also some suggestions for improvements. While there were some clear benefits, reservations were expressed, some of which were addressed over time. This highlighted the capacity for adaptation and innovation that is sometimes identified as a hallmark of General Practice. Early on in the SHIP project, one of the four practices withdrew from this initiative so our observations were only pertinent to the remaining three that took part in MDTs. Meetings were held monthly and brought a wide range of health, social work and third sector professionals together to discuss complex patients. The three practices varied considerably in the ethos of meetings, some appearing more collaborative/collegiate than others, and also displaying a different range of external professionals’ involvement.

As only two MDTs were observed in each of the practices, we simply present here observations across the board of what worked well, what the facilitating factors may have been as well as identifying challenges to be overcome. Observations are supplemented by commentary from both phases of interviews.

MDT Working Pre-SHIP

Some interviewees pointed out that MDT working was not new to them. Particularly DNs, HVs and SWs had been involved in cross sector MDTs for many years, albeit in meetings without GP involvement. It is perhaps unfortunate that nursing and other professionals had not been consulted or involved in planning the MDTs as the new initiative might have been informed by their prior experiences. In contrast, while GPs had varying degrees of experience with MDTs, this tended to be with GPs, PNs, HVs and DNs, for instance, rather than including members of social work or third sector. Secondary care appeared to routinely benefit from MDTs with social work or SCW involvement.

One stakeholder contextualised the potential value of the SHIP model of MDTs for complex patient care:

"multidisciplinary teams weren’t discovered by the Govan SHIP, I mean, there are plenty of examples elsewhere. I think what the Govan SHIP has tried to do is to give them a much higher profile and make them much more essential for complex cases and had consideration about the range of services that need to be involved" (Int 18 Stakeholder).

GP led MDTs with social work involvement were an innovation new to all, despite varying levels of prior exposure to MDT working.

"it has become more formalised and more structured and obviously the big difference is having the attached social worker at the meetings to be able to access social work records which we couldn’t do before. And through their laptop thankfully we can access Care First." (Int 2 GP).

Benefits and strengths

When the MDT works well, it provides a positive platform for integrated working, establishing and fostering cross sector relationships.

"You build up networks over the phone with social workers but you never really get to see these people and it’s actually nice at the MDT you can actually put a face against a name and you can start to sort of engage and build up a rapport with the social workers." [..] I think, networking’s
got to be good, it's got to be good and it's all done for the good of the patients, so ultimately it's them that we're here for (Int 15 DN).

One of the major benefits is that the MDT enhances complex health and social care planning by bringing professionals from a range of disciplines together to inform patient care. This is another illustration of the implicit attention to addressing the inverse care law that runs throughout the SHIP initiatives. By bringing together a range of professionals to address the needs of complex patients, this served to once again target considerable additional resources to those in most need. Patient care was facilitated by the sharing of information between those attending the meeting, each of whom may have had different encounters with the patient.

just to discuss patients within the MDT was been very useful because you get a lot of background social information from having the social workers there, and equally we’re able then to share information with them about patients. So it's a lot more joined up I think and I think that's a positive. (Int 3 OT)

The MDT also appeared to facilitate anticipatory care planning prior to hospital discharge. In one meeting the SW was able to update the team that a patient, who was complex with continual changes in circumstances, was being discharged from hospital. Being able to then describe SW and housing actions allowed a GP to then plan a review with the patient. The information sharing that took place at these meetings was enhanced partly through tapping into wider networks (in this case the SW links with the hospital-based social worker) or through gaining access to the SW information systems via the social worker’s laptop. This was widely regarded as beneficial to staff and patients alike.

While SW involvement (at least initially) in the MDTs did not lead to referrals, with the SCWs came the ability to work with patients within the community at a level that was below risk and eligibility criteria thresholds. One SCW spoke enthusiastically about the benefits of receiving referrals from colleagues within the MDT,

Social Work would never have got this as a referral, it came up at the [MDT] meeting. So it wouldn’t have been picked up that there was a young mum maybe not coping, until there was a crisis… (Int 16 SCW)

Another benefit of MDTs was the positive impact on staff wellbeing (with the caveat that this was when there were no unpleasant or tense encounters between staff). The MDTs were perceived to have a supportive role, breaking down isolation.

you can feel quite isolated and feel that you’re the only person feeling that way and then when you’re round the table and there's other folk round that table that have had the same problems, you know, and ultimately sometimes that’s even just a support to hear that (Int 15 DN).

Furthermore, there was the potential to reduce worry and anxiety about patients by getting feedback about patients who were a long-standing concern.

we had someone came along from the money advice service for a particular patient that we’ve been struggling with for a long time with housing issues, with benefit issues, with various issues tied up to chronic ill health throughout most of his adult life, and it was great to have them come in and say ‘right well actually I've been working with him, we've found this, we've found that, I've
made contact and the go to person at his housing association is this person, pop that in his notes so that if you ever have an issue in the future...’ That’s been brilliant (Int 6 GP).

**Facilitating factors for positive MDT working**

From observations of meetings with more positive ethos as well as outcomes, a number of factors were identified as facilitators or active mechanisms. These gradually became more obvious over time with an observed improvement in relationships across the sectors:

- Welcoming atmosphere with staff introductions at the beginning
- Encouraging all members to engage in discussion and contribute views
- Being respectful of each others’ views and disciplinary perspectives
- Social workers/SCWs providing advice and reassurance regarding patients even when direct action/referral were not possible
- Being willing to build and maintain relationships and a willingness to learn from other disciplines
- Being adaptive to change and receptive to criticism (see adaptations below)

**Adaptations and improvements**

Over time a number of improvements were made to the format and organisation of MDTs. Firstly, agendas were better planned to allow staff to drop in and out according to relevance. This was also facilitated by preparing and disseminating an agenda and list of patients for discussion in advance of meetings in order to facilitate information gathering prior to the meetings as well as timing of attendance.

*So you need to be, obviously cause they’re really busy people, so you need to organise it so that you’ve got the people that you need to talk to them about perhaps at the one time, cause they obviously don’t have the luxury of coming sitting for a meeting for two hours, that’s been, you know, like trying to make sure that everybody gets their say* (Int 12 PN)

**Challenges**

One senior manager explained how the SHIP MDTs were a work in progress, acknowledging the organisational challenges posed by large meetings including a wide constituency of professionals:

*I think about whether Govan has necessarily found the most efficient way to do that and I think when you always have meetings with a wide membership the task is often about making sure you utilise that most efficiently, and I know Govan has been searching for ways to make the best use of everybody’s time* (Int 18 Stakeholder).

Nursing staff in particular express concerns that they are less involved in the meetings, some stating that they do not have the opportunity to suggest patients for the list in advance of the meeting and there appears to be work to be done to ensure participation across all disciplinary groups. However, there are differences across practices, reflecting perhaps different team relationships between GPs, PNs, DNs, HVs and AHPs. Indeed one GP spoke explicitly about the fact that although the MDT was currently GP-driven, his wish would be that this need not always be the case:

*I could see a situation and I would hope for a situation in the future if an MDT like this works well, where a social worker would bring your patient along and saying ‘we’re seeing this patient,*
they’ve not seen the GP for a while but they have been seeing the district nurse, can we get some feedback from the district nurse?” and actually I have nothing to contribute there, that would be great. That would be the MDT working well, it’d actually be where an interaction happens between health and social care that isn’t GP driven (Int 6 GP).

Time devoted to meetings versus a perceived patient benefit requires to be maximised in order to fully engage all who are invited to the MDT. This poses significant challenges and there is a need for further and more collaborative planning across health, social work/care, third sector and any other professional groups that may have involvement in these meetings.

One further issue that poses a challenge is the issue of sharing information of a confidential nature by accessing social work or general practice electronic databases. This was mainly highlighted by social workers and SCWs and was yet another bone of contention in some MDTs. However, this challenge appears to have been addressed to a certain extent by limiting the amount of information passed on to, for instance, reassuring that a patient was in the system or already allocated to a social worker rather than divulging full details. While some GPs found this frustrating and deemed it unnecessary, nevertheless given legal restrictions on the sharing of personal information, this is one challenge that should be carefully considered, with perhaps the need to work on agreements between sectors about data sharing.

Finally, while important work can be done during these meetings, several participants pointed out that these meetings are only monthly and ‘a lot can happen in a month’. While the time investment suggests that more frequent meetings may not be feasible, perhaps the more extended networks might devise informal, ad hoc arrangements to facilitate more regular cross sector involvement where required (such as the informal cross sector networks already used by some DNs and HVs).
Wider Issues Related To Ship Initiatives

There were some other wider benefits of the SHIP initiatives. One GP suggested that the positive impact of the SHIP initiative had made the practice an attractive prospect to GPs and had facilitated recruitment during a period where practices across Scotland were facing GP shortages. Furthermore, general practice can be regarded as a site for innovation, because of the relative autonomy enjoyed by GPs.

because we are self employed and employ people or staff, you know, we can be quite... you know, we are working in a managed environment but we’ve got more opportunity to be dynamic and think ‘let’s change how we work within those parameters’. Social work I don’t think have got the same liberty (Int 10 GP).

However, some professional groups expressed concerns that GPs were not necessarily the best placed to lead the integration agenda, and that SHIP required a driving leadership that was neutral in terms of the two key sectors/professions. A stakeholder interview revealed that in fact SHIP had initially been led by a project manager within the HSCP, which would have ideally placed them in a neutral managerial role. However this person moved on and another project manager was brought in who, by all accounts ‘did a terrific job’ of picking up the pieces and attempting to rescue what by then may have deteriorated into a difficult situation.

With the impending move towards GP cluster working, the imperative to find management solutions to continuing the SHIP journey become even more pressing. In addition to this, there needs to be a widening of consultation and involvement in planning of services. Currently, only GPs appear to have been involved in cluster planning and development. Concerns were expressed thus:

And we haven’t been [involved] at all and the practice managers have been excluded as well. Now when you’re... you know, the people who run the practice are the practice managers and the practice nurses, the GPs do not run the practices, so I mean, if they want the clusters to be a success they need to be bringing in definitely the practice managers and... And practice nurses (Int 12 PN).

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

Yeah I think the cluster’s the way to go isn’t it, it’s to have like your midwifery clinic in the cluster and your health visitor. I mean, it used to work really well, we used to have the midwife clinic and the health visitor clinic running at the same time so the health visitor got to see the girls that were pregnant and the girls that were pregnant got to see who the health visitor was and everybody knew who everybody was and we all knew who everybody was [laugh], but it’s not like that now (Int 12 PN).

It was also felt that cluster working could facilitate the integration agenda as it would maximise scarce resources and professional capacity. Furthermore, cluster working was regarded as an opportunity to disseminate the learning from SHIP more widely to other GP practices.
I think the fact we’re moving forward to neighbourhoods and communities and clusters model, again that’s ideal for us, we’re not going to be able to send a social worker to every single MDT, so how do we make sure the learning from this event and from our project is shared with the other GPs, how do we build that understanding? And it won’t be any one thing, it’ll be a whole combination of things all coming together to make a difference (Int 11 Stakeholder).
Discussion

While the SHIP project has experienced considerable challenges, ongoing adaptations to various components of the intervention demonstrate benefit from the lessons learnt along the way. This discussion focuses on synthesising our findings, informed by normalisation process theory (NPT). NPT offers an analytical framework to unravel the implementation issues inherent in complex interventions, it: ‘focuses on the social processes and work that people do, individually and collectively, to make an intervention work’ (Bamford et al. 2012: 2). The key components of NPT are as follows:

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

The following sections are structured under the NPT headings, with each section referring to the integration and change management literature that is also presented in summary tables in Appendix 3. Borrowing from the approach used by Bamford and colleagues (2012), the SHIP evidence is synthesised in tabular format with potential strategies for overcoming challenges highlighted as appropriate. These strategies are informed both by the analysis and available evidence. Recommendations informed by the literature are synthesised in Appendix 4.

**Coherence: initial understanding, values, and shared goals**

The cultural dynamics of NHS and Local Authority organisations have been identified as a “major barrier” to integration (Hutchison 2015), and there is evidence that changes in reaction to political agendas are frequently under-researched and undermined by short-termism, restrictive deadlines, and lack of support for building collaboration (Lewis 2001, Williams & Sullivan 2010, Hudson 2015, Drum 2012). Lack of time for organisational development, preparation, training and support can cause initiatives to fail; while unclear distinction between integrated organisations at the strategic level, integrated working (at the level of organisations) and integrated care (at the patient-focused level) is unhelpful (Dickinson & Glasby 2010, Griffiths & Glasby 2015, IRISS 2012, Glasby & Miller 2015, Petch 2012). There has been insufficient research on integration and inter-professional working, despite being a constant theme since the 1970s. Indeed the existing literature highlights a lack of knowledge and skills to achieve integration (Cameron & Lart 2003, Davey et al 2006, Valentijn et al 2015).

Key to the issue of coherence of the SHIP project was that although senior managers from the HSCP and Social Work Department along with the GP partners within GHC had long established planning relationships, the aims did not appear to have been worked through into how the social work and health integration would be implemented. Although the core values and goals were agreed by all, the lack of consultation and involvement across all professional groups led to a variable understanding of what SHIP meant and how it would be implemented.

There seemed to be some variance in understandings of how core values might feed into action, particularly around health inequalities and the Inverse Care Law. All participants recognised, from their practice or management perspectives, the reality of many patients’ lives: premature multimorbidity and widespread psychological problems, exacerbated by deprivation and complex social need. Research
evidence suggests that these factors, resulting in low patient confidence and enablement (O’Brien et al 2011, Mercer & Watt 2007, Mercer et al 2016), are a major barrier to the current strategic aims of improved self-management, lifestyle modification and shared decision-making (Scottish Government: Healthcare Quality Strategy 2010, National Clinical Strategy 2016). In addition, it is asserted that the consequent increase in unmet need impacts primary and social care co-ordination and results in more patients accessing acute care (GPs at the Deep End).

Addressing the Inverse Care Law is a core project aim from the Deep End perspective and that of the practices, particularly the GPs – however, whilst the Strategic Plan commits to supporting primary care approaches to tackling inequalities, addressing the Inverse Care Law (by whichever actions) is not an explicitly stated aim of the HSCP. Whilst improving health outcomes and enablement by targeting care on the most vulnerable were universally shared values, how this would be actioned and what short-term outcomes could be achieved varied in the responses from participants.

It is clear that having more time to address the complex needs of vulnerable patients reduces GP stress and may improve recruitment and retention in deprived practices; and it is likely that longer consultations will support relationship-based care (Scottish Government 2010). As recent research has suggested (Mercer et al 2016), this may also help to prevent decline in patients’ quality of life. Clearly a qualitative study cannot answer whether the extra time is effective in meeting the goals of extra time, but the quantitative data collection that is ongoing within the GHC practices may be able to link data collected on GP extra time with patient outcomes.

Table 4: Coherence of the SHIP aims and goals

<table>
<thead>
<tr>
<th>SHIP Aims and goals</th>
<th>Understanding</th>
<th>Strategies for promoting coherence</th>
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<tbody>
<tr>
<td><strong>Strategic level aims:</strong>&lt;br&gt; To promote integrated health and social care services via the GHC pilot; reduce hospital admissions and demands on GP time spent on social needs, anticipatory care</td>
<td>Differential understanding: GPs, SWs and stakeholders have full understanding; other practice and community staff focusing on integration of social work and general practice.</td>
<td>Involve all staff categories in planning, intervention development and pre-implementation activity.</td>
</tr>
<tr>
<td><strong>Values</strong>&lt;br&gt; Addressing the inverse care law&lt;br&gt; Addressing the complex and health and social needs of GHC population&lt;br&gt; Better working relationships, better understanding</td>
<td>Stakeholders and GPs use this language but the ethos of targeting care at those of most need also understood/valued by other staff.</td>
<td></td>
</tr>
<tr>
<td><strong>Intervention level</strong>&lt;br&gt; SW linked to primary care</td>
<td>All practice staff: rapid referrals/access to SW services; governance of SWs&lt;br&gt; SW: advice, education re eligibility criteria; accountable to SW line management</td>
<td></td>
</tr>
<tr>
<td><strong>SHIP time</strong></td>
<td>Differential understanding: Addressing inverse care law; complex care planning for patient</td>
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Cognitive Participation: engagement and buy in to the intervention

The next stage of pre-project work is that of engaging all of the relevant professional groups in order to encourage ‘buy in’. Evidence from previous studies suggests that this stage of intervention development is crucial, given the challenges identified in the integration project. While practitioners are often supportive of joint working, the default position of managers may be self-interest and turf protection (Williams & Sullivan 2010, IRISS 2012, Ham et al 2013, Cameron et al 2014) and given the budgetary constraints on social work in particular, and potentially behind the scenes protectionist activity instigated by the wider integration agenda, it is unsurprising that ultimately there were mismatched expectations between/across sectors. Professionals may also have high levels of scepticism and protectionism due to fear of losses in the process of policy-driven change (Cameron & Lart 2003) and this may well have been the starting point for social workers entering into GHC, which was clearly led by a group of GPs who were seen to be driving change.

<table>
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<tr>
<th>Mechanisms</th>
<th>Outcomes</th>
<th>Strategies for promoting cognitive participation</th>
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</thead>
<tbody>
<tr>
<td>Initiation</td>
<td>Are key personnel working together to drive the initiative forward?</td>
<td>Shared goals and values ensure that all personnel are engaged from the outset.</td>
</tr>
<tr>
<td>Enrolment</td>
<td>Has engagement been achieved with key personnel?</td>
<td>Consensus building &amp; ownership of shared values, understandings &amp; outcomes is essential at all stages (Rummery &amp; Coleman 2003, Petch 2013).</td>
</tr>
<tr>
<td>Legitimation</td>
<td>Is engagement such that others believe that they can contribute?</td>
<td>Interprofessional training &amp; professional development essential to address poor understanding of others’ roles, stereotypes and culturally reinforced attitudes (Mangan et al. 2015).</td>
</tr>
</tbody>
</table>

All key personnel from senior stakeholders (SW, HSCP) through to frontline SWs, GPs, nursing and AHP staff are on board at the outset.

Initial enthusiasm for SHIP from all staff until they realise that they had misunderstood what would happen in practice.

Differential legitimation: GPs are fully invested and are driving the steering group. Project manager from HSCP has referent authority to manage change. However other categories of practice and community staff are not consulted/involved. SWs are initially involved in the steering group led by the GHC GPs. Engagement and planning at too
### Activation

Is engagement in the project maintained?

| high a level to prepare for implementation |
| Senior stakeholders and GPs continue to be engaged. SWs linked to GHC are removed from the steering group (perhaps a sign of deteriorating relationships). There is a change in project manager (timeline to be explored further) who has potential to act as boundary spanner but change is driven by GP led steering group. Increasing resentment from nursing as initiatives regarded as a time burden with little perceived benefit. |
| Networking between historically hostile professional groups must be facilitated to build relationships (Glasby et al. 2013) |
| ‘Boundary spanner’ in a leadership position has the ability to understand different cultures of working and facilitate positive relationships and networks (Greenhalgh et al. 2004, Williams and Sullivan 2010). |

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### Collective Action: the impact of implementation in practice

Often it is only this phase of complex interventions that is more visible, that is, the implementation activity itself. As the intervention gained traction, the mismatched expectations of the two key sectors led to professional confrontations and rapidly deteriorating relationships. These issues have been noted elsewhere in studies of integration projects (reported in the results) and bear replication. Historically, there has been little understanding or appreciation of each other’s roles (GPs and SWs) and this has not changed in over 40 years (Ratoff 1974, Cameron & Lart 2003). While the literature states that GPs were sceptical about the quality of SW assessment and have little knowledge of SW training or skills (Glasby & Miller 2015, Xyrichis & Lowton 2008, Mangan et al 2015), our data reveal that this attitude persisted across all of the professional groups linked to GHC that were interviewed. However, the literature also suggests negative stereotypes held by SWs persist, regarding GPs as controlling, arrogant, disrespectful and intent on enforcing the ‘medical model’ whilst GPs see SWs as incompetent, unavailable, and ‘all about box-ticking’ (Abramson & Mizrahi 1996, Griffiths & Glasby 2015, Hudson 2015, Mangan et al 2015). The interviews certainly revealed this still to be the case and the project proceeded along a trajectory reported elsewhere, with relationship characterised by impatience, frustration, ‘hostility & antagonism’; ‘distrust and even contempt’ (Williams & Clare 1979, Corney 1985, Cameron et al 2014 ). Finally, another aspect highlighted by the literature is that historically, SWs felt that GPs did not recognise that SWs had pre-existing professional networks with Health Visitors, District Nurses, Midwives and so on (Hudson et al 1997, Mangan et al 2015). This also proved to be the case here.

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### Mechanisms Impact Strategies for promoting collective action

<p>| Interactional workability: Shared goals and expectations about the form of work, roles of participants, rules of conduct, beliefs about meaning of work, shared |
| Different expectations about the form of social work (attachment/liaison) Varying goals - social workers aimed to clarify, share info and advise, GPs wanted them to react by accessing services or providing assessments, community nurses wanted a closer working relationship with social workers, joint planning etc. |
| Attention to joint CPD/shared learning would help to ensure all share realistic expectations of what can be achieved. |
| Joint learning must emphasise different philosophies of care; achieve a shared understanding of |</p>
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<tr>
<th>Mechanisms</th>
<th>Impacts</th>
<th>Strategies for promoting collective action</th>
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<tbody>
<tr>
<td>expectations about outcomes</td>
<td>Different philosophies of care: social workers feel their role is to identify strengths and promote independence (partic in adult work) whilst HPs believed SW role is to prevent risk.</td>
<td>risk, vulnerability and capacity; limitations on service access and eligibility criteria.</td>
</tr>
<tr>
<td></td>
<td>Different expectations of behaviour – HPs and practice staff expected SWs to actively engage with them and become part of the practice; SWs expected to attend MDTs and that practice or NHS staff would consult them if necessary.</td>
<td>Mutual respect is vital to effective integration, this may be fostered by joint learning sessions where all contributors are equally valued.</td>
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<td></td>
<td>GPs and nurses wanted informal discussions; SWs avoided informal contact &amp; wanted formal meetings.</td>
<td>SWs/SCWs require more autonomy to deliver ‘enabling’ social work practice.</td>
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<td></td>
<td>Different beliefs about legitimacy of MDT – GPs feel they are essential focus for anticipatory planning; nurses felt they were generally not relevant to their practice.</td>
<td>MDTs require careful planning and organisation in order to reduce time burden, demonstrate relevance and ensure that engagement is maintained across all roles/sectors.</td>
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<td></td>
<td>Different meanings of SW priorities between SW practitioners and senior mgmt. – values &amp; practice issues vs ‘budgets and boundaries’ SCWs seem to share HP expectations about early intervention, direct support, active navigation of SW system, patient focus, direct referral. Also seem to share beliefs about what are legitimate referrals. SWs/team leaders disagreed that their role should include joint working, felt this was a luxury; SCWs felt joint working with DN and HV was essential.</td>
<td>SWs/SCWs can demonstrate collegiality and willingness to help by advising on the information necessary to achieve relevant referrals.</td>
</tr>
<tr>
<td>Relational integration: credibility of practice within the network</td>
<td>GPs, PNs, PMs unaware of SW knowledge or expertise or how they were using it. Lack of mutual respect between SWs and HPs for assessment of risk and vulnerability. SW dept felt the project required very experienced qualified workers who could use their experience to articulate and educate re SW roles, practices wanted workers who could navigate and explain the system, address vulnerabilities not yet eligible for SW intervention, say ‘how can we help?’ SCW knowledge and contribution fits this expectation much more closely. Over time, (and increasingly) MDTs appear to demonstrate agreement about the expertise and usefulness of participants, accept practice as valid and create a collegiate environment (although not the case earlier).</td>
<td>Shared information across sectors can also reduce staff anxiety and improve relationships.</td>
</tr>
<tr>
<td>Agreement about knowledge required, expertise and contribution of participants, what practice is valid, useful, authoritative</td>
<td>Agreement was reached pre-project but without clear understanding.</td>
<td>Leadership should be driven by an individual without vested interest in either professional group/sector where possible. The ‘boundary spanner’ should be given the power to drive implementation processes.</td>
</tr>
<tr>
<td>Skill set workability: definition of agents and tasks &amp; ability to deploy</td>
<td></td>
<td>Care should be taken to demonstrate benefit for both key sectors and to all personnel.</td>
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<tr>
<td></td>
<td></td>
<td>Patient-centred care should be emphasised as a shared value and goal at every opportunity.</td>
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<tr>
<td>Mechanisms</td>
<td>Impacts</td>
<td>Strategies for promoting collective action</td>
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<td>--------------------------------------------</td>
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<tr>
<td>Agreement about allocation of tasks and resources, hierarchies,</td>
<td>No agreement between GPs, SWs and other HPs about either nature of SW tasks or whether these could/should be allocated by MDTs, taken on by SWs at MDTs or allocation reserved to SW managers.</td>
<td></td>
</tr>
<tr>
<td>definition of skill sets, autonomy of agents, quality of skills</td>
<td>Different levels of autonomy between participants; SWs and nurses have insufficient autonomy to be full partners. SCWs seem to have more autonomy than SWs. Skill sets of SWs/SCWs not clear to project. Skills/expertise (eg around workstreams, MDT working) not recognised or shared. Project manager not given due authority to act as boundary spanner and drive change.</td>
<td></td>
</tr>
<tr>
<td>Contextual integration: control over resources and agents</td>
<td>Resources seen (by nurses particularly) to be allocated mainly to GP partners Different sources of authority – GPs, SW managers, community health managers Disagreement about who should have control. Project manager had only referent authority. SW dept/SWs had greater risk as more exposed to public scrutiny/misunderstanding, less well resourced, more uncertain about place in integrated services. Little advantage to SW dept Nurses felt little advantage to them GPs seen as main beneficiaries; some HP acknowledgement of patient benefit.</td>
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Reflexive Monitoring: looking back at the experience of implementation

In this section we explore the capacity to reflect, adapt and learn from the SHIP project thus far. Rather than set this in tabular format as above, we instead report under the NPT headings: systemmatization, communal appraisal, individual appraisal and reconfiguration.

Systematization

This item concerns how those involved in an intervention determine impact through data collection. At the whole project level, the commissioning of this qualitative evaluation demonstrates a willingness for independent scrutiny and it is hoped that this document will promote further reflexive monitoring across the community involved in the SHIP project. At the GHC level, data collection instruments/processes have been implemented in order to measure quantitative outcomes and this is ongoing. Thus the project will benefit from learning and reflection regarding key outcomes achieved in future. This evaluation may contribute towards understanding some of those outcomes within the context in which they are achieved.

Communal and individual appraisal

Communal reflection and appraisal appear to have been confined to the community of GPs and stakeholders within the HSCP, academic general practice and the social work department. Interviews with these participants revealed a sea change over the course of the project indicating a change in knowledge, attitudes and behaviours that bode well for future integrated working within the GHC. However, the learning that has driven this positive change has again involved the capacity to reach out to senior managers across sectors and to benefit from the ability to have an impact on the direction of travel. Unfortunately, many of the other staff linked to the GHC adhere to negative attitudes towards SW and feel increasingly frustrated and disempowered by an intervention that affected them as individuals but over which they had little or no ability to change. Team leaders in SW are the exception to this, as they appear to have maintained a commitment and positive attitude towards the project and continue to play an important role in generating improved relationships.

Reconfiguration

This aspect of SHIP demonstrates the dynamic nature of the remaining SWs involved and the GPs in three of the four practices who remained engaged in the intervention. Adaptations have been made to MDTs to reduce the time burden on attendees and there are indications that they may eventually become more collaborative in organisation and leadership rather than remaining solely GP led. This may help to maintain or revitalise engagement across all professional groups. The introduction of SCWs also highlights a positive response to an initially ‘bruising’ encounter between SW and general practice and there are early indications that many of the initial (misguided) expectations of SWs may now be met by SCWs. The caveat remains that access to services will still require meeting eligibility criteria, although it is clear that GPs at least now understand the pressure on services and the thresholds for access to these. Shared learning has also taken place to ensure improved quality of information provided in SW referral requests and time will, it is hoped, no longer be wasted by poor information provision or an lack of understanding of risk thresholds. Unfortunately, it appears that this learning has not been shared more widely, and although there have indeed been some positive examples of collaborative working between SWs/SCWs and other HPs within
GHC, nevertheless work remains to be done to undo negative perceptions, disappointments and frustrations experienced by other staff during the course of SW integration.

**Strategies for promoting reflective monitoring**

Shared learning events and dissemination (highlighted in several sections above) may help to address remaining tensions and negative experiences.

Efforts should be made to involve all categories of staff in consultations and planning going forward in order to maximise learning from other professional integrated networks such as those pre-existing among nursing staff and SW/SCWs.
Study limitations
While this evaluation has taken a multi-strategy approach to exploring the implementation of the SHIP project, as a qualitative study it can only present data on implementation views and experiences. While qualitative methods are ideally suited to achieving an understanding of the finer nuances and processes inherent in a complex intervention, they cannot provide an answer to the question of effectiveness, which is better suited to randomised controlled study designs. Furthermore, the evaluation was commissioned when the initial SWs were ending their involvement in GHC therefore we were mainly informed by retrospective accounts, some of which remained coloured by negative experiences and emotions. The analysis has paid careful attention to variations in views and experiences, thus we urge caution in attributing views of one health care professional to all who share that role as indeed has this report. Finally, this report does not benefit from the views of those who might benefit most from the SHIP project, namely, GHC patients. This limitation will be addressed in the time remaining to the evaluation team.

Conclusions
This report has drawn on qualitative methods to explore the implementation of the SHIP project implemented in the GHC. The SHIP project has met with considerable challenges posed by bringing together two formally distinct sectors. Boundary maintenance and protectionism underly much of the tensions experienced here and elsewhere in integration projects and the members of the SHIP team are to be congratulated from moving from a position of negative, entrenched views and hostility towards a shared understanding and new learning. However, as highlighted above, more needs to be done to engage a wider constituency of professionals in SHIP project implementation in order to maximise benefit from the wide range of expertise and experience within health, social work and third sector organisations. Ultimately, SHIP began with an ethos shared and valued by all: to develop new ways of working to address the complex health and social needs of the GHC population. With time, it is hoped that a further iteration of the NPT cycle reported above, might reveal a reflexive monitoring where all constituents remain engaged, invested and full contributors of the SHIP integration model.

Acknowledgements
The project team would like to thank all of those involved in the SHIP project who gave generously of their time to this evaluation. Particular thanks is due to Vince McGarry for support, encouragement and feedback throughout.
References


Cameron A, Bostock L & Lart R (2014), Service user and carers perspectives of joint and integrated working between health and social care, *Journal of Integrated Care*, 22. 2: 62 - 70


Drumm M (IRISS) (2012) *Culture change in the public sector*, IRISS Insights No 17

Elston S & Holloway I (2001), The impact of recent primary care reforms in the UK on interprofessional working in primary care centres, *Journal of Interprofessional Care*, 15:1, 19-27, DOI: 10.1080/13561820020022846


General Practitioners at the Deep End (2009), Report 1: *General Practitioners at the Deep End: Final report of a special meeting held on 16 September 2009*, University of Glasgow
http://www.gla.ac.uk/media/media_430491_en.pdf (accessed 3.04.16)

General Practitioners at the Deep End (2012), Report 18: *Integrated Care*, University of Glasgow,
http://www.gla.ac.uk/media/media_238713_en.pdf (accessed 3.04.16)


Lymbery M (1998), Social Work in General Practice: Dilemmas and Solutions, *Journal of Interprofessional Care*, 12, 2: 199-208


Petch A (IRISS) (2011) *An Evidence base for the Delivery of Adult Services*, Institute for Research and Innovation in Social Services


### Appendix 1: Cross case comparison of interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Green</th>
<th>David Elder</th>
<th>Blue</th>
<th>Yellow</th>
<th>Comments</th>
</tr>
</thead>
</table>
| **Additional GP time** | 4 SHIP sessions : 1 shared session to facilitate MDT attendance  
Some SHIP time used to keep 2 slots per surgery for ‘breathing space’ or unplanned longer consultations, home visits  
Double appts for patients with multimorbidity  
Physical space constraints impact on practice | 4 SHIP sessions  
1 per GP partner  
Home visits  
Case review/conferences  
Follow up on social prescribing  
Some physical space constraints | 4 SHIP sessions  
1 per GP partner + 1 additional session shared by 2 GPs  
Text reminder system reduces DNA  
Home visits  
Case review/conferences  
Follow up on social prescribing | Not participating at present – seeking locum | Positively regarded by practice staff  
Increased GP capacity evidenced, felt to have improved patient outcomes/reduced crisis appts/ improved links with external agencies  
Strong relationships with GP trainees = familiar & reliable locums with investment in SHIP |
| **MDT meetings** | GP partners attend  
DN attends  
PN attends some meetings  
HV attendance impacted by staffing shortage  
External workers attending (Rehab OT)  
CF SW & Adult SW TL attend  
SWs have laptops: CareFirst  
CLP attends  
EMIS available on MDT pc - GP shares with MDT & records discussion  
Sept 2016: SCWs attending in place of SWs  
Admin: HSCP | GP partners attend  
GP trainees attend  
DNs attend  
PN attends  
HV attendance impacted by staffing shortage  
External workers attending (Pall Care Nurse, CFSW)  
CF SW & Adult SW TL attends  
SWs have laptops: CareFirst  
CLP attends  
EMIS on large screen  
Lunch/refreshments provided  
Sept 2016: SCWs attending in place of SWs  
Admin: HSCP | GP partners attend  
PN does not attend  
DNs attend but attendance variable due to staffing issues  
HV attendance impacted by staffing shortage  
External workers attending (Community Staff Nurse, Rehab OT)  
SW attendance variable  
EMIS not on screen  
Sept 2016; Rehab OT attending  
SCWs or other SWs attending in place of SWs  
Admin: HSCP | Not participating at present | MDT meetings observed to vary in terms of attendance, duration, external workers.  
Attendance observed to be increasing for all practices  
Observation was limited to 2 MDT meetings for each practice |
<table>
<thead>
<tr>
<th>Intervention</th>
<th>Green</th>
<th>David Elder</th>
<th>Blue</th>
<th>Yellow</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social workers</td>
<td>Elderpark Clinic Mon &amp; Fri</td>
<td>Elderpark Clinic Mon &amp; Fri</td>
<td>Elderpark Clinic Mon &amp; Fri</td>
<td>Not participating at present – not holding MDT meetings as no locum.</td>
<td></td>
</tr>
<tr>
<td>Adults/elderly</td>
<td>Attend MDT meeting</td>
<td>Attend MDT meeting</td>
<td>Attend MDT meeting</td>
<td>SWs not involved in other ways</td>
<td></td>
</tr>
<tr>
<td>1 WTE</td>
<td>Very low practice profile</td>
<td>Very low practice profile</td>
<td>Very low practice profile</td>
<td>Widely seen as an unsuccessful initiative by practice staff/HPs</td>
<td></td>
</tr>
<tr>
<td>Adult SW remit limited by eligibility criteria</td>
<td>Adult SW remit limited by eligibility criteria</td>
<td>Adult SW remit limited by eligibility criteria</td>
<td>Viewed as more successful by SW staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CF SW undertaking some limited preventive work</td>
<td>CF SW undertaking some limited preventive work</td>
<td>CF SW undertaking some limited preventive work</td>
<td>Some GPs felt it had limited success</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some joint working CFSW/CLP</td>
<td>Some joint working CFSW/CLP</td>
<td>Some joint working CFSW/CLP</td>
<td>Some communication issues around language, attitudes to risk, understanding/acceptance of roles</td>
<td></td>
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<tr>
<td>Sept 2016: SW co-location discontinued, replaced by SCWs</td>
<td>Sept 2016: SW co-location discontinued, replaced by SCWs</td>
<td>Sept 2016: SW co-location discontinued, replaced by SCWs</td>
<td>Sept 2016: Some of above issues resolved, issue of consent to share information ongoing</td>
<td></td>
<td></td>
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</tbody>
</table>

<p>| Social care workers | Elderpark clinic Mon &amp; Fri | Elderpark clinic Mon &amp; Fri | Elderpark clinic Mon &amp; Fri | No - not holding MDT meetings as no locum. SCWs not involved in other ways |
| Adults/elderly      | Attend MDT meeting | Attend MDT meeting | Attend MDT meeting | Both very experienced |
| 0.25 WTE             | Remit to share CareFirst &amp; some direct support work | Remit to share CareFirst &amp; some direct support work | Remit to share CareFirst &amp; some direct support work | Appears more scope for preventive or supportive work with patients |
| CF 0.5 WTE           | Sept 2016: | Sept 2016: | Sept 2016: | Appeared keen to build relationships with practice, community health &amp; Links workers |
|                      | | | | |
| Some joint working SCW/CLP | Some joint working SCW/CLP | Some joint working SCW/CLP | | |
| Links worker attached? | Yes | Yes | No | Highly regarded by clinicians |
|                      | Attends MDT meeting | Attends MDT meeting | | Practices report increased knowledge of local resources |
|                      | Based in practice | Based in practice | | |
|                      | Strong identification with practice | Strong identification with practice | | |
|                      | No | No | | |</p>
<table>
<thead>
<tr>
<th>Intervention</th>
<th>Green</th>
<th>David Elder</th>
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<th>Yellow</th>
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<tr>
<td></td>
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<td>CLPs having to take on complex case management roles Yellow Practice was keen to have CLP</td>
</tr>
</tbody>
</table>
## Appendix 2: Key points from the General Practice and Social Work Integration Literature

<table>
<thead>
<tr>
<th>Themes</th>
<th>Summary</th>
<th>Source</th>
</tr>
</thead>
</table>
| **CULTURAL/PROFESSIONAL**     | **Philosophies of Care; Aims & values**  
Professional training & identity shapes philosophy of care. Professional identity reinforced by tacit or implicit knowledge which confers power but excludes others  
Medical training emphasises personal competence, accountability & decisiveness; a curative approach. SW training emphasises exploratory assessment, identification of strengths, enablement of choice & rights.  
Rescue v empowerment: very different attitudes to risk and urgency. GPs tend to seek immediate response & elimination of risk (eg residential care for a frail patient); SWs tend to aim for management of an acceptable level of risk in order to facilitate patient choice (eg remaining at home in a less than ideal environment)  
| **Understanding of roles; attitudes** | Little understanding or appreciation of the other’s role on either side, & no change in this position over 40 years  
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’  
Relationship characterised by impatience, frustration, ‘hostility & antagonism’; ‘distrust and even contempt’  
SWs felt GPs do not recognise they have established professional networks already – with Health Visitors, District Nurses, Midwives etc  
GPs see SW role as accessing resources; SWs in 1980s described their role as therapeutic, by 2000 SWs reporting role as ‘assessment’  
<p>| <strong>Status &amp; autonomy</strong>         | GPs’ professional status established &amp; unchallenged. SWs’ professional status threatened due to managerial control; lack of autonomy reduces the ability to develop new networks &amp; ways of working                                                                                                                                                                                                                           | Hudson et al 2002, Johnson et al 2003, Kharicha et al 2005, Lymbery 2006 |</p>
<table>
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<tr>
<th>Themes</th>
<th>Summary</th>
<th>Source</th>
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<tbody>
<tr>
<td><strong>SWs’ low status attributed to working with poor &amp; socially excluded groups</strong></td>
<td>GPs seen as ‘drivers of spend’ – essential partners in integration – so continue to have high status and power but nevertheless feel under attack and overworked. GPs see themselves as leaders &amp; are seen that way by others; Nurses felt less able to speak up, particularly when employed in Practices.</td>
<td>Lewis 2001, Leutz 2006, Hutchison 2015, Elston &amp; Holloway 2001, Xyrichis &amp; Lowton 2008</td>
</tr>
<tr>
<td><strong>ORGANISATIONAL</strong></td>
<td><strong>Budget disparities</strong></td>
<td>Funding disparity between Health and Social Care continues to be a barrier to collaboration; constant restructuring &amp; service cuts entrench negative &amp; fearful attitudes. Means-testing, charging &amp; eligibility introduced in Social Work/Social Care in 1980s and has become increasingly constrained, resulting in resources being reserved for those in critical or substantial need only; preventive work difficult or impossible in adult services. Social work management fear of cost-shifting (in frail elderly care) or losing their budget to the competing organisation, caused resistance to, or even sabotage of, collaborations with ‘Health’.</td>
</tr>
<tr>
<td><strong>POLITICAL/STRUCTURAL</strong></td>
<td>While Primary Care continues to be generalist, generalist Social Work was phased out in the 1980s in favour of ‘client groups’ and specialisation; incompatible with General Practice. The NHS &amp; Community Care Act 1990 introduced a care management model in Social Service departments, replacing social casework with technical tasks, standardised assessment procedures &amp; routine care plans, discouraging creativity &amp; discretion.</td>
<td>Hudson et al 1997, 2002, Kharicha et al 2004, Lymerby 2006</td>
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<tr>
<td>Themes</td>
<td>Summary</td>
<td>Source</td>
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| Quasi-market model introduced by the 1990 Act required SW departments to outsource social care, resulting in fragmentation and SW having an ‘enablement’ & signposting rather than direct support role | Joint Futures (in England, NHS Plan 2000) & similar initiatives have had little positive impact on interprofessional relationships due to continued budget conflicts particularly in area of chronic conditions & frail elderly, outsourcing of ‘traditional’ SW to the growing Third Sector & disempowerment of practitioners and MDTs, preventing innovation | Lewis 2001
Johnson et al 2003
Glasby et al 2013
Johnson et al 2003
Glasby et al 2013
Cameron & Lart 2003
Glasby et al 2013
Valentijn et al 2015 |
| Insufficient research on interprofessional relationships in general & GP/SW relationship in particular | | |
## Appendix 3: Key Points in Health & Social Care Integration and Change Management Literature

<table>
<thead>
<tr>
<th>Key Points</th>
<th>Summary</th>
<th>Source</th>
</tr>
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<tbody>
<tr>
<td>Organisational &amp; professional cultural barriers are a significant problem, but can be addressed by skilled &amp; transparent collaboration leadership</td>
<td>Cultural dynamics of NHS and Local Authority organisations are a “major barrier” to integration</td>
<td>Hutchison 2015</td>
</tr>
<tr>
<td></td>
<td>Existing social and professional networks influence attitudes to change &amp; should be valued</td>
<td>Greenhalgh et al 2004, Cameron &amp; Lart 2003</td>
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<td></td>
<td>Professionals have high levels of scepticism and protectionism due to fear of losses in process of policy-driven change</td>
<td>Cameron et al 2014</td>
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<td></td>
<td>Consensus building &amp; ownership of shared values, understandings &amp; outcomes is essential at all stages</td>
<td>Rummery &amp; Coleman 2003, Petch 2012, Mangan et al 2015</td>
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<td></td>
<td>Practitioners often keen on joint working, but default position of managers may be self-interest &amp; turf protection; bureaucratic management models are often unsupportive of change</td>
<td>Wiliams &amp; Sullivan 2010, Drumm 2012</td>
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<td></td>
<td>Interprofessional working most effective when professionals retain clear roles but “put on the team jersey” in the MDT</td>
<td>Hubbard &amp; Themessl-Huber 2006</td>
</tr>
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<td></td>
<td>Requirement for leaders to be honest, flexible &amp; transparent in engaging with their staff &amp; counterparts.</td>
<td>Hutchison 2015, Iriss 2013</td>
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<tr>
<td>Change as a reaction to political agendas, with “delivery deadlines”, can be detrimental to outcomes</td>
<td>Change in reaction to political agendas are frequently under-researched &amp; undermined by short-termism, deadlines &amp; lack of support for building collaboration</td>
<td>Lewis 2001, Williams &amp; Sullivan 2010, Hudson 2015, Drum 2012</td>
</tr>
<tr>
<td></td>
<td>Unclear distinction between integrated organisations (strategic), integrated working (organisational) &amp; integrated care (patient-focused) is unhelpful</td>
<td>Hubbard &amp; Themessl-Huber 2006, IRISS 2012</td>
</tr>
<tr>
<td></td>
<td>Insufficient research on integration &amp; interprofessional working, despite being a constant theme since the 1970s, means the knowledge &amp; skills to achieve integration are lacking</td>
<td>Williams 2012</td>
</tr>
<tr>
<td>Change is emergent; new knowledge can be synthesised &amp; new networks &amp; processes can be constructed; MDT</td>
<td>Integration in complex systems takes time, and can only work through continued practice, experimentation and reflection</td>
<td>Hubbard &amp; Themessl-Huber 2006, IRISS 2012, Williams 2012</td>
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<td></td>
<td>Sense-making is a central activity in all organisations &amp; is retrospective</td>
<td>Checkland 2007</td>
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<tr>
<td></td>
<td>Synergistic outcomes may include new networks &amp; processes which build social capital for both project &amp; participants</td>
<td>Williams &amp; Sullivan 2010</td>
</tr>
<tr>
<td>Key Points</td>
<td>Summary</td>
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<tr>
<td>working can become part of a new professional identity</td>
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<tr>
<td>Integration is more successful if practitioner-led</td>
<td>Horizontal networks more likely to implement change &amp; necessary for effective collaboration; hierarchies are a barrier to change&lt;br&gt;Integration is more successful when operational decision-making is devolved to practitioners or MDTs&lt;br&gt;Lack of practitioner autonomy in Social Work perceived as a barrier to integration&lt;br&gt;Most effective collaborations are between equal networks of autonomous practitioners; empowering participants with less power in the MDT (eg nurses &amp; social workers) is likely to produce more effective integration&lt;br&gt;Top-down, policy-driven imposition of change may result in resentment and unwillingness to share tacit knowledge</td>
<td>Greenhalgh et al 2004, Johnson et al 2003, Bliss et al 2010&lt;br&gt;Greenhalgh et al 2004&lt;br&gt;Hudson et al 2002, Johnson et al 2003, Lymbery et al 2006&lt;br&gt;Hudson et al 1997, Lymbery 1998, Leutz 2006, Bliss et al 2000.&lt;br&gt;Williams &amp; Sullivan 2010&lt;br&gt;Dickinson &amp; Glasby 2010&lt;br&gt;Ahlgren &amp; Axelsson 2011</td>
</tr>
<tr>
<td>Relational mechanisms are key to effective integration</td>
<td>Relationships more important than structure &amp; function&lt;br&gt;Engagement &amp; communication with all relevant stakeholders necessary from an early stage&lt;br&gt;Historical relationships influence attitude to change; Empathy, humility &amp; respect necessary to improve historically difficult relationships&lt;br&gt;Trust essential for sharing of tacit knowledge necessary for interprofessional working&lt;br&gt;Informal networks support relationships crucial to integration&lt;br&gt;Networking between historically hostile professional groups must be facilitated to build relationships</td>
<td>Valentijn et al 2015, Williams &amp; Sullivan 2010&lt;br&gt;Rummery &amp; Coleman 2003&lt;br&gt;Petch 2011&lt;br&gt;Petch 2012, Drumm 2012&lt;br&gt;IRISS 2013&lt;br&gt;Mangan et al 2014&lt;br&gt;Hutchison 2015&lt;br&gt;Williams 2012&lt;br&gt;Glasby et al 2013&lt;br&gt;Glasby et al 2013</td>
</tr>
</tbody>
</table>
Appendix 4: Recommendations from literature on integration of health & social care & relations between general practice & social work 1974-2015: Structure & Agency

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Source</th>
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<tbody>
<tr>
<td><strong>STRUCTURE</strong></td>
<td></td>
</tr>
<tr>
<td>Adaptivity &amp; flexibility in organisational structures</td>
<td>Greenhalgh et al 2004</td>
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<tr>
<td>New primary care focused social work teams aligned with GP clusters</td>
<td>Mangan et al 2014</td>
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<td></td>
<td>Lotinga 2015</td>
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<tr>
<td>Workers with linking role between medical and social care</td>
<td>Leutz 2005</td>
</tr>
<tr>
<td>Sufficient development capacity, particularly around organisational cultures, trust and attitude</td>
<td>Williams &amp; Sullivan 2010</td>
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<td></td>
<td>Petch 2011</td>
</tr>
<tr>
<td>MDTs with control of resources</td>
<td>Johnson et al 2003</td>
</tr>
<tr>
<td>Support for existing horizontal networks</td>
<td>Hudson et al 1997</td>
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<tr>
<td></td>
<td>Bliss 2000</td>
</tr>
<tr>
<td></td>
<td>Cameron &amp; Lart 2003</td>
</tr>
<tr>
<td></td>
<td>Greenhalgh et al 2004</td>
</tr>
<tr>
<td>Time to learn by doing and synthesise knowledge</td>
<td>Hubbard &amp; Themessl-Huber 2005</td>
</tr>
<tr>
<td></td>
<td>Williams &amp; Sullivan 2010</td>
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<tr>
<td></td>
<td>Williams 2012</td>
</tr>
<tr>
<td><strong>AGENCY</strong></td>
<td></td>
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<tr>
<td>Co-location</td>
<td>Williams &amp; Sullivan 2010</td>
</tr>
<tr>
<td>Interprofessional differences should be addressed at planning stage</td>
<td>Rummery &amp; Coleman 2003</td>
</tr>
<tr>
<td>Support continuous experimentation and reflection to facilitate learning</td>
<td>Williams &amp; Sullivan 2010</td>
</tr>
<tr>
<td></td>
<td>Williams 2012</td>
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<tr>
<td>Shared training &amp; interprofessional development</td>
<td>Ratoff 1974</td>
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<td></td>
<td>Corney 1985</td>
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<td></td>
<td>Elston &amp; Holloway 2001</td>
</tr>
<tr>
<td></td>
<td>Cameron &amp; Lart 2003</td>
</tr>
<tr>
<td>Conscious team building (&amp; resources to do this)</td>
<td>Lymbery 1998</td>
</tr>
<tr>
<td></td>
<td>Cameron &amp; Lart 2003</td>
</tr>
<tr>
<td>Empowerment: Social workers/nurses need more autonomy to vary practice to suit primary care setting</td>
<td>Lymbery 1998</td>
</tr>
<tr>
<td></td>
<td>Leutz 2005</td>
</tr>
<tr>
<td>Empathy and humility on both sides</td>
<td>Mangan et al 2014</td>
</tr>
<tr>
<td>Collaboration leadership - “boundary spanners” – individuals in leadership positions with the ability to understand multiple cultures and create relationships and connections</td>
<td>Greenhalgh et al 2004</td>
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<td>Williams &amp; Sullivan 2010</td>
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The Govan SHIP Project
(Social & Health Integration Partnership)

Appendix to the main report

APPENDIX F - EVALUATION OF THE IMPACT OF PHARMACIST POLYPHARMACY REVIEWS WITHIN THE GOVAN SOCIAL AND HEALTHCARE INTEGRATION PARTNERSHIP (SHIP) PROJECT
Evaluation of the impact of pharmacist polypharmacy reviews within the Govan Social and Healthcare Integration Partnership (SHIP) project

Abstract

Introduction: There is a rise in multimorbidity within frail and ageing populations, which can naturally lead to an increase in polypharmacy. Local and national guidelines, such as National Institute for Health and Care Excellence guidance and Realistic Prescribing Scottish Polypharmacy guidance, recommend that patients at risk of inappropriate polypharmacy should be identified for review. However, owing to low levels of patient engagement in deprived areas and stringent thresholds used to define polypharmacy, a large population of patients may be excluded from pharmacy review.

Aim: The Govan Social and Healthcare Integration Partnership (SHIP) project aimed to provide multidisciplinary care to patients in one of the most deprived areas in Glasgow, Scotland, in an attempt to reduce the health inequality gap. Pharmacist polypharmacy reviews were developed to provide pharmaceutical care for patients enrolled in the SHIP project, which included a consultation with a pharmacist independent prescriber to reach a joint informed decision and formulate an individualised pharmaceutical care plan. While the project ran from 2015–2018, pharmacist involvement commenced in January 2018 and ended in August 2018.

Method: Patients were referred for pharmacy review by healthcare professionals from four participating general practices in Govan, based on the referrer’s clinical judgement and not a predefined criteria. Desktop medicine reviews were performed for all SHIP patients and appointments made for polypharmacy review based on pharmaceutical needs (n=151). Changes in medicine were discussed between the pharmacist and the patient, after which the GP and the multidisciplinary team (MDT) were informed of the outcome of the review, either directly if urgent or at monthly MDT meetings. The project team continuously collected intervention data and gathered feedback from members of the MDT.

Results and conclusions: Pharmacist medication reviews were effective, with positive feedback received from patients and members of the MDT. Deprescribing and inhaler counselling were the most common interventions. The team behind the project concluded that this comprehensive method of identifying patients for pharmacy review can be transferred to any location, and should be modified to include further follow up and evaluation.

Key words: Complex medication review, deprescribing, frailty, inhaler review,
medication review, medicine review, multidisciplinary team integration, pharmacist, polypharmacy review, social prescribing

Original submitted: 26 June 2019; Revised submitted: 30 August 2019; Accepted for publication: 5 November 2019; Published online: 12 May 2020; doi: 10.1211/PJ.2020.20207920

The Social and Healthcare Integration Partnership project created opportunities to provide pharmaceutical care for patients with inappropriate polypharmacy, who would otherwise have not received significant input.

Pictured: study author Rizwan Din with a patient

**Key points**

- Pharmacists are integral members of the multidisciplinary team (MDT), bringing with them a unique clinical skillset as medicines experts;
- Pharmacist polypharmacy reviews are valuable to all patients, especially for those with complex healthcare needs. In this group of patients, GPs normally spend a large amounts of time with medicine-related issues that could be dealt with by a pharmacist;
- MDT cross-referral and social prescribing can reduce GP burden;
- Many of the older, frail patients who took part in the study took a large number of medicines, many of which are no longer indicated and/or causing adverse effects; therefore, deprescribing was a significant intervention;
- Polypharmacy reviews are cost-effective, not only owing to immediate interventions such as deprescribing and medicines optimisation, but also owing to the downstream effects these reviews can have, such as reduced falls and fracture risk following the deprescribing of anticholinergics and proton pump inhibitors.
Introduction

Polypharmacy can be appropriate and beneficial for a wide range of patients, but inappropriate polypharmacy can emerge owing to several reasons, including increasing age, frailty, multimorbidity, complex medication regimens, declining kidney and/or liver function, drug–drug interactions and drug–disease interactions[1].

In primary care, pharmacist contributions to the care of the most complex patients can be varied, which is often dependent on the perceived need for a holistic polypharmacy review.

Some patients in the community remain unidentified by data examined using the Scottish Patients at Risk of Readmission and Admission (SPARRA) risk prediction tool and as a result are often omitted from cases assigned for additional pharmacy review[2][3].

Complex patients, with multimorbidity and polypharmacy, are regularly in contact with their GP and out-of-hours healthcare services owing to frequent, acute presentations. However, this means that there are few opportunities for a polypharmacy review while the patient is well, resulting in little or no input from pharmacy services.

There are more than 8.6 million unplanned hospital admissions in Europe each year owing to adverse drug reactions, up to 50% of which could have been avoided. Those who take five or more medicines and patients aged over 65 years are the most affected[1]. Each disease has national and local guidelines outlining optimal management and best practice, but there is no distinct guide on how to treat multiple morbidities and complex medication regimens[4]. There is evidence suggesting that patients living in deprived areas are more likely to become frail 10–15 years earlier than patients in less deprived areas, which poses a risk of inappropriate polypharmacy because these patients are more likely to take medicines from a younger age[1][5].

With an increasing rate of frail and older patients with complex multimorbidities and poor engagement with healthcare services, socio-economically deprived communities display the classic characteristics depicting Julian Tudor Hart’s ‘inverse care law’, which suggests that those who most need medical care are least likely to receive it, while those with least need of healthcare tend to use health services more (and more effectively)[6].

Govan — a district of Glasgow — is one of the most socio-economically deprived areas in Scotland, with a diverse population of over 29,000 people served by six GP practices[7]. All GP practices in Govan are among the 100 ‘Deep End Practices’ serving the most deprived communities of Scotland[8]. It is recognised that these practices lack the time, links to other services, and NHS support that is needed to prevent and reduce inequalities in health[9].

The Govan Social and Healthcare Integration Partnership (SHIP) project, supported by the Scottish government’s ‘primary care transformation fund’, commenced in 2015 and aimed to develop new ways of working between general practice and social care services to provide seamless patient care. The SHIP project was conceptualised by teams from four GP practices in Govan, which then went on to pilot the project. The two remaining Govan GP practices were not involved owing to financial and logistics constraints.

The SHIP project was developed to promote shared working among the practice’s local primary care healthcare team — a multidisciplinary team (MDT) of healthcare and social work professionals. It was envisaged that greater horizontal and multi-agency referral would enhance continuity of care and provide both supportive and preventative measures. More regular and consistent referrals would, in turn, ensure that the most appropriate professional responded to patient needs at the most appropriate time[9].
When each patient was identified for inclusion within the project, the project team sought verbal consent and referred each participant to a patient information notice (see Supplementary file: ‘Appendix – The Govan SHIP Project’), which was available on each GP practice’s notice board. The notice contained essential information about the project, including who was involved as well as confidentiality information. Patients were invited to ask the practice manager or project manager for further information where required.

The SHIP project used a person-centred approach to identify patients based on individual needs and within the four GP practices participating in the project, any patient with complex healthcare considerations, regardless of age, were eligible for inclusion, including:

- Frailty;
- Vulnerability;
- Complex polypharmacy;
- Medication compliance issues.

The SHIP project created opportunities to provide pharmaceutical care for patients with inappropriate polypharmacy who would otherwise have not received significant input, especially those who were housebound. The type of medication review can be described depending on the level of pharmacy input required (see Table 1). ‘Level 1’ and ‘level 2’ medicine reviews were non-patient facing and could be mostly desktop-based, with/without access to the patient's full medication record, and could result in some technical amendments with little or no clinical involvement. ‘Level 3’ required a holistic medication review, with direct patient contact either in person or via telephone, with full access to the patient's medical history.

<table>
<thead>
<tr>
<th>Level</th>
<th>Type</th>
<th>Context</th>
<th>Outcome</th>
<th>Patient present</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Prescription review</td>
<td>Pharmacist reviews prescriptions</td>
<td>Issues relating to prescription ordering or medicine quantities</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Concordance and compliance review</td>
<td>Pharmacist reviews medical notes and prescriptions</td>
<td>Issues relating to the patient’s medicine taking behaviour, and desktop medication review</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>Polypharmacy review</td>
<td>Pharmacist conducts face-to-face interview with patient, using full access to medical notes</td>
<td>Issues relating to the patient’s use of medicines in the context of their clinical condition. Full polypharmacy review based on Scottish Polypharmacy Guidelines</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Table 1: Levels of medication review conducted during this project
Methods

Pharmacist polypharmacy reviews

Patients were identified for review by individual need and vulnerability based on the judgement of the healthcare professional from the participating practices and not by traditional search tools, such as SPARRA or the electronic frailty index (eFI)\(^{19}\). This was a novel approach used to test a new way of working, contrary to a similar study by Nightingale et al.\(^{10}\), where patients were identified by medicine burden\(^{11}\).

The authors found that some patients in need of polypharmacy review were “missed” from traditional search tools as they may not fulfil the criteria (e.g. number of medicines, age, frailty).

An experienced pharmacist with a qualification in independent prescribing was introduced to work across the four SHIP surgeries (0.5 whole-time equivalent) to provide polypharmacy input for patients identified by the MDT. The MDT for each participating GP practice comprised existing healthcare professionals within the practice, such as GPs, nurses and district nurses. For the purposes of the SHIP project, the MDT was further extended with the addition of representatives from the children and family support team, social care team, community links practitioner, dedicated pharmacist and physiotherapist.

Patient screening

The pharmacist involved in the project from January 2018 to August 2018, had access to the medical records of all participating patients and proactively screened each patient referred. As the pharmacist’s presence became more established within the MDT, further direct referrals from other members of the MDT for patients who required specific pharmacy input were received.

The pharmacist screened each patient and carried out level 1 and 2 medication reviews, depending on the information required (see Table 1). These were non-patient facing desktop reviews using available prescription information (level 1) and medical records (level 2)\(^{11}\). Factors considered during the desktop reviews were risk of falls, based on falls history and current medicine; complex medication regimens; medicine toxicity; frailty; evidence of poor medicines compliance; and patients with limited mobility who have little contact with practice.

From the level 1 and 2 reviews, the pharmacist was able to outline the patients’ pharmaceutical needs, allowing prioritisation for patients who required further pharmacy input. All patients taking medicines were invited for a review. Although patients were treated equally, those with higher perceived risk of harm were contacted first, based on the pharmacist’s clinical judgement from the desktop review. All eligible patients (i.e. those who required further pharmacy input) were then contacted to arrange level 3 reviews, involving a dedicated face-to-face polypharmacy review, either at the GP practice or during home visits for housebound patients. If patients were unable to attend, the pharmacist would consider a telephone review if appropriate, based on the complexity of their medicine.

Tools and resources
Resources, such as the Scottish polypharmacy guidelines and local disease-specific guidelines, were used to ensure a holistic polypharmacy review was performed\(^2\). Furthermore, the pharmacist focused the review based on what was important to the patient. Patients were asked to bring all their medicines to the appointment, including anything bought over the counter, herbal medicines and supplements.

Medicine packaging can change over time, so it is important to make sure that patients could identify the medicines they were taking, which formed a basis for assessing current and future requirement for the medicine. This also helped the pharmacist to assess compliance because they were able to calculate over/under-ordering based on the medicine's most recent issue date compared to the number of tablets remaining. **Inhaler technique** was assessed in all patients with **asthma** and **COPD**.

To assess the current requirement of medicine versus risks, tools such as the screening tool of older people's prescriptions (STOPP), screening tool to alert to right treatment (START) and the anticholinergic burden (ACB) calculator were used and, if appropriate, dose reduction and deprescribing was discussed with the patient\(^{12}\),\(^{13}\),\(^{14}\). To identify unmet needs, tools such as QRISK and the fracture risk assessment tool (FRAX) were used where appropriate\(^{15}\),\(^{16}\). Once these assessments were carried out, the pharmacist could authorise changes to the medicines where required, refer the patient to colleagues within the MDT and/or refer onwards to the community pharmacy for access to services, such as the minor ailments service (MAS), 'Pharmacy First' scheme and smoking cessation service.

**Referrals**

The pharmacist discussed non-pharmacological options with patients, where appropriate, with referrals made to services such as physiotherapy, rehabilitation and the mental health team. Networks were formed with the social care team, community links practitioner, and children and families support workers, which ensured the option of social prescribing.

Relevant members of the MDT could be contacted directly on an *ad hoc* basis, as well as at monthly MDT meetings. Each practice held its own monthly MDT meeting comprising of the practice team and the SHIP pharmacist and physiotherapist. All patients referred to the SHIP project were discussed at these meetings and new referrals could be added.

**Data recording**

After an invitation for review, patient engagement was assessed by recording attendance rates at appointments. Then, after each review, intervention data were recorded on a spreadsheet created by a senior prescribing support pharmacist in South Glasgow. Once medication changes were confirmed and actioned on the patient medical records system, the pharmacist made an entry reflecting this on the spreadsheet. A follow-up via telephone, further appointment or home visit was arranged depending on the complexity of the intervention.

The SHIP pharmacist also contacted and liaised with community pharmacies with the aim of building better relationships. Informal feedback was sought from pharmacy teams.
At the end of the project in August 2018, members of the MDT who were involved with the care of the SHIP patients and had worked with the pharmacist were invited to provide anonymous, formal feedback on pharmacy involvement using an online survey. The link to the survey was emailed to each practice’s lead GP, practice nurse and prescribing support pharmacist. To receive feedback from the stakeholders, members of the MDT were invited to provide feedback based on their involvement with the SHIP project and patients. The following questions were asked:

1. How did you find pharmacy input to the SHIP project? ‘Excellent’, ‘good’, ‘satisfactory’ or ‘not effective’?
2. Was pharmacy input into MDT meetings useful? Yes or no?
3. Would you like to give any other feedback?

Seven out of eight MDT members responded to the survey. To make the form quick and easy to use, only three questions were asked. These questions were asked to gain a basic level of insight into MDT feedback for pharmacist involvement and interventions. Although there was informal feedback offered by patients, this was not recorded.

Ethical considerations

Verbal consent from each patient was obtained during the consultation with the original healthcare professional who, using their clinical judgement, felt the patient was eligible for a MDT review. At this stage, the referring healthcare professional explained why the referral to the MDT was required and what details would be discussed. Printed notices in each SHIP surgery explained the nature of the project and the inclusion of an anonymous service evaluation (see Supplementary file). All participants were able to opt out of the project at any point if they wished and each practice consented to anonymised data collection for purposes of service evaluation. The local Research Ethics Committee stated that formal clearance was not required as the study was an evaluation of a service.

Results

Patients

Table 2 shows characteristics of all patients screened. A total of 110 patients were eligible for polypharmacy review (see Table 2). It was found that 66% (n=209) were on anywhere between 1 and 24 repeat medicines (median 9.2). Patients with no medicines were screened for unmet needs and 82% (n=259) of all referred SHIP patients were from the most deprived quintile of socio-economic status (see Figure 1), as defined by the 2016 Scottish Index for Multiple Deprivation (SIMD). Of the total number of patients who participated in a full level 3 review (n=88) a higher proportion of females engaged with reviews (73% [n=64]), and 63% of reviews (n=55) completed were for patients aged over 65 years old.
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of patients referred</td>
<td>316</td>
</tr>
<tr>
<td>Total number of patients taking medicines</td>
<td>208</td>
</tr>
<tr>
<td>Total number of patients who received level 1 review</td>
<td>151</td>
</tr>
<tr>
<td>Total number of patients who received level 2 review</td>
<td>22</td>
</tr>
<tr>
<td>Total number of patients eligible for full level 3 review</td>
<td>110</td>
</tr>
<tr>
<td>Total number of patients who participated in full level 3 review</td>
<td>88</td>
</tr>
</tbody>
</table>

**Gender breakdown**
- Male: 42%
- Female: 58%

**Age (years)**
- <16: 4.4%
- 17-24: 2.9%
- 25-44: 14.5%
- 45-64: 27.5%
- >65: 50.7%

Table 2: Characteristics of all patients eligible for polypharmacy review
Interventions

A total of 65 medicines were stopped while 18 were started and 28 doses were optimised or reduced (see Figure 2). There were found to be various reasons as to why medicine was no longer required and considered for discontinuation. The most common deprescribing interventions were for those where there was evidence of side effects and harm, such as increased risk of falls and toxicity (see Table 2). Overdue monitoring was identified in 17% of patients (n=19) and appropriate tests requested.
<table>
<thead>
<tr>
<th>Medicine</th>
<th>Rationale for stopping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amtriptyline (all strengths)</td>
<td>Increased anticholinergic burden and risk of QT interval</td>
</tr>
<tr>
<td>Aspirin 75mg tablet</td>
<td>No longer indicated for primary prevention</td>
</tr>
<tr>
<td>Quinine 200mg tablets</td>
<td>No longer required</td>
</tr>
<tr>
<td>Thiamine 100mg</td>
<td>No longer required</td>
</tr>
<tr>
<td>Laxatives</td>
<td>No longer required</td>
</tr>
<tr>
<td>Fluoxetine 20mg capsule</td>
<td>Increased side effects with other mental health medicine, risk of serotonin syndrome</td>
</tr>
<tr>
<td>Omeprazole 20mg capsule</td>
<td>Proton pump inhibitor not indicated long term</td>
</tr>
<tr>
<td>Ferrous fumarate 210mg</td>
<td>Haematology levels have returned to normal</td>
</tr>
<tr>
<td>Folic acid 5mg</td>
<td></td>
</tr>
<tr>
<td>Anti-hypertensives (i.e. amlodipine 5, 10mg and atenolol [all strengths])</td>
<td>Low blood pressure, light-headedness</td>
</tr>
</tbody>
</table>

Table 3: Common deprescribing items and rationale for stopping
The electronic Key Information Summary (eKIS) is an important source of information relay from primary to secondary care in the event of an unplanned admission or contact with unscheduled care services. When essential information relevant to anticipatory care (e.g., complex medication regimens), social care arrangements, such as power of attorney, was found as a result of the face-to-face meeting with the patient it was added to eKIS by the pharmacist. The pharmacist updated eKIS information for five patients.

The pharmacist judged concordance to be poor in up to 13% of patients (n=14). Proactive blood pressure (BP) checking was undertaken in 12% of patients (n=13) and revealed that two patients had untreated hypertension, who were later started on appropriate medicine. Inhaler technique was checked in all patients with prescribed inhalers and the reviews revealed that 69% of all patients (n=15) with inhalers displayed inappropriate technique.

Non-pharmacological options were also considered — the pharmacist referred 29% of patients (n=37) to non-GP members of the MDT. Dependent on need, some patients required multiple referrals (i.e., social work and referral to the rehabilitation team). Of all 37 referrals made by the pharmacist, 40% (n=15) were for community pharmacy to ensure patients were utilising all available pharmacy services, such as the MAS and nicotine replacement therapy (NRT), or for the dispensing of medicine compliance aids (MCA). Community links practitioners provided a good source of social prescribing and 21% of patients (n=8) were deemed suitable to access community links practitioner services. Referral was made for the district nurse for 21% of patients (n=8) because they are regularly in contact with housebound patients. The social work team was contacted for 11% of patients (n=4).

**Multidisciplinary team survey**

Pharmacy input into shared patient care was rated as excellent by 71% and good by 29% of all respondents (n=7). Pharmacy input into the MDT meeting was rated as ‘useful’ by 100% of respondents. An open question was asked for “any other feedback” and the feedback was perceived by the author as being positive. Example responses:

“Excellent relationship with the pharmacist benefiting the patients and the practice in equal measure.”

“Pharmacy input was extremely helpful and became a valued member of our SHIP meetings.”
Changes to referrals

A general observation from the authors was that during the early stages of the project reviews were generally carried out in response to screening from the pharmacist. This was potentially due to the MDT not being accustomed to having a pharmacist as part of the team. As pharmacist presence became more established within the MDT, there were an increased number of direct referrals made from different members of the MDT. This helped identify patients requiring pharmaceutical review that otherwise may have been missed via traditional search tools (SPARRA/STU).

Discussion

Deprescribing

It is estimated that up to 5% of all hospital admissions are medicine-related and up to 50% of these are owing to adverse drug reactions that could have been prevented\textsuperscript{18}. Those aged over 65 years and taking five or more medicines are at highest risk of medicine-related hospital admission\textsuperscript{19}. Level 3 polypharmacy reviews (n=88) were performed within the SHIP project, with 63% (n=55) undertaken with patients aged over 65 years taking an average of eight medicines each.

A working definition of deprescribing has been proposed by Reeve \textit{et al}, describing it as a “process of withdrawal of inappropriate medication supervised by a healthcare professional with the goal of managing polypharmacy and improving outcomes”\textsuperscript{20}. During the review, each item was discussed with the patient and medicines that were no longer indicated or required were considered for discontinuation.

Deprescribing should not be undertaken without careful consideration; therefore, the benefits and risks of each medicine were discussed with the patient considering up-to-date guidelines\textsuperscript{21}. Owing to the importance of patient input, side effects as well as positive and negative experiences were discussed in each review. Tools such as the ACB calculator and STOPP/START were utilised to identify risks, and numbers needed to treat was used as a tool to help demonstrate the effectiveness of the drug\textsuperscript{11,13,14}.

If they agreed to stop a medicine during a review, patients were reassured that it would be done in a controlled and step-wise approach, with follow-up as appropriate. Patients were generally open and agreeable to recommendations for stopping certain medicines, especially as it meant a reduced tablet burden, reflecting similar findings from recent research\textsuperscript{22}. Deprescribing was found to be one of the most common interventions made during the polypharmacy reviews, with a total of 65 items being stopped. The medicines deprescribed ranged from the relatively straightforward, ineffective medicine that was no longer needed or caused side effects, to more complex cases where secondary care were contacted if required (see Table 3).

Concordance
Compliance and adherence are important patient factors to ensure optimal therapeutic response. It is now recognised that patient–healthcare professional relationships are an important factor in ensuring concordance, thereby improving compliance and adherence\cite{23,24}. In developed countries, only 50% of patients with chronic illness follow their treatment as prescribed\cite{25}. It has been previously demonstrated that patients with
little or no knowledge of how their medicines work are more likely to miss doses. To improve patient compliance, patients need to be treated like a partner in their own care[25].

The SHIP project was developed to provide an opportunity for patients to gain better understanding of their medicines and ask questions about possible side effects and concerns that they had not previously mentioned to their GP. With more information about their medicines and being treated as a partner in their care, patients felt more empowered to take control of their own medicines and therefore, to be concordant with medicine regimens. Owing to project timescales, a review and follow-up of medicines compliance after the initial intervention was not always possible.

The majority of patients who received a polypharmacy review (71% [n=78]) already used an MCA to take their medicines. Some patients required a medicine prompt and/or supervision as part of their care package, where a social carer would visit them to ensure they take it appropriately. In this group of patients, adherence to medicines was found to be good and, if a dose had been missed, it was easy to notice and identify trends. However, in some patients, non-compliance was evident with regular missed doses and confusion about medicines, which lead to poor adherence. This trend was picked up during a face-to-face level 3 review. Out of the total number of patients eligible for a full level 3 review (n=110), 6% of patients (n=7) had compliance issues, these ranged from omitting medicines periodically to frequently missing doses; and nearly 3% of patients (n=3) had a new MCA arranged with a local pharmacy and new prescriptions provided for weekly dispensing following their review.

Inhaler review

A review of inhaler technique was performed with each patient with asthma or COPD. Of patients with inhalers, 69% (n=21) demonstrated inappropriate technique or poor dexterity, both of which were more common in patients aged over 75 years. However, a low rate of attendance at annual respiratory reviews was also noted for all patients with poor inhaler technique. As a result, inhaler technique counselling was provided during the review. Inhaler devices were also switched in line with guidelines, where appropriate. In cases of poor dexterity, a simple switch from multi-dose inhaler (MDI) to a dry powder Easyhaler helped patients; alternatively, they were provided with spacer devices to aid MDI inhalation. By improving inhaler technique and ensuring the majority of the dose is being administered appropriately, the risk of exacerbations was reduced[26]. With more stable respiratory symptoms, it is hoped that quality of life would also improve, while reducing attendance at GP appointments and reducing other forms of unscheduled care, such as attending an accident and emergency department.

Patient engagement

The SIMD identified Govan as being among the top 5% of the most deprived areas in Scotland[17]. Figure 1 indicates that the greatest percentage of patients receiving pharmacy reviews were within the most deprived quintile, which is similar to the profile of the overall population of the surgeries in this study. This supports the theory that those who are requiring the most interventions are from the most socio-economical deprived communities[1][27].

Despite traditional search tools such as SPARRA/STU not being used to identify patients, Figure 1 shows that appropriate patients were identified based on deprivation, and that the majority of patients were aged over 65 years. However, there was no measurement of frailty.
Patient engagement was challenging when arranging polypharmacy review appointments. From the 151 patients that were offered a pharmacist review, 5% of patients (n=7) refused and a further 8% of patients (n=12) failed to attend, despite agreeing to.

In the case of missed appointments, attempts were made to reschedule or perform a telephone consultation, if appropriate. If this was not possible, details of desktop review findings would be entered on GP medical records for information for the GP. For urgent issues, changes were made and contact with the patient made via telephone and/or letter.

The 2017 Scottish government publication, ‘Achieving excellence in pharmaceutical care: a strategy for Scotland’, stated that one of its aims was to increase “access to community pharmacy as the first port of call for managing self-limiting illnesses”. Community pharmacy is an essential provider of services and up to 10% of patients who undertook a SHIP review were referred to services such as the MAS, NRT and Pharmacy First. Within this patient group, awareness of community pharmacy services was particularly low, as stated by patients or their carers. It was also found that families with young children were commonly presenting at GP and out-of-hours services for ailments that could have been appropriately treated by their community pharmacy (e.g. conjunctivitis and rashes in children, and symptoms of urinary tract infection in mothers). To help raise awareness of community pharmacy, social work and health visitors were updated and informed of current community pharmacy services because of their frequent contact with parents and children.

To improve patient experiences with community pharmacy, it is imperative that there is good communication between GP practices and community pharmacies. During the project, local community pharmacies were visited by the SHIP pharmacist to gather feedback on their current communication with GP surgeries. The feedback showed that a common theme was lack of information when changes were made to MCAs that could result in medicine errors, which in turn could result in a patient safety risk. The most common reason for a referral to pharmacy from a GP owing to MCAs, indicating the importance of good communication between community pharmacy and GP practices. This issue was discussed with surgery teams to ensure all changes to a patient’s medicines regimen were being communicated to the community pharmacy as per existing primary care standard operating procedures.

Social prescribing

The SHIP project facilitated a closer working relationship between the different members of the MDT, resulting in a more efficient process of referring patients to appropriate healthcare professionals. The pharmacist attended monthly MDT meetings to discuss complex cases, to inform MDT colleagues of interventions made and to gain input from the medical and nursing team. This also provided an opportunity for the pharmacist to refer patients to the attention of social work or community links practitioners. This highlighted the importance of close working within the MDT and the role pharmacists can play in identifying patients for social support — effectively a ‘social prescription’.
The physiotherapist also referred patients who were taking a combination of analgesics and treatments for mental health conditions, for level 3 polypharmacy review when they noticed during consultation that the patient was not managing their medicines well or was taking several complex or high-risk medicines. Similarly, during home visits, the community links practitioner identified patients with medicine issues and refer them to the pharmacist for a review, demonstrating the important roles of all MDT members in identifying patients who may be having difficulty with their medicine. The flow of referrals meant that patients received input from appropriate members of the MDT without having to continually seek GP assessment and onward referrals. As the role of the pharmacist was established within the MDT, the number of direct referrals being received from all members of the MDT increased. This indicated that having a pharmacist as part of the team reduces barriers to communication and raises awareness of the benefit of pharmacist polypharmacy reviews.

**Home visits**

A large proportion of SHIP patients were housebound, therefore of those who received a level 3 polypharmacy review (n=88), 37% (n=33) were performed as home visits. Housebound patients are at the highest risk of complications and are often vulnerable and socially isolated. Practice pharmacists rarely have the opportunity to visit these patients, meaning it was particularly useful to see these patients at a time when they did not have acute symptoms. Home visits provided additional benefits because the pharmacist was able to assess issues that otherwise would not have been detectable, such as medicine storage, falls risk and social circumstances.

As a result, medicine storage advice was provided and changes to social work care packages were implemented where patients required further support with medicines. It was also found that housebound patients are more likely to have outstanding observations, tests and/or monitoring needs. The pharmacist was able to carry out a BP/pulse check and request blood tests from the district nurse, where required.

**Unmet health needs**

Of all referred SHIP patients, 33% (n=104) were not prescribed medicines. However, during pharmacy screening, unmet health needs were considered where investigations and medicines were initiated as appropriate. As a result, two patients were prescribed medicine for previously undiagnosed hypertension and one patient resumed a medicine that had previously been started by secondary care, but had since lapsed. This finding shows the importance of regular reviews in which the pharmacist can carry out proactive observations that at the very least can be used as a baseline for future observations or could be used to pre-empt potential issues.

In 2008, Kuipers et al. found a link between polypharmacy and underprescribing whereby it was thought that when a patient is taking a large number of medicines, prescribers may be less likely to prescribe further medicine. However, the study included an older, geriatric population and, in this way, differs from the SHIP project. These findings indicate that unmet needs should always be considered in a medication review. Also, START offers a strategy to reduce underprescribing.

**Transferability**
One aim of the Govan SHIP project was to understand the potential for scalability and transferability. The project was explicitly set within the context of socio-economic deprivation; however, the findings suggest that this type of review process could be transferred to any locality, irrespective of demographic profile. Patient selection for screening is universal, allowing varying types of patients to be included. An experienced independent prescribing pharmacist is required and could integrate into any existing practice or local MDT. This new model of working fits well as an elective element of the new pharmacotherapy service envisaged by the 2018 General Medical Services contract in Scotland[29].

Clinical effectiveness

Although no formal feedback was sought from patients following their medication review, most patients volunteered informal feedback. While feedback was not recorded, reports from those involved in the project indicated that it was overwhelmingly positive. Pharmacist input was evidently valued by patients by way of informal feedback and the MDT by way of informal feedback.

Seven members of the MDT — a representative cohort of the full team — provided feedback via survey, five of whom indicated that pharmacist input was ‘excellent’. All respondents found pharmacist input into team meetings to be useful, which demonstrates that pharmacists should be fully integrated members of the MDT in order to support the healthcare team in managing complex patients. Not only did interventions increase patient safety, they also increased prescribing cost-effectiveness.

The long-term benefit of these reviews may be significant for the patient, (e.g. reduction in falls and fractures, improvement in cognition etc.); however, significance was not measurable within the scope of this project.

Limitations

This was a medium-scale local project within one locality of Glasgow and referrals were only from within the participating primary care practices. There was not enough scope or resources to allow for secondary care referral as described in the Lewisham Integrated Medicines Optimisation Service — or LIMOS — study, which was able to provide an interface between primary and secondary care, helping with seamless patient care[30]. If more time was granted, further awareness of the project within secondary care and perhaps scope for secondary care referral would have been made. Self-referral was not considered in this study owing to concerns that the resources may be utilised by frequent attenders and as is common in deprived areas, the most in need of support are least likely to seek it[6].

Owing to the short duration of the project, it was not possible to evaluate the long-term effects of the reviews in certain scenarios, such as asthma exacerbations; medicines-related hospital admissions; frequency of GP appointments; and unscheduled care presentations. In addition, although this method of pharmacist intervention is transferrable, the results may not be reproducible as the impact will depend on existing prescribing practices; therefore, there may be more/less scope for intervention. The impact could be even greater in areas where there is little or no pharmacy support.
The MDT questionnaire asked three questions to make it quick and simple to use for the respondents, which also helped improve response rate. For a more thorough review of pharmacist input, more in-depth questioning may have been used. There was positive
and useful informal feedback received from patients and the pharmacy teams, but this was not collated formally. Patient feedback may have provided a good indicator for impact that pharmacists can make and could be an area of further research.

Conclusion

The inclusion of a pharmacist within the SHIP project is in line with commitment two of the Scottish government’s ‘Achieving excellence in pharmaceutical care: a strategy for Scotland’, which aimed to integrate pharmacists with advanced clinical skills and pharmacy technicians in GP practices to improve pharmaceutical care and contribute to the MDT. The interventions made by the pharmacist not only addressed immediate concerns, but also contributed towards preventative care, helping to reduce GP workload and ensures that pharmacists are utilising their skills as medicines experts, reducing unwanted medicines reduces tablet burden as well as reducing risk of toxicity. Within this group of patients, deprescribing was found to be a common intervention. This is an area of current interest and requires further research. The results and feedback from patients and members of the MDT reaffirm that pharmacists have an important role in ensuring excellent pharmaceutical care for patients.

About the authors

Rizwan Din is a prescribing support pharmacist at NHS Greater Glasgow and Clyde, Glasgow South (now NHS Lanarkshire); Colette Montgomery Sardar is part of the research and development team at pharmacy services for NHS Greater Glasgow and Clyde; Graeme Bryson is the lead pharmacist at NHS Greater Glasgow & Clyde, Glasgow South (now D&G); and Vince McGarry is project manager at Govan Social and Healthcare Integration Partnership project, NHS Greater Glasgow and Clyde

References:


n=30

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APPENDIX G - IMPROVING PRIMARY CARE ACCESS BY INTRODUCING AN ADVANCED PHYSIOTHERAPY PRACTITIONER (APP) INTO 3 DEEP END GP PRACTICES - GOVAN SHIP PROJECT
Improving Primary Care Access by Introducing an Advanced Physiotherapy Practitioner (APP) into 3 Deep End GP Practices

Govan SHIP Project

November 2017 to November 2018

Project Team:
Vince McGarry, Govan SHIP Project Manager
Caroline Horn, Physiotherapy Manager
Eden Keiller, Advanced Physiotherapy Practitioner
Margo Pratt, Clinical Improvement Coordinator, Clinical Governance Support Unit
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SECTION 1. INTRODUCTION

A 1 year pilot was proposed to introduce an MSK Advanced Practice Physiotherapist to the Govan SHIP project to support the overall objectives of the project and to test the redirection of patients from the GP in an area of high deprivation. The 3 GP practices participating were all Deep End practices*.

Govan SHIP

The original objectives of the Govan SHIP (Social & Health Integrated Partnership) project were to:

- Shift demand to the right person, in the right place, at the right time, through structured multi-disciplinary team working
- Lower the threshold for intervening in problems, using horizontal referral to resources within the community and primary care rather than vertical referral to more expensive parts of the health and social care system, with a view to containing problems at a low level
- Work to the top of the licence
- Develop anticipatory and preventative approaches to reduce inappropriate use of Unscheduled Care and avoid or delay hospital admission
- Provide improved support for chronic illness

Advanced Physiotherapy Practitioner

The role of Advanced Physiotherapy Practitioner (APP) was introduced into the Govan SHIP project in its third year. This APP would function as an alternative first point of contact with the aim of releasing GP capacity and improving patient outcomes, educating a change in practice across the system to support a shift in line with national policy.

This APP role had already been introduced in Inverclyde (another part of NHS Greater Glasgow & Clyde) with favourable outcomes. The Govan SHIP provided the opportunity to allow for exploration of the APP model of health care delivery within an area of high deprivation as opposed to a previously more mixed demographic. This also afforded the opportunity to test the dynamics of adding to an established model of structured multi-disciplinary team (MDT) working and potentially further shifting of demand through direct access and enhanced relationships and communications with other members of the multi-disciplinary team.

Capacity modelling 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.

APP role and MDT working

Early experience suggested little crossover between the patients referred to the MDTs and those internally referred for MSK physiotherapy. The number of patients recruited to the SHIP and who also attended the APP were only 49 out of 1,722. It was therefore determined that participation with the structured MDT process would only be necessary on a case by case basis while retaining direct access between the APP and other MDT professionals as required.

*GPs at the Deep End are the group of 100 general practices serving the most socio-economically deprived populations in Scotland
SECTION 2. AIMS AND OBJECTIVES

This report describes one year of activity across 3 GP practices working in deprived areas, offering a multidisciplinary response to complexity presenting at a practice level.

Aims

The aim of this test was to identify the potential benefits and further opportunities presented by locating an Advanced Practitioner Physiotherapist within GP practices in a highly deprived area who have already established a degree of multidisciplinary team working within the practice.

Objectives

In addition to the Govan SHIP objectives, MSK APP specific objectives were identified:

- Redirect patients from GP to APP where MSK issues identified
- Improve the patient experience of access to timely support with MSK problems
- Reduce inappropriate demand for hospital services
- Further enhance the mix of healthcare professionals and therefore interventions available at a practice level

Standards

- Whilst no direct standards about demand were created, it was expected that
  - Appointment slots would be fully utilised
  - Patients experiencing minimal wait for an appointment

- In line with the Inverclyde test, a target of 60% of appointments being booked directly from Receptionist, Practice Nurse or Pharmacist (or via triage where this exists) was discussed informally, whilst acknowledging that the particular features of the Govan SHIP practices presented a different population type.
The group have worked hard to balance the data burden on evaluating this test. Information used in this report has been taken from a variety of sources.

The **Advanced Physiotherapy Practitioner collected a small amount of data on an excel spreadsheet** over the period that demonstrated activity of the APP role. This dataset included indicators like how the person had been directed to the APP, and what happened after they had seen the APP. This information is not easily extractable from the Practice information systems and real time data collection provides a valuable insight into how well the project is progressing by monitoring changes in uptake, the number of sessions and whether or not the patient has come directly or via a GP. The physiotherapist reported that even at this small scale, providing regular feedback via informal evaluation took clinical time away from the role.

The **Advanced Physiotherapy Practitioner was interviewed** by a member of the Physiotherapy Team to make sure that these views were also incorporated. As well as describing their own experience of this new way of working, the APP offered suggestions and recommendations for subsequent tests of this approach.

Some data has been **extracted from hospital and practice based information systems**. Information about number of people seen and what onward referrals occur can be tracked across the whole practice population. However there have been challenges in being able to isolate the hospital data which relates only to the test underway.

**Patients** who had accessed the APP were asked about their experience of using the service through a **paper questionnaire distributed and collected by the practice team**. It is good practice to ask people using the service about their experience. This exercise has limitations and includes the views of only those individuals who were prepared to see the APP instead of the GP about their MSK problem.

**Practice staff** themselves were asked about their experience in a number of interviews with receptionists, GPs, nurses and practice managers. The information gathered during this exercise describes the reality of introducing a MSK APP into a GP practice. As well as exploring benefits to the Practice, through a series of individual and group interviews the practice staff were able to describe the journey from developing their theories about the change, to being able to reflect on how well their ideas and ambitions had matched their experience.

Interviews took place in a range of different ways and as well as the key groups identified below, we were able to include the nurse in one practice who had a triage role for same day appointment requests.

- **Reception Staff** are the gatekeeper to practice appointments and key to the success of the project. As part of the evaluation, reception staff were interviewed as a small group in individual practices, with one or 2 individual interviews also taking place. Reception staff were asked about the support they were given to introduce the pilot, what issues or difficulties they could see with its practical application, and what other steps might help to improve uptake of APP appointments.

- **GPs** are who a person expects to see when they ask for an appointment in practice, and responsible for clinical services delivered within the practice. They are key to reassuring patients that they can expect an improved service from the APP and need to champion the idea with their patients. GPs were asked how this worked in practice, and what issues had emerged.

- **Practice Managers** have managed the practical introduction of the APP role into the practice. This includes making sure that IT issues, training, induction / shadowing, room bookings and appointment slots are all in place and easy to use. Practice Managers describe what was done to make sure that the APP could fit quickly and easily into practice activity.
SECTION 4. RESULTS

The following report pulls together the information from a variety of sources. Individual reports were prepared summarising GP, APP, Practice Managers, Reception staff and Patient feedback. These are included as appendices for further detail.

4.1. Resource Allocation & Number of Patients

The APP resource was allocated across the 3 practices as follows:

- Mair Practice: 3 clinics per week (27 patient slots)
- Blue Practice: 2 clinics per week (18 patient slots)
- David Elder (DE) Practice: 2 clinics per week (20 patient slots)

During the first 16 weeks of the project, the numbers of appointment slots was slowly increased as the staff member’s induction progressed. This accounts for the overall number of people seen (n = 2119) being in excess of the number of available slots (n=1866) over the whole period.

One physiotherapist covered the 3 practices. Practice staff described an induction phase where the APP was able to work with them to establish appointment patterns that would provide the best way to organise APP sessions in the clinic. The availability of accommodation was a significant factor when planning which days the APP would be around. Practice Managers highlighted that this is becoming increasingly difficult as a wider range of people become involved in primary care services.

Whilst this work is still in very early stages of development, the APP highlighted that there is still some uncertainty in identifying how the APP resource should be deployed within individual practices.
The reception staff made most comments about the pattern of appointments offered, and highlighted the following features of scheduling as important:

1. Whether or not the APP appointments were released in advance, or only released that week
2. How many days wait there was between the person calling and the next available APP appointment
3. Whether the APP had a mix of morning and afternoon appointments.

### Number of Appointment Slots Allocated to each Practice

<table>
<thead>
<tr>
<th></th>
<th>Wk 1-4</th>
<th>Wk 5-8</th>
<th>Wk 9-12</th>
<th>Wk 13-16</th>
<th>Wk 17-20</th>
<th>Wk 21-24</th>
<th>Wk 25-28</th>
<th>Wk 29-32</th>
<th>Wk 33-36</th>
<th>Wk 37-40</th>
<th>Wk 41-44</th>
<th>Wk 45-48</th>
<th>Wk 49-52</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mair</td>
<td>84</td>
<td>82</td>
<td>87</td>
<td>45</td>
<td>108</td>
<td>97</td>
<td>97</td>
<td>76</td>
<td>105</td>
<td>781</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blue</td>
<td>63</td>
<td>63</td>
<td>63</td>
<td>36</td>
<td>71</td>
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<td>64</td>
<td>52</td>
<td>70</td>
<td>535</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DE</td>
<td>76</td>
<td>66</td>
<td>68</td>
<td>29</td>
<td>73</td>
<td>50</td>
<td>68</td>
<td>50</td>
<td>70</td>
<td>550</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>223</td>
<td>211</td>
<td>218</td>
<td>110</td>
<td>252</td>
<td>200</td>
<td>229</td>
<td>178</td>
<td>245</td>
<td>1866</td>
</tr>
</tbody>
</table>

### 4.2. Demographics

The information in this section describes the individuals who presented to the MSK APP, and how that relates to the general practice population.

### Number of Patients Booked in at each Practice

<table>
<thead>
<tr>
<th></th>
<th>Wk 1-4</th>
<th>Wk 5-8</th>
<th>Wk 9-12</th>
<th>Wk 13-16</th>
<th>Wk 17-20</th>
<th>Wk 21-24</th>
<th>Wk 25-28</th>
<th>Wk 29-32</th>
<th>Wk 33-36</th>
<th>Wk 37-40</th>
<th>Wk 41-44</th>
<th>Wk 45-48</th>
<th>Wk 49-52</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mair</td>
<td>44</td>
<td>72</td>
<td>58</td>
<td>41</td>
<td>61</td>
<td>58</td>
<td>72</td>
<td>42</td>
<td>103</td>
<td>82</td>
<td>91</td>
<td>67</td>
<td>84</td>
<td>875</td>
</tr>
<tr>
<td>Blue</td>
<td>16</td>
<td>40</td>
<td>32</td>
<td>30</td>
<td>52</td>
<td>54</td>
<td>58</td>
<td>36</td>
<td>57</td>
<td>51</td>
<td>54</td>
<td>42</td>
<td>47</td>
<td>569</td>
</tr>
<tr>
<td>DE</td>
<td>36</td>
<td>50</td>
<td>36</td>
<td>41</td>
<td>70</td>
<td>58</td>
<td>67</td>
<td>28</td>
<td>68</td>
<td>49</td>
<td>66</td>
<td>46</td>
<td>60</td>
<td>675</td>
</tr>
<tr>
<td>Total</td>
<td>96</td>
<td>162</td>
<td>126</td>
<td>112</td>
<td>183</td>
<td>170</td>
<td>197</td>
<td>106</td>
<td>228</td>
<td>182</td>
<td>211</td>
<td>155</td>
<td>191</td>
<td>2119</td>
</tr>
</tbody>
</table>
Age and Gender

On the understanding that under 14s were deliberately excluded*, the data suggests that those in the 45-64 age group benefitted most proportional to the overall practice population and that differences in gender accessing the APP were marginal.

Deprivation

The chart above suggests that the profile of people attending the MSK APP reflected the practice profile.

*MSK Physiotherapy service is an Adult service seeing patients aged 14 years and over.
Morbidity

The chart above indicates that a much higher proportion of patients referred to the APP were multi or poly morbid.

4.3. Average Clinic Capacity

This average has been taken from the average across each practice. This is because the number of slots was not established until week 16 and the total number of people seen exceeds the capacity. The APP entered a manual calculation of capacity during the first 16 weeks.
Whilst every member of the practice team was quick to assert that an APP appointment would be offered to everyone who was suitable, there were also a series of caveats or explanations that provided further insight into some of the issues that stopped the APP from filling all available appointment slots.

Some practices explain on their answerphone / call waiting message that receptionists will ask for more information and may suggest seeing someone other than the GP. However receptionists reported challenges in routinely asking for more information. See P12.

There is the possibility to include APP appointments in the online bookings in the event that the APP role becomes permanently embedded in the GP practice although this was not initiated in the early stages by any practice. Allowing people to directly make appointments with any profession would reduce the opportunity that the reception staff currently have to direct requests to the most appropriate healthcare professional.

The whole practice team identified that a lack of certainty about continuity of the role had an impact on appointment slots. Receptionists were less likely to remember to offer APP appointments if they had got used to the APP being fully booked, or on holiday, or simply unavailable for a period of several days. Similarly, if they were unsure if the project was going to continue, there was less of an impetus on securing full use of the appointments. This might offer some explanation as to how peak capacity was reached in the middle of the project timeline but has been reducing again since the week 29 – 32 data collection period.

The APP reported that much of their time was spent trying to think of ways to improve the number of referrals direct from reception. The APP has an initial role to help the reception staff understand what is on offer in an APP consultation. This includes both the more specialised MSK assessment, as well as the ability to make sure that medicines or fit notes are provided if those are required. Highlighting the ways in which the service differed from self-referral to community physiotherapy was also needed, as both staff and patients have their own impression of what those services might offer.

### Average Utilised Capacity by Individual Practice

<table>
<thead>
<tr>
<th>Practice</th>
<th>Wk 1-4</th>
<th>Wk 5-8</th>
<th>Wk 9-12</th>
<th>Wk 13-16</th>
<th>Wk 17-20</th>
<th>Wk 21-24</th>
<th>Wk 25-28</th>
<th>Wk 29-32</th>
<th>Wk 33-36</th>
<th>Wk 37-40</th>
<th>Wk 41-44</th>
<th>Wk 45-48</th>
<th>Wk 49-52</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Mair</td>
<td>73%</td>
<td>71%</td>
<td>83%</td>
<td>93%</td>
<td>95%</td>
<td>85%</td>
<td>94%</td>
<td>88%</td>
<td>80%</td>
<td>80%</td>
<td>85%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blue</td>
<td></td>
<td>83%</td>
<td>86%</td>
<td>92%</td>
<td>100%</td>
<td>80%</td>
<td>96%</td>
<td>84%</td>
<td>81%</td>
<td>67%</td>
<td>85%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DE</td>
<td>92%</td>
<td>88%</td>
<td>99%</td>
<td>97%</td>
<td>93%</td>
<td>98%</td>
<td>97%</td>
<td>92%</td>
<td>86%</td>
<td>93%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>61%</td>
<td>72%</td>
<td>84%</td>
<td>75%</td>
<td>84%</td>
<td>82%</td>
<td>91%</td>
<td>97%</td>
<td>89%</td>
<td>93%</td>
<td>92%</td>
<td>87%</td>
<td>78%</td>
<td><strong>83%</strong></td>
</tr>
</tbody>
</table>

### 4.4. Route of Access

A measure identified by the Project Team was the percentage who came Direct from Reception, with a target set at 60%. In discussion, the main focus of concern has remained the percentage of appointments direct from GP. Initially, it was considered that requests would either come from the GP, or directly from reception. In reality, there are a number of other potential routes and the following chart therefore focuses instead on the target discussed, which is to reduce the percentage of people directed from the GP.

2 ambitions of this work that practices were focussed on perhaps played against each other somewhat. One indicator was whether or not the capacity given to the practice was fully utilised. Because practices were keen to ensure the resource would be used, and therefore available in the future, this may have encouraged more GP referrals to the APP, meaning that there were less suitable appointments available for the receptionists to offer.
GP referrals to APP

A GP referral implies that the person has been seen twice. Once by the GP, who has then redirected to the MSK APP in line with the agreed pathway. There are a number of situations where this might occur, and many of those are considered to be wholly appropriate.

**MSK 1 - Presented with only a MSK condition**

**MSK 2 - Presented with more than one complaint of which one was a MSK problem**

- A total of **920** GP referrals were recorded (GP referrals in the first 3-months of the project were recorded but not categorised as MSK1*/MSK2**, therefore, not included)

- **409** (44%) presented with a primary MSK complaint (MSK1), which when reviewing the EMIS entry would have appeared suitable for APP. The data is unable to establish how many patients were asked whether they wanted to see APP rather than GP but declined versus how many were not asked the question. This group included patients who attended the APP as an alternative to a review appointment with the GP (e.g. following an investigation or failure to improve) or where the GP wanted an expert opinion to ensure the patient was on correct pathway.

- **511** (56%) presented with more than one complaint (MSK 2) of which one was a MSK problem therefore not initially appropriate for APP.

<table>
<thead>
<tr>
<th>Breakdown of GP referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Practice</strong></td>
</tr>
<tr>
<td>Mair (n=344)</td>
</tr>
<tr>
<td>Blue (n=309)</td>
</tr>
<tr>
<td>DE (n=267)</td>
</tr>
</tbody>
</table>

**Percentage of Appointments that were Directed from the GP**
It was recognised that people who present with multiple problems during one consultation can be directed to the APP by the GP to seek more specialised support from the APP in relation to their MSK issue specifically. Not only does this allow the GP more time to deal with the things that only they can help with, but it also means that the person will be given a full assessment of their MSK problem, rather than making it one of a number of things tackled during a 10 minute GP consultation.

GPs felt that the APP was able to offer a more comprehensive assessment, better able to quickly access advice and explain what exercises might help and why. One GP described this as having a ‘rehab mindset’ and felt there may be benefits to the practice and population as a whole in having someone who was able to assist with behavioural activation and empowering patients to be more responsible for their own condition management. In addition, the APP was more likely to know the best referral routes, what support was available from other resources, and appropriate referral pathways and criteria.

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<th>Wk 37-40</th>
<th>Wk 41-44</th>
<th>Wk 45-48</th>
<th>Wk 49-52</th>
<th>Total</th>
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<tbody>
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<td>GP</td>
<td>77%</td>
<td>59%</td>
<td>58%</td>
<td>61%</td>
<td>63%</td>
<td>60%</td>
<td>50%</td>
<td>46%</td>
<td>56%</td>
<td>55%</td>
<td>57%</td>
<td>55%</td>
<td>52%</td>
<td>58%</td>
</tr>
<tr>
<td>All Others (exc GP)</td>
<td>23%</td>
<td>41%</td>
<td>42%</td>
<td>39%</td>
<td>37%</td>
<td>40%</td>
<td>50%</td>
<td>53%</td>
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<td>45%</td>
<td>43%</td>
<td>45%</td>
<td>48%</td>
<td>42%</td>
</tr>
<tr>
<td>Reception</td>
<td>19%</td>
<td>36%</td>
<td>32%</td>
<td>32%</td>
<td>27%</td>
<td>24%</td>
<td>36%</td>
<td>41%</td>
<td>28%</td>
<td>36%</td>
<td>32%</td>
<td>32%</td>
<td>40%</td>
<td>32%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>5%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
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<td>5%</td>
<td>1%</td>
<td>3%</td>
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<td>6%</td>
<td>2%</td>
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<tr>
<td>Practice Nurse/triage</td>
<td>6%</td>
<td>8%</td>
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<td>4%</td>
<td>10%</td>
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<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Physio</td>
<td>4%</td>
<td>9%</td>
<td>5%</td>
<td>7%</td>
<td>11%</td>
<td>11%</td>
<td>8%</td>
<td>8%</td>
<td>6%</td>
<td>6%</td>
<td>8%</td>
<td>8%</td>
<td>5%</td>
<td>7%</td>
</tr>
</tbody>
</table>

2 early categories recorded by the physio to track how easy it was for patients to be directed to the APP when requesting appointment are in the top 2 rows in the table above – GP / All Others. All others includes Reception, Practice Pharmacist, Practice Nurse, or follow up appointment (recorded as ‘Physio’).

**Direct from Reception**

It was a key ambition of the pilot to ensure that as many people as possible were being directed from Reception (instead of first seeing the GP and being redirected). The practices continued to test new ways to encourage patients to see the APP directly throughout the test period. Reception staff were described by other members of the practice team as having a problem solving mentality and acknowledged the hard work they do in trying to find the right solutions for their patients.

**Reception staff need to lead the patient change** and therefore be resilient to rejection or the range of negative reactions they may get from patients who perhaps see them as trying to block GP appointments. Individual practices reported different behaviours from their population that had an impact on how easy it was to ask patients for more information about the problem they were seeking assistance with.

Reception staff are aware of the importance of a quick response to a ringing telephone and it was clear that they sometimes felt unable to ask patients for more details when feeling under pressure to deal with the next call. Staff said they would always offer up appointments, except at the really busy times. On further exploration, those busy times are the early morning calls, during which time the majority of appointment slots for the day are filled. This is an area where more work is required to make sure that asking people for more information about their request becomes a routine part of answering a telephone in the practice, and second nature to patients calling to request an appointment.
The overall data combines the 3 practices. Those practices undertook different interventions at different times to improve the percentage of people coming direct from reception. At an individual practice level, the APP was able to provide data that demonstrated the impact of those interventions.

### Percentage Direct from Reception in Each Practice

Over the period, the practices undertook a number of interventions to improve the number of people being directed by reception to the APP. This included changes to the practice answerphone message, booking system changes, posters, etc. Practices were able to track the impact of those changes to establish whether they were leading to the anticipated improvements in direct from reception appointments.

<table>
<thead>
<tr>
<th>Week</th>
<th>Mair</th>
<th>Blue</th>
<th>DE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>WK 1.4</td>
<td>11%</td>
<td>39%</td>
<td>8%</td>
<td>19%</td>
</tr>
<tr>
<td>WK 5.8</td>
<td>33%</td>
<td>40%</td>
<td>36%</td>
<td>36%</td>
</tr>
<tr>
<td>WK 9.12</td>
<td>24%</td>
<td>50%</td>
<td>22%</td>
<td>32%</td>
</tr>
<tr>
<td>WK 13.16</td>
<td>31%</td>
<td>33%</td>
<td>31%</td>
<td>32%</td>
</tr>
<tr>
<td>WK 17.20</td>
<td>20%</td>
<td>30%</td>
<td>31%</td>
<td>32%</td>
</tr>
<tr>
<td>WK 21.24</td>
<td>25%</td>
<td>15%</td>
<td>31%</td>
<td>27%</td>
</tr>
<tr>
<td>WK 25.28</td>
<td>49%</td>
<td>22%</td>
<td>29%</td>
<td>24%</td>
</tr>
<tr>
<td>WK 29.32</td>
<td>64%</td>
<td>19%</td>
<td>36%</td>
<td>36%</td>
</tr>
<tr>
<td>WK 33.36</td>
<td>38%</td>
<td>35%</td>
<td>27%</td>
<td>41%</td>
</tr>
<tr>
<td>WK 37.40</td>
<td>40%</td>
<td>30%</td>
<td>32%</td>
<td>36%</td>
</tr>
<tr>
<td>WK 41.44</td>
<td>38%</td>
<td>26%</td>
<td>29%</td>
<td>32%</td>
</tr>
<tr>
<td>WK 45.48</td>
<td>39%</td>
<td>24%</td>
<td>30%</td>
<td>32%</td>
</tr>
<tr>
<td>WK 49.52</td>
<td>43%</td>
<td>24%</td>
<td>52%</td>
<td>40%</td>
</tr>
<tr>
<td>Total</td>
<td>35%</td>
<td>30%</td>
<td>30%</td>
<td>32%</td>
</tr>
</tbody>
</table>

A significant number of patients were still referred directly by reception (32% average across all three practices) achieving one of the overall project objectives to shift demand to the right person with the aim of releasing GP capacity as part of the 2018 GMS contract for Scotland.
Other referrals to APP

- There were a number of referrals made by the practice based pharmacist however this only occurred in one practice (3%). This can be explained through early adoption of the new pharmacotherapist role rather than the tradition prescribing support pharmacist.
- Practice nurse referrals were evident in one practice where nurse triage is in place.

4.5. Did Not Attends

The DNA rate across the 3 practices is comparable DNA rates in other services.
4.6. Outcome Following APP Consultation

The vast majority of patients who were reviewed by the APP received advice and exercises to help manage their condition (72%). GPs reported that they believed the APP was likely to be better at delivering such interventions, and felt that although this had not been quantified, was probably reducing the time that patients were in pain following an acute injury, and also reducing the number of repeat appointments and need for analgesia.

This important change was supported by a Practice Manager reporting that they could think of examples where the patient might use 6 or 7 GP appointments whilst on the waiting list for community physiotherapy, or a hospital referral. GPs identified that these appointments were where they were mostly likely to end up climbing an analgesic ladder whilst waiting for advice or exercise from a physiotherapist.

Access to services for low back pain were described as an area where GPs knew that patients were having more time off work and more medicines whilst waiting for appropriate treatment. Being able to provide a quick intervention avoided acute injuries turning into chronic problems and was felt to reduce the number of people who needed time off work for this type of problem.

10% of people were referred to MSK services. This number includes both those referred via SCI for urgent rehabilitation, with others who had ongoing physiotherapy needs and were encouraged to use a self-referral form to access community services. It is not possible to identify how many people who were advised to self-refer for physiotherapy actually did so, or how many patients later self referred to physiotherapy on their own initiative. Regarding other outcomes, 8% required analgesia, 5% required further imaging and 3% required onward referral to secondary care (Orthopaedics, Neurosurgery, Rheumatology or Pain Clinic). In each case, the APP would be able to manage the administration of those referrals, making sure that the right person made it to the right service as quickly as possible. One GP said it seemed that people were seen more quickly when the APP made the referral, suggesting they might have a better understanding of the right language to use, or processes to be followed.
Very few patients needed a GP review, blood tests, a fit note or a steroid injection. Where the GP was required to carry out some action to assist the patient, APPs were usually able to request this through the practice information system with the patient experiencing minimal delays.

**Serious Pathology**

- The APP is currently aware of one case of serious spinal pathology. A patient who initially presented with radicular arm pain and was referred to Neurosurgery was later diagnosed with primary lung carcinoma and bony metastases. At the time of assessment and referral the bloods were satisfactory and a repeat CXR undertaken by the GP was reported as normal. He later presented with progressive unexplained weight loss.
- A second patient is currently being investigated for suspected malignancy.
- Four patients have been picked up with undiagnosed fractures (scaphoid, OP lumbar vertebral fracture, 5th metatarsal and shoulder) and referred on appropriately.
4.7. Staff Experience

There was a real sense throughout all of the interviews that the APP had settled well into the practice and that personalities were mixing well. It was frequently stated by practice staff that they felt that the introduction of an APP had been successful in large part because of the particular nature of the APP who filled the role.

Reception staff were happy to be able to offer another option to patients who were looking for help (albeit within the challenges noted previously). In one practice, the only on the day appointment that receptionists could offer was with the APP which may have helped them to feel more likely to push for an APP appointment slot to be filled. Receptionists all said that they were happy with the approach, and felt confident to ask the question, when time permitted. This highlighted a real challenge in making sure that Reception staff feel able to take a little more time with telephone calls to make sure that the person gets the right appointment. Practice Managers and GPs both said that asking the question was encouraged and regularly discussed, however Reception staff felt clear that their first priority would be to turn calls around quickly.

Practice Managers reported positive experiences of how the induction had worked, how the APP had settled into the role and the team, as well as the confidence that other primary care team members had in the APPs ability to deliver safe and effective care. They also had some level of concern that reception staff had to be incredibly resilient to be able to take the constant rejection of APP appointments being offered, and still to keep offering them anyway.

As well as GPs providing much of the detail of the APP role, how they fit within the practice, what had helped and hindered along the way, GPs could also identify that many patients would be receiving a better level of assessment, and almost definitely a smoother pathway of care. Whilst a number of GPs stated confidence in MSK assessment, they also felt that having a longer assessment time meant that the person may have a more comprehensive assessment if seen by the APP. Some other GPs did not feel confident that GPs delivered the best care in the acute phase of an MSK problem emerging. Everyone reported that they had learned something from having the APP in the practice. This ranged from GPs reporting that they didn’t know the full range of Physiotherapy skills, to learning about different treatment options through collaboration, discussion, and a whole range of information sharing that happens on an informal basis when people are located in the one area. A number of GPs identified that people who may in the past have returned to the GP several times with escalating analgesia needs whilst waiting for secondary care MSK services, could be offered expert assessment and treatment options within a much more satisfactory timeframe.

The APP had highlighted that trying to maintain positive relationships and fit into the practice whilst also trying to fundamentally change the way that some people work required a sensitive and thoughtful approach. Many of the observations and reflections are incorporated throughout this report and provide context to some of the detail.

In summary, much of the feedback from all staff demonstrated the benefits that can be realised from having a better understanding of the roles of other people and the challenges that role presents. The APP recognised the high levels of risk that practitioners work with in the primary care setting, the pressure of a service-when-needed approach, the limitations of short appointment times and the need to maximise the clinical contribution.
4.8. Patient Experience

It was not possible to identify how many people had been asked if they would see the APP but had declined. Information therefore has been based on the views of the practice team, and through the distribution of a patient questionnaire.

It was acknowledged that those who saw the APP were likely to be a particular subset of people who were more engaged in self care and willing to try some exercises to improve their pain.

What Practice Staff said about the patient experience

- GPs and other clinical staff who were interviewed were confident that the APP delivered a better patient experience in the practice. Some had intentionally followed up with patients to ask about their experience of seeing the APP
  1. Those who saw the APP had a comprehensive assessment and follow up carried out by a specialist they would normally have to wait to see
  2. MSK knowledge in the practice was seen to be improving as a result of having access to the APP and their specialist input
  3. By redirecting MSK appointments so that more people could be seen with non-MSK issues
- Practice Managers were able to describe individual situations or individuals they felt were accessing services differently as a result of having seen the MSK APP
- Receptionists reported that patients regularly gave positive feedback about their APP appointment.

Patient Survey Results

Each practice issued a postal questionnaire to 100 people who had seen the APP
- Mair Practice returned 47 questionnaires
- Blue Practice returned 42 questionnaires
- David Elder Practice returned 62 questionnaires.
Patients were asked 6 questions about their experience of seeing the APP – Question text is included in the table below this chart.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Other</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 Were you happy with the speed of service that you received from our practice based physiotherapist?</td>
<td>149</td>
<td>1</td>
<td>1</td>
<td>151</td>
<td>99%</td>
</tr>
<tr>
<td>Q2 Following your appointment with our physiotherapist did you find the service useful in helping to diagnose or manage your condition?</td>
<td>143</td>
<td>6</td>
<td>2</td>
<td>151</td>
<td>95%</td>
</tr>
<tr>
<td>Q3 Would you be happy to use the practice based physiotherapy service again?</td>
<td>149</td>
<td>1</td>
<td>1</td>
<td>151</td>
<td>99%</td>
</tr>
<tr>
<td>Q4 Would you consider referring yourself directly to the practice based physiotherapist if you have future muscle or joint problems, rather than seeing a GP first?</td>
<td>150</td>
<td>1</td>
<td>0</td>
<td>151</td>
<td>99%</td>
</tr>
<tr>
<td>Q5 Would you recommend this service to your friends and family?</td>
<td>150</td>
<td>0</td>
<td>1</td>
<td>151</td>
<td>99%</td>
</tr>
<tr>
<td>Q6 Would you like to see this service to become a standard part of the service offered by your GP practice?</td>
<td>151</td>
<td>0</td>
<td>0</td>
<td>151</td>
<td>100%</td>
</tr>
</tbody>
</table>

Patient feedback on their experience of seeing a APP was exceptionally high with 95% of patients finding the service useful and 100% wanting the service to become a standard part of their GP practice.
Patients were asked if they would like to make any other comments about the service. The wordcloud below provides a visual representation of the key words that were identified. The full report contains each response given in full.
SECTION 5. OBJECTIVES SUMMARY

The evidence indicates that embedding an APP within the SHIP GP practices supported the project in meeting a number of its original and APP specific objectives.

<table>
<thead>
<tr>
<th>Govan SHIP Objectives:</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Shift demand to the right person, in the right place, at the right time, through structured multi-disciplinary team working. Lower the threshold for intervening in problems, using horizontal referral to resources within the community and primary care rather than vertical referral to more expensive parts of the health and social care system, with a view to containing problems at a low level</td>
<td>Volume of referrals to the APP by both reception and other MDT professionals New internal practice pathways Lower Orthopaedic referrals Lower imaging referrals Use of supported self management.</td>
</tr>
<tr>
<td>2. Work to the top of the licence</td>
<td>Shift in referrals to imaging from GP to APP Lower rate of onward referral in comparison to GPs Teaching role within the practice. Serious pathology pickup</td>
</tr>
<tr>
<td>3. Develop anticipatory and preventative approaches to reduce inappropriate use of Unscheduled Care and avoid or delay hospital admission</td>
<td>GP and PM feedback describing patients accessing services differently after seeing the APP.</td>
</tr>
<tr>
<td>4. Provide improved support for chronic illness</td>
<td>High number of multi and poly morbid patients being referred to the APP.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>APP Specific Objectives</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Redirect patients from GP to APP where MSK issues identified. Improve the patient experience of access to timely support with MSK problems. Reduce inappropriate demand for hospital services. Further enhance the mix of healthcare professionals and therefore interventions available at a practice level.</td>
<td>Volume of referrals to the APP by both reception and other MDT professionals. 99% of patients were happy with speed of service 95% found the service useful. 8% patients required analgesia, 5% required further imaging and 3% required onward referral to secondary care (Orthopaedics, Neurosurgery, Rheumatology or Pain Clinic). Successful integration of APP into established MDT teams 100% of patients wishing the service to be continued</td>
</tr>
</tbody>
</table>
SECTION 6. CONCLUSION

This evaluation has evidenced that the APP role has integrated well into the practice MDT. It is accepted by patients, with high levels of satisfaction and few patients seeking a GP review after seeing the APP.

Only small numbers of patients managed by the APP required attendance at hospital for imaging or onward referral to secondary care. This is in keeping with findings from a previous Inverclyde pilot where APPs had significantly lower referral rates for prescribing, imaging and orthopaedic referrals compared to a GP baseline audit.

The pilot did not measure the impact on GP return appointments for patients with MSK conditions but feedback from practices has indicated that seeing the APP reduces patients returning multiple times for their MSK problem. This saves GP time and avoids repeat attendances for escalating analgesia.

In areas of high deprivation like Govan, it is beneficial to streamline patient pathways and provide healthcare locally in and around primary care settings where appropriate to do so. The APP role supports this, with GP feedback that many patients seen by the physiotherapist receive a better assessment and have a smoother pathway of care.

The proportion of patients attending the APP after a GP appointment was higher in Govan than in Inverclyde. As described in section 4.4 Route of Access, the cause is likely to be multi-factorial and may reflect the impact of deprivation. For many of these patients, the APP will still provide the “first contact” for the MSK condition as the GP concentrated on other co-morbidities during their appointment. The roll-out of the model to more areas of high deprivation will provide further insight into whether there is a direct correlation or whether there are other local practice factors.

The pilot has shown that the Practice Manager and reception staff are key to shifting workload from the GP to the APP. Strong leadership and support for practice staff is essential to overcome the challenges in implementing their signposting role, especially at busy times.

This is an area of major innovation for physiotherapy and Primary care. As one of the first projects to introduce Advanced Practice Physiotherapy across a group of GP practices, this pioneering work has informed the wider roll out of the model elsewhere in GGC and contributed to the changes happening in GP practices across Scotland. These innovative roles are still in their infancy and will continue to evolve over the coming years as the new GP multidisciplinary teams develop.

Meantime, the Govan SHIP APP pilot has identified a number of areas to consider for improving subsequent cycles of this work. This has been incorporated into the following action plan.
The MSK Physiotherapy service is working with a national MSK short life working group, the NHSGGC Primary Care Programme Board and the MSK Oversight group to address the areas identified for further work. The workstream is also linking with NES through the Transforming Roles group to develop a framework for MSK Advanced Practice roles in primary care.

### SECTION 7. ACTION PLAN

<table>
<thead>
<tr>
<th>RECOMMENDATION</th>
<th>ACTION</th>
<th>TIMESCALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support leadership and change within the practices to deliver new ways of working.</td>
<td>Use evaluation and feedback from Govan SHIP MSK pilot to shape roll-out to new practices, and inform ongoing Programme Board workstream on MDT working.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Development of knowledge, skills and behaviours framework with competencies.</td>
<td>Work with national MSK Lead and Transforming Roles group to develop and pilot framework and accompanying tools.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Induction and ongoing training for role</td>
<td>Update current induction pack to reflect feedback from recent recruits. Access training and portfolio resources when available from Transforming Roles group.</td>
<td>August 2019 2019/20</td>
</tr>
<tr>
<td>Consider risk of “burn-out” and retention of staff.</td>
<td>Monitor and review all APPs’ weekly workplan, balance of clinical, non-clinical time and MSK session. Optimise support available to new and current staff including from Clinical Lead, GP lead, peers, MSK service.</td>
<td>Reporting from March 2019.  Work progressing throughout 2019/20</td>
</tr>
<tr>
<td>Improve access to imaging</td>
<td>Develop proposal for MSK Oversight group. If agreed, work with Radiology to increase access.</td>
<td>March 2020</td>
</tr>
<tr>
<td>Trainee/development roles for succession planning</td>
<td>Work with Oversight group and HSCP leads to progress piloting of additional hub or hosted model which will facilitate introduction of development posts.</td>
<td>2020/21</td>
</tr>
<tr>
<td>Reduce potential de-skilling of GPs and GP trainees in MSK management.</td>
<td>Learning sessions for GP trainees. Providing second specialist opinion for MSK complex patients. Shadowing opportunities.</td>
<td>Available in all practices following completion of induction period.</td>
</tr>
<tr>
<td>Selection of performance and patient outcomes</td>
<td>National SLWG is standardising data collection and outcome information for Scotland. GGC is contributing to this. Work with Primary Care leads to ensure impact of APP role is included in overall evaluation of Primary Care Implementation Plans.</td>
<td>March 2020  Ongoing.</td>
</tr>
<tr>
<td>Equity of access</td>
<td>Scope, design and pilot additional hub or hosted model to improve access for practices unable to accommodate an APP within their MDT.</td>
<td>March 2020</td>
</tr>
</tbody>
</table>

An implementation pack exists in an informal way (Appendix 5) and may benefit from this being formalised to provide an Improvement / Change Pack for Practices.
APPENDIX 1 - Receptionist Summaries

The activities that are included in this test involved the introduction of an Advanced Physiotherapy Practitioner in 3 general practices involved in the GovanSHIP initiative. One further practice could not be involved due to lack of space for the APP to see patients.

This particular evaluation describes the Receptionists’ experiences of aligning an extended scope physiotherapist (APP) within general practices to divert patients requesting appointment for a musculoskeletal issue.

Did it lead to any changes in your role and how was that managed? Did you get a say?

Reception staff in the 3 practices could describe having been given a script sheet which had given them an example of how to ask the person if they would benefit from an appointment with the APP. Some had said it was attached to their computer monitor or telephone.

Everyone described being given information from their Practice Manager. This ranged from being invited to attend the meeting where staff from Inverclyde described how the MSK test had worked for them, and what they had done to prepare the practice and the patients for the APP role.

Posters, answerphone messages and text campaigns were all given as examples of how the Practice had helped the reception staff with this new role. All the Receptionists understood that they were key to making this work, although there was varying levels of enthusiasm for asking patients for more information about their request.

One practice are the ‘Asylum Practice’ in that anyone in the area who is seeking asylum or is a refugee is seen at that practice. This practice reported that things like telephone messages, text campaigns or posters were of limited impact in this group because of the way in which appointments are generally offered in the practice.

In one practice the reception staff had jokingly explained that staff rarely had any difficulties getting details from patients about why they needed an appointment so had noticed little change in how they done things. Across all 3 practices, the Reception staff described this as an easier job than the Practice Managers had reported on their behalf.

Other things that were seen to support the process were working in an office where colleagues were able to support and encourage each other, and getting feedback from the APP about people they had directed to them and whether it had been appropriate.
Did staff get a say in how it would be set up?

Whilst Receptionists weren’t specifically given a say in the set up of the initiative, they had a good understanding of any issues caused by the way in which MSK sessions were scheduled – ie ‘we had a Friday and a Monday, and then a long gap before the APP was around on the Friday again which wasn’t ideal’, or ‘it’s great because now there’s a good mix of early and late appointments to offer’. The people answering the phone and offering appointments have a good understanding of their patients’ behaviours and are keen to meet their needs. Receptionists were able to describe the different approaches that had been taken to maximise APP activity by releasing appointment slots at different times to try to find the best balance of in advance and on the day allocations. The importance of having slots available whenever a patient called was reiterated by everyone, who highlighted how easy it is to stop asking if the APP appointments have been fully booked for a while.

Receptionists worked hard to make sure that the APP slots were always fully allocated and are very aware that patients waiting a long time on a telephone queue may well be using up all their mobile phone credit. Reception staff were mindful of the implications of taking a long time to answer a call, and this will undoubtedly influence how willing they are to ask for more info, particularly during busy times. They acknowledged that morning calls are less likely to be asked about suitability of an APP appointment because they feel under so much pressure with the volume of calls at that time.

The APP clearly saw their input as critical to the process and the Reception staff advised that they are kept up to date about the percentage of referrals that are coming direct from reception, as well as being given feedback about the appropriateness of who they are sending forward. This appeared to be motivating for the staff.

Reception staff demonstrated that they are making a lot of judgements when they are answering the telephone to offer appointments. Comments like ‘we use our instincts’ and ‘if they said they had a sore back or neck I’d try to cajole them along’ and ‘there’s no point mentioning it to some patients’.

Benefits to Patients of MSK Specialist

There were some individual anecdotes where Reception staff offered examples of people who had seen the APP, or about feedback they had been volunteered. They said their patients had reported the APP having healing hands, and commented on how some of the people who had benefited from an MSK appointment weren’t who they had expected. One receptionist gave an example of an older person in their practice who had been encouraged to seek assistance with mobility after joking about needing crutches.

Receptionists were aware of the long wait to be seen by community physiotherapy and felt that the APP in practice was not only was this better for patients because they could be assessed sooner, but it was also better for community physiotherapy they expected would have fewer DNAs because people attending will be more confident that they actually need physiotherapy treatment.
Other Benefits to Patients and Practice

Reception staff, more than any other group, see the cumulative effect of adding different roles into the service. When asked about the benefits in the practice, staff reported that it was the combination of lots of different things that was making it easier to manage the huge volume of activity that is required in primary care.

Practice staff reported being very open to change, as a consequence of being in the GovanSHIP initiative, however this was the first time that Receptionists themselves were trying to redirect patients to someone other than the GP.

There is no doubt however that this group of staff are used to being on the front end of any changes that are planned within the practice, and also the group who first get feedback about patient views. Receptionists were keen to point out that the patients who used the MSK service were delighted with it.

Challenges in Taking APP Test Forward

Encouraging patients to change their behaviour was noted as being the most difficult thing about this test. Receptionists were carefully choosing who to offer an APP appointment to, based not only on their problem, but also how receptive to new ideas they knew the person to be. They stated that some patients just want to make sure they can get a sick line or medicine if they need it, and can’t be convinced that the APP would be able to sort that out for them if they needed it, by the next day at the latest.

Another difficulty of this test was finding the right balance of appointments. Things the Receptionists identified as being important included

- Whether the physio made appointments available in advance, or whether they were only released that week
- How many days wait were between the APP being in surgery
- Whether the APP was able to offer a mix of morning and afternoon appointments

Some sustainability factors made it hard to take this test forward, namely

- Changes to things like online appointments and telephone messages will only happen once the post had been confirmed as permanent
- There is only one person covering this post for 3 practices – whenever there are no appointments to offer, it becomes harder to remember

When asked about the challenges, almost all Reception staff stated that asking about MSK problems doesn’t work first thing in the morning due to the volume of calls, and the urgency of dealing with your call quickly so you can pick up another ringing phone. This is clearly a real challenge given that most appointments are allocated during this time.
Has it been helpful / worthwhile?

Definitely. The APP can do referrals for the hospital and MRIs, etc which is great because it means the doctor doesn't need to see the person first. There are rarely any physio appointments left now unless there are cancellations. I think that’s a good thing because it takes pressure off the doctors. If we had MSK appointments every day we would fill them.

MSK patients are really satisfied. We sent out satisfaction questionnaires and got great feedback. Word of mouth also helps other people to use the APP – he has helped a lot of people.

Other Comments

One practice commented that because their Receptionists don’t give same day GP appointments, it’s perhaps more of an encouragement for their patients that they may be able to get to see someone the same day.

October 2018
APPENDIX 2 - GP Summaries

The activities that are included in this test involved the introduction of an Advanced Physiotherapy Practitioner in 3 general practices involved in the GovanSHIP initiative. One further practice could not be involved due to lack of space for the APP to see patients.

This particular evaluation describes the General Practitioners’ experiences of aligning an extended scope physiotherapist (APP) within general practices to divert patients requesting appointment for a musculoskeletal issue. In one practice, the Advanced Nurse Practitioner was also interviewed as they triage requests for same day appointments in the practice.

How was it introduced and how were the different stakeholders prepared?

GP summaries:

GPs reported that because they have been part of the GovanSHIP initiative and testing lots of different ideas, that both the staff and their patients are becoming more accustomed to changes in how the practice operations.

Another feature was the need for more space. One practice had been unable to participate in the pilot because of a shortage of space, whilst another had been supported to convert their records room into an additional consulting room. GPs pointed out that the physio needs more space than might be required for a GP consulting room, on account of needing a bed.

Patients

Telephone messages, text reminders and posters had all been used to share the message at a patient level. In addition, GPs were very clear that how they ‘sold’ the idea to patients had an impact on how receptive some patients would be. The Nurse also reinforces the benefits of seeing the APP when triaging calls. There is an acknowledgement that such large scale behaviour change will be slow, and some people are reluctant to buy into the message that exercise may help them with their physical pain. GPs saw themselves as being central to taking patients by the hand and leading this change.

It was felt that national work and media campaigns are now beginning to help get this message across. It no longer feels like there’s only one or 2 practices where you might call for an appointment and see someone other than the GP.

Another common report was that patients themselves were great advertising agents for the APP. They reported that if a person had a good experience then word of mouth meant they were likely to help other people understand the benefits of seeing the APP.

Reception Staff

In one GP practice, the Reception staff were described as having ‘a problem-solving mentality’ – they are listening to what patients are telling them and being able to advise them of the most appropriate options based on what patients are telling them. It was clear in each of the practices that the GPs were mindful of the pressure placed on Receptionists to implement this change, and how that balances with other pressures such as the need to answer the call quickly, or deal with a call quickly in order to pick up the next call.

Physiotherapist

GPs reported that there was ‘no work’ required to settle the physiotherapist into the role. It was clear from wider comments that the character of the individual APP had a role to play in this with GPs eager to point out that the APP had given them a clinical confidence straight away.
Clinical tasks are managed using the same processes that are in place for other members of the practice team, and it seemed fairly straightforward for the APP to get access to the IT and training needed for the practical elements of the job.

Other comments made it clear that there were good informal relations among the staff, usually commenting that it was easy to speak with the APP, or for the APP to speak with the GP throughout the course of the working day, without having to make any special arrangement for that to happen. The APP was described as approachable and informative. Examples were given of how the practice team supported the APP by reviewing their appointments and letting them know if there were any issues of note, ‘tricky characters’, psychosomatic pain, etc.

Many of the processes are learned as situations arise, with the level of oversight appearing to reduce from the start of the test to the current time. One GP pointed out that whilst there is a lack of standardisation across GP practices, there are risks that the APP will carry out an action that is inkeeping with one practice process, but is not in line with another practices processes.

Others
These practices have a wider multidisciplinary approach with nurse practitioners, different specialities of prescribers, pharmacists, physiotherapists, etc. It was clear that there was a real understanding of the conditions which set people up to make sustainable changes confidently.

GPs felt that in order to create new roles, or to ask people to change their roles, people first need to feel competent and confident in the role that they already do. This was as true for Receptionists as it was for GPs.

Another critical role identified was that of the project manager. This was particularly relevant to the organisation of multidisciplinary team meetings. Co-ordinating an ever-more complex team and supporting the communication around that was something which has been given to the practices by the GovanSHIP Project Team and was described as a valuable component in making this and the other tests work. Aligned with this was the provision of data and the scheduling of regular progress reviews where practices can come together and discuss their new ways of working and what they are learning as they go.

Everyone interviewed made it clear that the option to see the APP is a choice, and patients may choose to see the GP regardless of what option they are advised to take.

Benefits to Patients of MSK Specialist

GPs identified that general day to day communication with the APP was helping them better understand aspects of the physiotherapy role that they were not particularly informed about previously. The APP gave regular feedback on who was or wasn’t an appropriate referral and the reasons for that.

There was a mix of views about whether or not it mattered that the APP couldn’t prescribe. GPs said it didn’t take a lot of time to process the small number of requests for medicines that came through, and there would generally be someone available if there was a request that needed immediate action.

GPs acknowledged the time that the APP saved them by having a clear understanding of referral pathways to address different issues, what tests or results might be needed in different situation, and how to interpret these. The APP was able to fully manage a presentation where his assessment identified a need for further actions and follow this up appropriately.

GPs reported that the long waiting list for community physiotherapy led to complaints and follow up appointments whilst the person was waiting to be seen. Some GPs felt that the number of times
this happened has reduced and most reported that they personally had dealt with less MSK issues. There were different views as to whether it would be reasonable to ask someone who attended with a variety of complaints to speak with the APP about their MSK issue separate from the remainder of the appointment.

GPs felt like their own referral pathways to services like Orthopaedics was smoother, and one suggested that perhaps the hospital services were more likely to agree with referrals made by the APP than they sometimes experienced themselves. Having a good relationship with diagnostic and imaging services, and a good understanding of hospital pathways was very helpful to the practice.

Services back out of the hospital were also seen to benefit from having an APP in the practice. Rehabilitation following discharge from hospital was a key area with one GP describing the normal situation being where someone is given exercise / advice at a time when they are least able to process and use it. The APP is able to reinforce that message at a time when people are in a more settled position and have come looking for help. The opportunity to have a clear and informative discussion about exercise and activity with the expertise supporting that was thought to be delivering benefits for patients whose physiotherapy included rehabilitation following an acute episode. ‘Physio’s have a rehab mindset’.

Services for low back pain were highlighted as being frustratingly difficult to access. When the MSK APP in the practice is able to provide timely access to appropriate care in the acute phase of injury, the ability to get a good resolution for the patients was much higher. To get some simple, helpful advice you might have to wait half a year. Your problem will definitely have got worse than if you haven’t had good advice about how to deal with it at the time.

In general, it was felt that patients who recognised the value of seeing a more specialised individual for their care were more likely to stick with their exercises, work with any medicines suggested by the physio and better understand their pain and how they could help themselves.

GPs were keen to highlight the particular benefits of the APP being in the practice, noting there are regular DNAs when asking people to attend services at the local Health Centre.

Other Benefits to Patients and Practice

Whilst everyone reported that they saw less MSK consultations, they all also recognised that they will continue to deal with those issues in some situations. Patient willingness to engage with another professional within the practice, or the simplicity of addressing the issue instead of using another practice appointment were clear drivers for GPs managing their patient’s MSK issues. Respondents stated that there would be no real ability to change that whilst the provision was limited in terms of availability.

The work of the APP was described as complimentary to, but not a replacement for, what the GP does. It improves access for everyone because if people with an MSK problem are seen by the APP, it frees up a GP appointment for somebody else. In primary care, people always use as many appointments as you can make available. This seems to be getting worse recently with newspapers and other media suggesting that people speak with their GP about a whole host of social or financial issues.

Having the APP in the practice was seen to benefit the practice generally because even if he wasn’t seeing a person, the GP has access to the APP’s expertise and can get advice if needed. GPs reported having a better understanding of who was appropriate for referral to hospital and which services would be appropriate. Some GPs reported that their referral to hospital had reduced as a result of being more confident about their decisions relating to MSK.
The Physio working across different locations was also seen to be a general benefit where ideas could be shared across practices easily.

In the way that this fits within the wider GovanSHIP initiative, there was a general feeling that it would be difficult to isolate individual benefits of this pilot, given that the MSK test is part of a wider suite of interventions designed to improve access to primary care services. GPs did say that they feel the people they are seeing are increasingly complex, with simple care issues able to be devolved to other parts of the Primary Care Team.

Challenges in Taking APP Test Forward

All interviewees reported that changing patient behaviour was the hardest part of this initiative. The issues ranged from not liking to be asked about the nature of their problem to being accustomed to a model of care where the GP was the sole care provider.

Space was identified as an issue for practices, and something which has become increasingly complicated as different individuals and staff groups become involved in the wider multidisciplinary team.

Consistency of provision was something which emerged when GPs were discussing the ways in which they could encourage and support use of the initiative. One GP had suggested that having someone who works between the hospital and practice would be ideal in that cover could be arranged, training would be better aligned, a physical location for the person would be less of an issue, and it would build further on the relationship benefits that can be seen from having someone in the practice who understands the hospital systems well.

One GP took this opportunity to reinforce the importance of having the right person in the role – ‘the skill level of the APP is vital to it working. I’d be worried that someone with less experience might create more work in the practice’.

Difficulties in obtaining useful data were raised by one GP on this group. Whilst work had been done at practice level to create templates that collect the right information at practice level, there is a lack of hospital data – is this reducing referrals to orthopaedics? How is it impacting on the demand for MSK services?

Has it been helpful / worthwhile?

All of the GPs indicated that the test had been worthwhile and they would like to keep the role. The wide range of benefits drawn out across the body of this summary include:

1. Better MSK expertise in the practice meant that not only was the GP knowledge improving, but patients who needed referred on would be likely to have a better experience

2. Someone else who can manage an entire episode from assessment through to onward referral and following through with any activities relating to that

3. Physios have a rehab mindset. They are better able to discuss health benefits of exercise and ways of managing pain. This can be particularly important when someone has come out of hospital and there are MSK issues, such as rehabilitation following a joint replacement.
Other Comments

This group was able to clearly articulate the benefits they had seen from participation in the GovanSHIP Project. These practices are slowly chipping away at the problem of primary care access, using a whole range of different ideas that can be moulded and shaped to fit the individual practice needs and their own confidence to engage.

GPs valued the contribution of the GovanSHIP Project Team to support their activities, whether they were relating to the clinical test, or whether they were about supporting the wider infrastructure.

Individual support to conduct and document multidisciplinary team meetings was a role of the Team that GPs felt was critical to the success of the wider GovanSHIP project. Specifically relating to the MSK pilot, GPs valued the provision of data, co-ordination and documentation of Steering Group meetings and other platforms where practices could share learning. GPs were given time to participate in these meetings as part of the wider support infrastructure around the GovanSHIP Project.

October 2018
The activities that are included in this test involved the introduction of an Advanced Physiotherapy Practitioner in 3 general practices involved in the GovanSHIP initiative. One further practice could not be involved due to lack of space for the APP to see patients.

This particular evaluation describes the Practice Managers’ experiences of aligning an extended scope physiotherapist (APP) within general practices to divert patients requesting appointment for a musculoskeletal issue.

How was it introduced and how were the different stakeholders prepared?

**GP**
GPs themselves have been leading the work and Practice Managers described the initiative first being introduced by GPs aligned to the Project Team. Regular meetings allow the practices involved to share learning and ideas with the other practices involved.

**Reception Staff**
Reception Staff had been invited to attend training which was organised so that practices who had tested an APP in their practice could share their learning about earlier pilots of a similar type. One Practice Manager suggested that everyone should have to attend this training, and that for that to happen, it would ideally need to take place within the practice. It was felt that it was more difficult to understand the difference between the role of the community physiotherapy service and this newly designed advanced physiotherapy assessor role.

The Practice Managers acknowledged that reception staff are under pressure to answer the telephone quickly and this can impact on how likely they are to ask the patient for more information about the nature of their problem.

**Physiotherapist**
The Physiotherapist had helped to prepare the practice for the implementation of this test. This included teaching reception staff how to ask the right questions, highlighting to GPs and receptionists which cases were or were not suitable to guide better use of the physio. All 3 Practice Managers made reference to the APPs particular character and how well he had fitted within the practice. They strongly reinforced the need for the person in this role to be knowledgeable, experienced, and confident communicating with other staff groups. Other skills that the individual brought to the role included a knowledge about local services, and appropriate hospital pathways for different situations (such as imaging, back pain, ongoing rehab, exercise / activity groups, etc).

The Practice Managers clearly appreciated the ability of all of stakeholders to work well together to deliver a seamless service that was all part of the practice activity.
Did staff get a say in how it would be set up?

Practice Managers reported that there were minimum changes to staff roles when introducing the APP role to the practice.

One Practice Manager described a change to one of their processes, which had come about as a result of different ways of working between the 3 practices. On this occasion, the APP had identified that a particular test was not part of the suite of investigations in one practice. It was routine in the other 2 practices. Through discussion, the 3rd practice introduced the test to its suite of investigations.

The Practice Manager in the practice who introduced the test highlighted this as demonstrating the complexity of a single practitioner working across a number of different practices. The Practice and the APP will be assessing whether or not they are knowledgeable about particular processes, based on what they’ve learned in one practice. The particular processes in another practice might however be different and it would be impossible to cover everything in advance in sufficient detail to be able to identify those anomalies easily.

Some assistance had been given to make space available for the APP in one practice by supporting the electronic scanning of all documents to support paperless working and the reallocation of the old records room.

Benefits to Patients of MSK Specialist

GPs were seen to be able to use the availability of specialist support to break up parts of complex presentations which they could then ask the person to take forward separately with the APP.

When asked if the test had delivered any unexpected results, one practice manager pointed out that by having more time to explain the physiology of pain and how muscles work they could engage patients better.

“GPs don’t have the time to do that well – there’s a huge scope to improve patient education when you think about that. Deprivation inevitably means that there are more barriers in people’s understanding and ability to change. Factoring that in is important in our area.”

One Practice Manager had said that some patients said that they feel spoiled because they have different experts in the practice now – the pharmacist can help them with their medicines and the Physio can help with MSK problems for example.
Other Benefits to Patients and Practice

One Practice highlighted how the APP had helped to change the model to allow for longer GP appointments for particular groups or individuals.

One other Practice Manager had said that whilst they were unable to measure the impact on call volume, seeing the APP had probably stopped the person going back to see the GP another 6 or 7 times whilst waiting for community physio appointment.

When asked about how this pilot had helped with making appointments more available generally within the practice, Practice Managers felt that GPs and receptionists were putting a lot of work into convincing appropriate patients to see the APP. Questions about whether their DNA rates were higher as a result of feeling pressurised to take an appointment they weren’t fully committed to were raised by one Practice Manager. All 3 Practice Managers used this question as an opportunity to highlight how it was difficult for staff to keep remembering to ask the question, especially at busy times.

Challenges in Taking APP Test Forward

Each of the practices described some challenges in getting the right number of sessions per week in the practice, across a good balance of morning and afternoon appointments, without creating long waits between sessions in the Practice. Another difficult balancing act was how many appointments should be filled in advance, and how many should be held for on the day requests. At least one of the Practices acknowledged that they were still tweaking that.

Each of the Practice Managers highlighted one main challenge in taking the test forward, and whilst described differently, all referenced the difficulties in changing behaviours. One Practice Manager described it as ‘pretty soul destroying’ when you keep offering physio appointments and everyone you ask says no. A second had said that none of their interventions had really had an impact on patient behaviours and the majority of people will only buy in when one person they know goes along and tells them it’s a good service. The third Practice Manager had pointed out that availability was the key issue – when appointment slots are busy then reception staff don’t have those appointments to offer. Later, when there are appointments, the Receptionists are out of the habit of asking the question again.

One practice who have a split location identified it would have been better to have the APP in both sites. They demonstrated the importance of the APP being based in their surgery by highlighting how their patients wouldn’t even go to the other site to access the physio.
Has it been helpful / worthwhile?

All of the Practice Managers indicated that the test had been worthwhile and they would like to keep the role. One added that the patients who access the APP are impressed with the speed of access for physiotherapy assessment. The wide range of benefits drawn out across the body of this summary include:

4. Better MSK expertise in the practice - GP knowledge
5. Someone else who can take a patient who presents in pain and safely and efficiently negotiate them through appropriate care and treatment including onward referral and management as appropriate
6. Better patient education around managing pain and physical injury

Other Comments

The GovanSHIP initiatives have all been refined through testing and adaptation to identify what works best. This initiative came ‘fully formed’ in the sense that training was available, data requirements had been established and resources had been created to help test the concept in other areas. This was described as a benefit by the Practice Managers who had had to put less thought into what may or may not go wrong than with other tests.

October 2018
APPENDIX 4

NHS GREATER GLASGOW AND CLYDE

PATIENT EXPERIENCE OF ADVANCED PHYSIOTHERAPY PRACTITIONER IN DEEP END PRACTICES

GOVANSHIP PROJECT

NOVEMBER 2017 – NOVEMBER 2018
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SECTION 1. INTRODUCTION

This report contains feedback given by patients receiving physiotherapy assessment in 3 GP practices in Govan participating in the GovanSHIP pilot.
SECTION 2. AIMS AND OBJECTIVES

The aim of the GovanSHIP initiative has been to explore and test different multidisciplinary contributions to the primary care team and identify opportunities to use other clinical specialities to delivery primary care in the future.

CHANGE THEORY:
A difficulty securing sufficient GP input to primary care has created access difficulties in primary care. This can be seen in long waits for an appointment with a GP (this is unmeasurable with current dataset yes?), and challenging working conditions for those GPs delivering primary care services.

AIMS: (specify aims)
To test the feasibility of introducing an advanced physiotherapy practitioner to practice and ascertain the potential for this role over the longer time

OBJECTIVES:
- People requiring GP appointment for MSK issues will be offered an appointment to see an Advanced Physiotherapy Practitioner
- Reduced burden of work for GPs (either in number of appointments or demonstrated via complexity of individual presentations)
- Improved patient experience by being directed to the most appropriate appropriate intervention in a timely manner

STANDARDS:
- 95% or more satisfied with experience across all questions (what do you think of this?)
SECTION 3. METHOD & SAMPLE

At a single point in time in each practice, the APP distributed patient questionnaires to 100 people seen by them. Each practice chose a different period in time, but in each case, the physiotherapist handed out the questionnaire and made arrangements for their return.

The following summary outlines the information gathered throughout this process.
SECTION 4. RESULTS OVERVIEW

4.1. Overview of Question Responses

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<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Other</th>
<th>Total</th>
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<td>Q1 Were you happy with the speed of service that you received from our practice based physiotherapist?</td>
<td>149</td>
<td>1</td>
<td>1</td>
<td>151</td>
<td>99%</td>
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<tr>
<td>Q2 Following your appointment with our physiotherapist did you find the service useful in helping to diagnose or manage your condition?</td>
<td>143</td>
<td>6</td>
<td>2</td>
<td>151</td>
<td>95%</td>
</tr>
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<td>Q3 Would you be happy to use the practice based physiotherapy service again?</td>
<td>149</td>
<td>1</td>
<td>1</td>
<td>151</td>
<td>99%</td>
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<tr>
<td>Q4 Would you consider referring yourself directly to the practice based physiotherapist if you have future muscle or joint problems, rather than seeing a GP first?</td>
<td>150</td>
<td>1</td>
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<td>151</td>
<td>99%</td>
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<td>Q5 Would you recommend this service to your friends and family?</td>
<td>150</td>
<td>1</td>
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<td>151</td>
<td>99%</td>
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<td>Q6 Would you like to see this service to become a standard part of the service offered by your GP practice?</td>
<td>151</td>
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4.2. Overview of Comments Returned

Individual comments are listed by practice in Appendix 1.
SECTION 5. INDIVIDUAL QUESTION RESPONSES

5.1. Were you happy with the speed of service that you received from our practice based physiotherapist?

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5.2. Following your appointment with our physiotherapist did you find the service useful in helping to diagnose or manage your condition?

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5.3. Would you be happy to use the practice based physiotherapy service again?

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5.4. Would you consider referring yourself directly to the practice based physiotherapist if you have future muscle or joint problems rather than seeing a GP first?

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5.5. Would you recommend this service to your friends and family?

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5.6. Would you like to see this service become a standard part of the service offered by your GP practice?

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SECTION 5. CONCLUSION

(How does what you have found relate to your theory of change? What should happen next?)
SECTION 6. ACTION PLAN

(For guidance purposes only, please delete.)
Clinical Audit is a Quality improvement tool, therefore it should be clearly stated what the challenges are, what the recommendations/actions will be arising from the findings of the audit, who will be responsible for implementing the recommendations/actions, and when the changes will be implemented. This can either be done by using text with bullet points, alternatively it can be stated through the use of a table (See below)

**Using free text:**
“How will this be achieved?”
“How will the results be disseminated?”
“Who will implement the changes?”
“When will the changes be implemented?”
“When will the changes be reviewed and evaluated?”

**Using table:** (Please alter layout according to needs)

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Action plan
Written by: [Name]
Designation: [Position]
Date: [Date]

Agreed with:
Designation: [Name]
Date: [Date]
Appendix 1 – List of Comments Returned

Blue Practice Comments

- A definite yes to all of the above. Thank you.
- Essential, Needed, Please continue, much better.
- Excellent - great physio, no waiting.
- Fast and professional service, would recommend and very helpful to have quick access to local physio.
- Great service.
- Hard for me to remember the last time I went to see physiotherapist. These yes or no, I would leave it to the health centre staff and doctors about this matter.
- I cannot praise Mr Keillar highly enough. He is a first class physio so when you have service of this calibre you do wish to lose him.
- I had suffered back pain for months and when I found out about Physio available at my GP, I made an appointment. He was thorough and attentive and gave me exercises and anti-inflammatories within 2 weeks my pain was gone. I was thrilled with this service and am recommending to everyone!
- I just felt the length of time it took for me to receive the appointment was a very long time and if I receive any appointments for the hospital they try to send me somewhere else when the queen elizabeth is close to me.
- I met Eden but unfortunately he could not help with my back but it was informative and I would see him again if required.
- I think this is a great idea having the physio within the practice.
- I was delighted to use the service. The physio is a specialist in his field so knew I was get the right advice, which I took on and me knee is in good shape. Eden made me feel comfortable.
- Limited resources available. Physio couch required with head space for back would be required to enable you to lie on your front. Happy that physio could arrange x-rays and referrals.
- Lovely young man, super efficient, speedy.
- Made such a difference to not have to wait months, I hurt my neck and the pain was severe. The physio was excellent and it really helped. Thank you.
- Mr Eden Keillar was very patient and understanding while I explained my injury to him. It turned out that my injury could not be helped with physio but Mr Keillar still took the time to explain and help me understand what was wrong and why physio couldn't help.
- Quick to get an appointment, professional, helpful.
- There is not much point seeing a Physiotherapist if they give you a sheet of paper to do exercises. I would prefer a massage if I had known it was a sheet of paper I wouldn't have gone. In my opinion they need to do more.
- This service may help younger people, but I was told to do the same exercises that I was told to do when I got my knee replaced 13 years ago. Didn't help me at all, was referred to see an Orthopaedic Surgeon 21st of August last year and i'm still waiting. I think it's a case of why waste money on a man of my age as he will die soon. I've given up on getting help from your practice or the hospital.
- Very pleased with physio.
- Was really surprised when GP told me this service was offered as I expected to wait months for a referral. Ended up having an appointment with Eden 24 hours after seeing GP in first place. Was very informative, helpful and was so relieved to have a consult straight away. This service is definitely needs more publicity in the practice 100% recommend!
- Would be great if the practice based Physiotherapist could also do treatments as I'm still having
to wait weeks to be seen.

Elder Practice

- After my appointment I was referred to the hospital physio's.
- After suffering an injury I visited the Physio who was fantastic, He diagnosed my problem and offered support as exercises to strengthen my muscle. He also referred me to the Hospital Physio who I saw for a further 6 months. I am waiting for an operation to solve my problem, however without the intervention of the practice physio I would still be severe pain.
- Although I am satisfied with the speed of the service i.e from GP appointment to "Physio" appointment I was informed it would take "approx" 4 weeks to start the treatment, so far it is almost 6 weeks and the pain is not easing.
- Although I circled no to Q2, this was actually because I knew what was wrong and was to see the physio to see if any extra help could be given. Fantastic to see a physio so quickly.
- Due to already having an appointment and also with clinics Physio Dept I am in need once again with Ortho Dept at hospital waiting for app. Physio could not do anymore.
- Excellent idea, was helped greatly by this service. Hope its a service that is kept in practice.
- Felt comfortable in the Physiotherapist's knowledge of my issue and was given good advice. He also mentioned that if anything further was needed, he would liaise with doctor. Hopefully freeing up an appointment space for someone else.
- Found the service really helpful, have not had anymore problems since seeing the physio.
- great service and would like to see if continue
- I don't think there's anything the physio can do for me apart from giving me exercise sheets which he has already one.
- I have found it very helpful to attend Physiotherapy with Mr Eden Kellar who checked me out with my problem and explained to me what to do.
- I thought it was a great idea, when I saw the physiotherapist I found out he has been there since November last year. I certainly did not see any information in the waiting room, if so I would have gone direct to him and not the doctor frist thus saving an appointment.
- I usually have a six week wait for a self referral much faster treatment.
- I would like to thank the physio for the attetion to detail and helpfulness in my recovery.
- Mr Eden Keillar was very friendly and made me feel comfortable.
- My appointment with Mr Eden Keillar was really helpful. I got a x-ray quicker which I never got by seeing a GP this service was alot quicker than waiting to be referred by GP.
- On the day of my appointment I found Eden very professional and courteous, gave me a thorough examination and also explains everything he was doing, would not hesitate in referring myself to Eden again.
- Please help me to remind Mr Eden that I am still waiting for my appointment call.
- The physiotherapist was warm and friendly. He listened to what I said and took up the exercises that I was already doing.
- This service is so much better, than waiting weeks/months for hospital appointment.
- Very good service, very quick explain well thank you.
- Very helpful put mind at ease.
- Very impressed with this service. Advice was very helpful, as was offer of future treatment if required.

Mair Practice

- Excellent service, quick and local.
- Excellent service.
- Good additional service.
- Good guy.
• Great service from a good professional. Adds another dimension to an excellent surgery.
• I find this service very helpful.
• Keep it going.
• Previously I had to wait a long time to see the Physio at the Hospital.
• quick and beneficial.
• Really handy.
• The exercises given for my injury helped me immensely to get back to work. Excellent service.
• The Physiotherapist was very thorough with great experience. He seemed very knowledgeable on my ailments.
• very beneficial to recovery time. High quality interactions. Very effective.
• Very helpful.
• Very pleased with speed of appointment.
The Govan SHIP Project
(Social & Health Integration Partnership)

Appendix to the main report

APPENDIX H - MENTAL HEALTH IN THE GOVAN SHIP PROJECT
MENTAL HEALTH in the GOVAN SHIP Project

Background

The Govan SHIP (Social and Healthcare Integration Project) was established in 2015 with the aim of providing additional resources within primary care to enable a more effective response to the challenges faced by health and social care professionals working in socio economically deprived areas. The foundations of SHIP were laid by the work of the GP’s at the Deep End Group and funding was provided by the Scottish Government Primary Care Transformation Fund.

The mental health sub project came from a recognition of high levels of mental health problems within poorer areas and an awareness among professionals that appropriate mental health support services are often not accessed by those most affected. The project was supported by the SHIP steering group which met bimonthly and by the SHIP project manager. Progress was reported to the Primary Care Mental Health Interface Group. In addition to the core work of the project contributions were made to the development of the Primary Care Improvement Plan.

The first stage for the project involved consultation and collaboration with GPs, secondary mental health service managers, Community Links Practitioners, the wider primary care team, and social work colleagues involved with SHIP. The Project Lead engaged with many of those involved in providing support and treatment to individuals seeking help for mental health issues within a community setting. This included Primary Care Mental Health Teams (PCMHT), Community Mental Health Teams (CMHT), commissioned service provider Lifelink and third sector support services including SAMH, GAMH, the Health and Social Care Alliance as well as smaller local organisations. Although there was consensus around high levels of need and a shared perception that support services are often not readily available or easily accessible there was not a shared understanding about the nature of the mental health needs or how pervasive they are.

The project went on to focus on developing a greater understanding of the type of mental health concerns that people present with in a primary care setting and attempting to quantify how prevalent these concerns are. Information was gathered from published reports by the World Health Organisation, The National Institute for Clinical Excellence, UK and Scottish government working groups, the Royal College of General Practitioners, the Scottish Association for Mental Health, Samaritans and others. Local health statistics and trends were pulled from the work of the Glasgow Centre for Population Health. Reports consistently showed higher levels of mental health problems within poorer areas along with proportionately less people accessing support services.

Analysis of mental health needs and difficulties accessing support at a local level was undertaken via two pieces of work; a review of GP consultations which had mental health as the presenting issue or a significant contributory factor (appendix A) and an audit of outcomes of referral to mental health support service (Appendix B).
The review of GP consultations showed that the majority of people presenting to their GP with mental health issues were experiencing symptoms relating to depression, anxiety, low mood or stress. A large number of these individuals were on medication to assist with their mental health and were not linked in with additional support services although a most had been referred or had engaged with treatment previously.

The audit of referral outcomes showed that less than 20% of individuals referred to PCMH and CMH services went on to engage with treatment. The reasons for this low engagement rate are multifactorial and varied but the audit results raise significant questions about current processes and invites further scrutiny across a wider area. Within the project a package was developed to enable repetition of the audit in other areas.

In response to the information gathered a guide was created for GPs to support referral to the most appropriate service. Further work is already underway within the Mental Health redesign team looking at referral pathways and interface issues.

The SHIP Mental Health Project provides a starting point for the future work that is needed to develop an understanding of what mental health needs look like within a Glasgow context. Its focus on poorer populations means that further work is needed across differing socioeconomic contexts to provide a more comprehensive picture.

There are a number of lessons that have been learnt during the project. The first, and perhaps most significant for future health service planning, is that mental health concerns are responded to differently by different practitioners. There is not a shared understanding about who should be responding to different needs and furthermore there is not a shared understanding of how mental health needs are defined. Defining and categorising levels and type of mental health needs is an important starting point.

It does appear that current support services can be challenging to navigate for both those referring and those being referred. Developing consistent practices and pathways, and ensuring guidance around what these are is available and accessible, could significantly reduce frustrations for all involved and improve the experiences of individuals seeking support.

Suggestions for future work:

- Further analysis of referral outcomes to PCMH and CMH with specific attention to referrals which are rejected or redirected.
- Consultation with primary care patients about their experiences of seeking help for mental health concerns. The gathering of feedback from individuals referred to services will facilitate a better understanding of how people feel the system works well or could be improved.
- Development of a protocol for the routine mental health screening of all primary care patients with long term conditions with the aim of facilitating early identification of emerging issues. Early intervention could reduce the burden of disease which increases significantly when mental health issues coexist with long term physical health conditions.
• Continued mental health input in to development of the Community Link Worker role to ensure that the role of the link worker in supporting the mental health of primary care patients continues to be valued and supported.

• Involvement of GP representatives in mental health service planning and development such as the proposals for crisis cafes and a single point of access for services.

• Creation of better links with NHS 24, SAS and Police Scotland so that service developments undertaken locally compliment, and do not duplicate, what is being done nationally.

• Update GG&C website and HSCP website mental health sections– remove old information and include links to ‘Heads up’ and ALISS. All GPs can, and most do, access online resources. The fact that the NHS and HSCP websites contains significantly out of date information and many broken links is a source of frustration and reflects poorly on the organisation.

• Provision of referral guidance to all GPs in a format that sits online and can be accessed easily.

• Creation of a visible leadership team at a strategic level for mental health. Cohesive working at a strategic level will support joined up working at a clinical level. Having a team which is accountable for overseeing all aspects of mental health strategy across the HSCPs and NHS GG&C would support collaborative working between mental health services, public health, health improvement and community planning teams.
Appendix A - GP appointments with a mental health component

Over a five day period from 14/05/18-18/05/18, information was collected by 11 General Practitioners about consultations they undertook which contained a mental health component. Over the five days the GP’s were involved in 768 consultations, just over 20% of these (156) were recorded as having a mental health issue as the presenting complaint or a significant contributory factor. Further information was then gathered about these 156 consultations in order to try and identify patterns and trends.

Ways of working and the recording of information within patient notes vary between different General Practices and furthermore between individual clinicians within the practices. The results detailed below provide an overview of the findings and are limited by the amount of information that was recorded.

About attendees

GP appointments with a mental health components by age and gender

65% of attendees were female, 35% were male. 3% were under 16 years of age, 12% were over 65 and the remaining 85% were of working age.

Frequency of attendance

- Only 13 individuals (8%) were attending with a new mental health issue.
- The average number of GP consultations that individuals had attended for in the previous 6 months was 7 (this excludes the 12 individuals with who attended more than 20 times as these patients often presented with complex issues relating to physical ill health or addiction issue).
- 34 of the 156 used the Out of Hours service or attended Accident and Emergency within the previous six months although 26 of those attendances were for physical rather than mental health complaints.
Most common presenting complaints:

115 consultations (74%) involved anxiety, depression or low mood.
13 (8.5%) were recorded as a situational crisis/stress.
The remaining 28 consultations included a wide variety of issues: ADHD and ASD, behavioural disturbances, drug and alcohol issues, psychotic disorders, cognitive decline and memory issues.

26 attendees (17%) were recorded as having been provided with a Fitnote in the course of their consultation.

Medication

112 individuals (72%) were on medication to assist with their mental health.
- 103 of these were on antidepressants
- 10 were prescribed benzodiazepines
- 9 were on anti psychotics

Contact with mental health services:

84 people (54%) had previously been referred to or had contact with mental health services.

Only 13 of the consultations (8%) resulted in new referrals for further mental health support or assessment although GP’s identified that further mental health follow up would be beneficial for 74 individuals (47%). The large difference between these numbers raises some questions although may be partially explained by the following factors:

- 5 people declined onward referral even although the GP recommended it
- 9 individuals had previously been referred and were awaiting the outcome of their referral
- 5 people had previously been referred but had failed to opt in or engage with services
- 14 patients were already linked in with services and receiving ongoing support
- 5 were advised to self refer to Wellbeing or Lifelink

It is possible that a poor engagement rate with mental health services has led to a decline in referrals and a tendency to ‘hold’ patients within primary care.

117 people (75%) were advised to follow up with their GP again, most commonly in 4 or 8 weeks time.

Summary

The majority of people presenting to their GP with mental health issues are experiencing symptoms relating to depression, anxiety, low mood or stress. A large number of these individuals are on medication to assist with their mental health and are not linked in with additional support services.
Appendix B - Mental Health referrals

*Aim:*
To evaluate the effectiveness of current practices involved in making and responding to referrals for specialist mental health care and treatment by reviewing referral outcomes.

*Method:*
Retrospective audit of referrals to Community Mental Health and Primary Care Mental Health.

*Scope:*
The audit involved three GP practices with combined practice populations of approximately 19,000. All referrals made via SCI gateway over a three-month period between 1/2/18 - 30/4/18 were included. The total number of referrals made was 98; 66 to Community Mental Health (CMH) and 32 to Primary Care Mental Health (PCMH)

**CMH referrals**

CMHT referrals by age and gender

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Categories of referral.

CMH accepts three different categories of referral; Emergency – to be seen the same day, Urgent – to be seen within five days, and Routine – to be seen within four weeks.

During the period audited no Emergency referrals were made.

Nine referrals were made on an Urgent basis; of these only one was accepted and followed up urgently. Another one was accepted but the team were unable to contact the patient and liaised directly with the referrer regarding this. Three referrals were downgraded to routine, usually after consultation with the referring doctor. Four were declined; one due to the patient’s presenting issues being attributed to polysubstance misuse, one with advice to refer to neurology or medical services after a phone call between mental health services and the referrer. One was declined because the patient had not been seen within the practice prior to referral One patient was admitted to hospital the same day with a medical emergency which made follow up impossible.

There were 57 routine referrals plus three additional downgraded urgent ones.
Accepted referrals:

38 referrals (63%) were accepted, of these 10 did not opt in or failed to attend the appointment that was offered to them. Fourteen (37% of those accepted) were offered appointments, attended and engaged with the service.

Nine referrals were redirected following an initial assessment by CMHT; five were redirected to Lifelink because their condition had improved, or they did not want CMHT follow up, one was redirected to PCMHT, one to psychotherapy and two were referred on to addiction services.

Redirected referrals:

There were 13 referrals (22%) which were redirected without CMHT seeing the patient. Six of these were to Wellbeing, one to addiction services, one to Esteem as the patient had previously been linked there, two were forwarded to older adult mental health services due to age and three were sent on to CMHT in other areas as the patient was not resident in catchment area of the team referred to.

Rejected referrals:

Nine referrals (15%) were rejected. Four of these were patients who had previously been seen by mental health services and had a history of not attending or were deemed inappropriate for ongoing psychiatry input. Four had medical issues and referral was suggested to alternative services (brain injury clinic, medical services, neurology and memory clinic). One was already being supported through criminal justice services (this had not been disclosed to the referrer).

Summary of CMH referral outcomes

A majority of routine referrals to CMH were considered appropriate with 63% being accepted. However, following an initial assessment 24% of accepted referrals were then redirected to other services. An additional 26% of accepted referrals did not progress as the individuals referred did not respond to an opt in letter or attend an appointment that was offered. Only 37% of accepted referrals resulted in any form of ongoing contact. The remaining cohort of referrals (13%) had no documentation or correspondence detailing the outcome of their referral. Overall only 23% of referrals to CMHT resulted in engagement with the service.
Patients are often encouraged by GP’s to self-refer to PCMH so the number of referrals does not reflect the number of patients advised or encouraged to engage with PCMH services. It is important to bear in mind that GP’s often complete referrals for those who have already been advised to self-refer but failed to do so or those who are considered less likely to self-refer.

A total of 32 referrals were made via SCI gateway during the three month period.

Accepted referrals:
26 referrals (81%) were accepted, 13 did not opt in when an initial letter was sent requesting that they contact service to arrange a screening appointment or assessment. Four were assessed then did not attend for the recommended follow up. Seven (27% of those accepted) attended for an assessment and were then redirected, two to CMH, three to Lifelink, one to employability services and one to a parenting program. Only three people opted in, attended an assessment and were offered therapy, of these, two accepted and one declined. This represents an 8% engagement rate.

Redirected referrals
Three referrals were redirected straight away, one to addiction services, one to salvation army for counselling and one to CMHT (this referral was bounced back by CMH and then followed up by PCMH)

Rejected referrals:
Two referrals were rejected, one because the patient had been admitted to psychiatric inpatient care and one because the individual already had other services in place.
Summary of PCMHT referral outcomes

A large number of people failed to engage with PCMH after their referral had been accepted. As was the case with CMH referrals a significant number of accepted referrals were redirected following initial assessment (27%). A relatively small number were redirected after initial screening. Less than 10% of the people who were referred to PCMH ended up receiving treatment from the service.

Overall summary of PCMH and CMH referral outcomes and conclusions

This review of referral outcomes shows that less than 20% of the individuals identified by GP’s as needing mental health support from services ended up receiving it. Fluctuating levels of need in individual patients is likely to be responsible for part of this; sometimes people are referred and then their situation changes or their difficulties resolve without intervention. It is likely however that process issues around how referrals are made and responded to plays a role in the lack of engagement with treatment. A wider review of referral outcomes over a longer time period is warranted to establish whether similar trends exist across different geographical areas where there are varying demographics. If results of the wider evaluation show similar patterns then there is a compelling argument to review referral management practices and protocols with the aim of improving access, engagement rates and outcomes.
The Govan SHIP Project
(Social & Health Integration Partnership)

Appendix to the main report

APPENDIX I - GP USE OF ADDITIONAL TIME AT GOVAN HEALTH CENTRE AS PART OF THE SHIP PROJECT
Deep End Report 29

GP use of additional time at Govan Health Centre as part of the SHIP project

The Govan SHIP Project is funded by the Scottish Government to improve integrated care for patients living in one of the most deprived areas in Scotland. The intervention package, based on a cluster of 4 general practices, includes additional GP capacity, attached social workers, support for multidisciplinary team (MDT) meetings and protected time for GP leadership. Two of the four practices also have an embedded community links practitioner.

This report summarises how GPs used their additional time ten months into the project during February 2016. It has been prepared by Professor Graham Watt at the University of Glasgow, with help from Doctors John Montgomery, Anne Mullin, Niall Cameron and Stephanie Maguire and Mr Vince McGarry, on behalf of the Govan SHIP Project Steering Committee.

June 2016
SUMMARY

- The Govan SHIP Project is funded by the Scottish Government to improve integrated care for patients living in a very deprived area.

- It is based on a general practice cluster comprising the four general practices at Govan Health Centre and serving the 16th, 28th, 30th and 32nd most deprived practice populations in Scotland, with a combined list size of 18,139 patients.

- The project involves additional GP and social work capacity, plus support for monthly multidisciplinary team (MDT) meetings to review vulnerable families and frail elderly patients.

- Two of the practices also have an embedded community links practitioners (CLP).

- The additional GP capacity comprises a 0.5 WTE salaried GP (SHIP locum) for each of the four practices and is used to provide one session of protected time per week for each of the 15 GP partners.

- During February 2015, 82% of all patient contact in the practices involved general practitioners (64% by GP partners, 19% by GP registrars, 6% by GP retainees and 11% by SHIP locums).

- In 25 protected GP sessions during two weeks in February 2015, 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 (an average of about 4 cases reviewed per GP per week).

- Other activities included correspondence, reports, contacts with professional colleagues and attendance at a range of meetings, including child protection case conferences.

- The content of extended consultations displays the nature, severity and complexity of physical, psychological and social problems within families and households, which is typical of patients in very deprived areas.

- The attached description of the extended consultations (Annex A) should be read by all who are unfamiliar with the nature of general practice in very deprived areas.

- Extended consultations, case record reviews and contact with professional colleagues provided opportunities to take stock, plan and coordinate care, and were hugely valued by the GPs.

- The range and complexity of cases required generalist clinical care. Only two cases were referred to a Community Links Practitioner.

- Ten months into the SHIP Project, the study shows that addressing unmet need remains the dominant use of additional GP time. Other uses of GP time are developing.

- The extended consultations not only provide better planning and coordination of individual patient care; they also provide a basis for driving change through local arrangements for integrated care, based on the needs of patients.
The long term outcomes of extended consultations in the SHIP Project are not known, but are likely to be similar to the outcomes and cost-effectiveness of the Care Plus Study.

It is not known whether, or how often, extended consultations need to be repeated.

This small study provides a snapshot of the use of additional GP time as part of the Govan SHIP Project. Follow up and further evaluation are needed.

“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 Scottish Government Health Department, the Royal College of General Practitioners, and General Practice and Primary Care at the University of Glasgow.

Deep End contacts
John Budd Lothian Deprivation Interest Group John.Budd@lothian.scot.nhs.uk
Anne Mullin, Govan Health Centre, anne.mullin@nhs.net
Graham Watt University of Glasgow graham.watt@glasgow.ac.uk
RCGP Scotland Scottishc@rcgp.org.uk
BACKGROUND

Govan Health Centre provides a base for 4 general practices, serving 18,139 patients and comprising the 16th, 28th, 30th and 32nd most deprived, of 980 general practice populations in Scotland. Such populations have higher levels of hospital use, premature mortality and complex multimorbidity, but receive no more general practice funding than the Scottish average (1).

Consultations in deprived general practice typically involve high levels of multimorbidity and social complexity, shorter duration, less patient empowerment (especially for patients with mental health conditions) and greater practitioner stress (2). Patients show less interest in joint decision-making, perceive lower levels of practitioner empathy and report poorer outcomes after one month (3).

This combination of factors poses a huge challenge for integrated care, not least because if the NHS is not at its best where it is needed most, inequalities in health will widen (4).

The Govan SHIP Project aims to improve integrated care for patients registered at Govan Health Centre in Glasgow. Funding has been provided by the Scottish Government Health Department (SGHD) since April 2015 to support the following elements:

- Additional clinical capacity, provided by 2 WTE salaried GPs working in the 4 general practices at Govan Health Centre
- Additional social work capacity, provided by 2 WTE social workers attached to the health centre, covering vulnerable adults and children
Support for monthly multidisciplinary team meetings (MDTs) to review cases of vulnerable adults and children

2 of the 4 practices also have full time community links practitioners as part of the SGHD-funded Link Worker Programme.

## USE OF ADDITIONAL CLINICAL CAPACITY

The additional clinical capacity, involving a 0.5 WTE salaried GP in each of the 4 practices, has been used to support the following activities:

- Clinical work by the salaried GPs (SHIP locums)
- One session of protected time per week for 15 GP partners in 4 practices

## THE STUDY

In February 2016, ten months after the start of the SHIP Project, a study was carried out to describe and quantify the uses of additional GP time. The study comprised:

1. A review of administrative data covering all patient contacts in the four general practices during the 4 weeks of February 2016, including the contribution made by the additional salaried GPs (SHIP locums)
2. Diaries submitted by 15 GPs describing their use of one session of protected time per week during 2 weeks of February 2016

### Study 1

Administrative data were only available for 3 of the 4 practices. In the other practice, exceptional circumstances meant that February was not a typical month and could not be used for the study.

The three practices have a combined lists size of 13,509 patients, of whom 21% are aged 0–14 and 21% are aged 65 years and over.

The following types of staff had contact with patients:

<table>
<thead>
<tr>
<th>Number of practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP partner</td>
</tr>
<tr>
<td>GP registrar</td>
</tr>
<tr>
<td>GP retainer</td>
</tr>
<tr>
<td>Salaried GP (SHIP locum)</td>
</tr>
</tbody>
</table>
In February 2016 these staff had 7035 patient contacts. The ratio of contacts between the three practices (26:31:42) was similar to the ratio of practice population numbers (26:33:42), which suggests that the three practices were similarly busy during the month.

Contacts with GPs comprised 82% of all patient contacts: GP partners were involved in 64% of GP contacts, GP registrars in 19%, GP retainees in 6% and salaried GPs (SHIP locums) in 11%.

There were variations between the three practices in the proportion of GP contacts carried out by the salaried GPs (SHIP locums), and the extent to which the SHIP locums were involved in surgery consultations and home visits.

### Study 2

In the first two weeks of February, when most of the GP diaries were recorded, the proportion of total GP contacts involving the different groups were: GP partners 67%, GP registrars 15%, GP retainees 7% and salaried GPs (SHIP locums) 11%.

GP diaries were provided by all GP partners, who described and (often) timed their activities in 8 categories. 2 GPs submitted diaries for one week only. 2 other GPs reported that rather than having a dedicated session of personal protected time they increased their average appointment time for all patients. These data extracts are true reflections of GPs’ experiences and their approach to complex situations in their everyday working lives. They are written in the own words, transcribed from the original format and anonymised for the purpose of this research so that individual patients and GPs cannot be identified. With these caveats, the diaries were analysed and individual activities aggregated as follows.

25 GP sessions were described, involving 136 activities in 8 categories:

- 76 extended consultations, including home visits (Annex A)
- 14 sessions reviewing 25 case records, without the patient being present (Annex B)
- 9 sessions used for correspondence (Annex C)
- 6 sessions used to prepare reports (Annex D)
- 5 sessions involving case conferences (Annex E)
- 9 sessions involving other types of meeting (Annex F)
- 11 sessions involving other types of activity (Annex G)
- 6 sessions involving GP leadership activity (Annex H)

The activities are combined by category, rather than by practice. The categories were not applied in the same way by all respondents and there is some overlap between categories. A GP session could involve more than one activity.

14 GPs provided free text comments on the use and perceived value of additional time (Annex I).
Study 2 Results

Abbreviations The Abbreviations section (p30/31) gives full definitions of the many acronyms used in the descriptions of additional GP activity.

A. Extended consultations

67 of the extended consultations were timed, and lasted 36.6 hours in total, with an average of 33 minutes per consultation. 43 took place at the Health Centre and lasted an average of 27 minutes, while 24 involved home visits lasting an average of 43 minutes.

The described content of the extended consultations defies simple classification but is typical of complex general practice consultations, reflecting the number, severity and complexity of physical, mental health and social problems which occur within individuals, families and households in very deprived areas. Their full listing in Annex A illustrates the nature of unmet need (i.e. patients whose problems GPs knew needed extra attention).

B. Case record reviews

25 case record reviews were described in 14 sessions, ranging from 5-50 minutes in length, and lasting 6.7 hours in total. They included reviews of case records, with and without other carers and often leading to further actions including updating records, discussions with colleagues, telephone calls and referrals.

C. Correspondence

22 activities were described as correspondence, including reports (ESA, DVLA, Attendance Allowance), support letters (Housing, DWP), letters to professional colleagues (psychogeriatrician, psychiatrist), telephone calls (pharmacist, social worker, patients) and letters to patients and relatives.

D. Reports

9 reports were described, including referrals (social work, psychiatry, rehabilitation team, Link Worker), CT scan) and reports (ESA, Asylum and Immigration Service, Significant Event Analysis).

E. Case conferences

5 activities involved planning or taking part in a case conference concerned with vulnerable families and child protection issues.

F. Other types of meeting

11 activities were described, lasting 9.1 hours in total and including 4 multidisciplinary team (MDT) meetings, 3 housebound dementia reviews, meetings/contacts with other professionals (police, pharmacist, CPN, psychogeriatrician) and planning a case conference for a patient making frequent use of A&E and the district nursing service.

G. Other types of activity

16 activities were described including: liaison with secondary care, 6 house visits on a protected afternoon, 4 telephone calls to sort problems, preparation for 6 cases going to the MDT meeting, analysing practice deaths, liaison with health visitor and social work department concerning a vulnerable family, and contact with pharmacist to arrange medication reviews.
H. GP leadership activity

6 activities were described including: SHIP Project meetings and discussions, a meeting with senior CORDIA staff, reviewing cases discussed at a MDT meeting and coordinating the registration of a new patient family with complex social work and psychiatric needs.

Comment

This study covered a typical two week period, ten months after the start of the Govan SHIP Project and the introduction of additional GP time.

As 2 GPs reported that their extra time was used to lengthen all of their consultations, or to provide vacant slots within surgeries, rather than a dedicated session, and 2 GPs provided information for only one week, it is likely that the above data underestimate by a small amount the total activity carried out within the additional time provided.

In the three practices which were able to provide administrative data for February, the 12 GP diaries for the first two weeks of February described 24 sessions and 115 activities, including 62 extended consultations. During the same period, the three SHIP locums were involved in 316 patient encounters, comprising 11% of all GP contacts in the practices during that time. The 62 extended GP consultations comprised 3.2% of all consultations carried out by the 12 GP partners but lasted about three times as long as routine consultations.

The described activities differ in their content, the presence or absence of patients and the nature and extent of contact with other professionals and services. What they illustrate very clearly is the unconditional nature of general practice and the need for decision-making across a variety of physical, psychological and social problems, occurring at different stages of the life course and involving contacts with a large number of colleagues inside and outside the health centre. The work requires generalist knowledge and skills in addressing individual problems, allied to a detailed knowledge of the role of other professions and services.

Although 8 of the 15 GPs had access to a Community Link Practitioner, as part of the Link Worker Programme, only two accounts of extended consultations mentioned a Link Worker, suggesting that most of the work that GPs took on in their additional sessions was not seen as appropriate for link worker referral.

In their free text comments 14 of the 15 GPs reflected on their use of additional time (Annex I). A common theme was the perceived value of the additional time in assessing and addressing complex problems, in a way that is not possible in routine consultations. It is clear that the GPs were able to identify a large number of patients who could benefit from a more comprehensive assessment (Annex A). Although this study is not capable of determining the long term value of extended consultations, a preliminary outcome mentioned by many GPs was the ability to plan patient’s care in a more comprehensive and coordinated way.

The experience of Govan GPs in their use of additional time is similar to that reported in the CarePlus Study, a randomised trial of additional time, professional support and support for patients with complex problems in very deprived areas, in which the participating GPs chose to use the extra time for a long initial encounter, re-calibrating the patient’s needs and priorities, which could then be followed up via shorter consultations. The principal finding of the CarePlus Study was better patient outcomes after 12 months, achieving partly by improvements in the intervention group, but mainly
by faster decline in the control group. The CarePlus intervention was cost-effective by NICE criteria.

Ten months into the SHIP Project, this study shows that the need for extended consultations was substantial and continuing. It is not known from this Study, nor the CarePlus Study, what the long term outcomes of extended consultations are, nor whether, or how frequently, they need to be repeated. The study shows that additional GP time was also being used for other activities, including GP leadership, liaison with other services and strengthening of the local health system. The balance of these activities may change as the SHIP Project develops.

All these questions require follow up and further evaluation. The clear preliminary conclusion is that the study has demonstrated the nature, volume, severity, complexity and range of unmet need in a very deprived area and the scope for addressing patients’ problems in a more coordinated and better planned manner, via extended consultations, case reviews and improved joint working. A 11% increase in clinical capacity has enabled these developments, by releasing the time of experienced practitioners.

References


## ANNEX A
Extended consultations – patient contact and outcomes

<table>
<thead>
<tr>
<th>Length</th>
<th>Patient Contact and Outcomes</th>
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</thead>
<tbody>
<tr>
<td>20 min</td>
<td>Patient with major depressive symptoms/suicide risk and substance misuse;</td>
</tr>
<tr>
<td></td>
<td><strong>Outcome</strong>: planning of future care and involvement of other organisations.</td>
</tr>
<tr>
<td>20 min</td>
<td>Patient with newly diagnosed depression and child protection issues;</td>
</tr>
<tr>
<td></td>
<td><strong>Outcome</strong>: during consultation likely COPD diagnosed referred for spirometry/smoking cessation.</td>
</tr>
<tr>
<td>20 min</td>
<td>Pregnant patient – major child protection concerns – background of domestic violence and drug misuse.</td>
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<td></td>
<td><strong>Outcome</strong>: SW contacted and telephone discussion re planned case conference.</td>
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<tr>
<td>20 min</td>
<td>Poorly controlled diabetic who is reluctant to engage with services.</td>
</tr>
<tr>
<td>30 min</td>
<td>HV to newly diagnosed palliative care patient;</td>
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<td></td>
<td><strong>Outcome</strong>: met with family and discussed management and DS1500.</td>
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<tr>
<td>20 min</td>
<td>Patient with h/o head injury personality change and depressive features very reluctant to accept input from support services.</td>
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<tr>
<td>25 mins</td>
<td>Planned palliative care discussion at home with patient and carer, non-cancer diagnosis.</td>
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<tr>
<td></td>
<td><strong>Outcome</strong>: clinical expectations discussed to allay fears over management. Linked with secondary care consultant by phone for agreement with treatment plan.</td>
</tr>
<tr>
<td>30 mins</td>
<td>Post hospital discharge visit in elderly lady with multiple co morbidities and polypharmacy;</td>
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<tr>
<td></td>
<td><strong>Outcome</strong>: medication review and link with social services and ACP planning.</td>
</tr>
<tr>
<td>30 min</td>
<td>Planned visit to elderly patient and carer with dementia and new diagnosis of advanced malignancy.</td>
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<tr>
<td></td>
<td><strong>Outcome</strong>: discussion over diagnosis, to some extent prognosis and palliative treatment. Linked into district nursing and palliative care team. ACP planning with carer.</td>
</tr>
<tr>
<td>20 min</td>
<td>Child &lt; 5 years frequent attender to surgery with minor self-limiting symptoms. English poor and requires translator. Planned review to discuss support and education of such illness;</td>
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<td></td>
<td><strong>Outcome</strong>: linked in with Health Visitor for further ongoing support which also involves local third sector agencies. Aim to support mother and reduce attendances at general practice.</td>
</tr>
<tr>
<td>Time</td>
<td>Activity</td>
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<td>--------------------------------------------------------------------------</td>
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</table>
| 20 min| Extended consult in surgery for a patient with complex medical and psychosocial needs.  
**Outcome:** management plan and education provided. |
| 30 mins | Seen GHC. Middle aged patient ‘A’ who has moved to homeless accommodation. Anhedonia, thoughts of self-harm, lack of self-worth and despondent. Little self-care. Patient whom I have known for many years. Family quarrel and patient feeling excluded.  
**Outcome:** discussion, DWP benefits arranged, housing officer appointment. Trial anti-depressant and advice in terms of family contact. Review planned for 1 week. |
| 40 mins (including travel time) | Housebound elderly patient, lives alone with carer support. Highly anxious and had prolonged admission for 2+/12 late 2015. Chest infection and anaemia of uncertain origin.  
**Outcome:** reviewed and blood checked. Medication reviewed and amended after discussion. With social support, aim is to pre-empt admission if possible. So far managing in community. |
| 30 mins | Patient well known to me for many years. Attends our substance clinic. Complex family circumstances - father has alcohol problems and mum died from a long term condition. Patient had been carer for both parents and has a dependent child. CAT worker had been concerned about suicidal thoughts from patient. Came to see me for prolonged consultation. History as above and father’s insanitary habits a great stress. Ambivalence about her care burden. Her extended family had decided to have nothing further to do with the father, leaving patient alone to care.  
**Outcome:** contact with housing and letter given of support. Review 1/52. |
| 30 min | 73 year old patient with CVA and incapacity. HV to assess and liaison with her husband who has guardianship.  
**Outcome:** DNA CPR discussed, agreed and Adult with Incapacity Form completed and provided to NH. |
| 30 min | 80 year old highly anxious patient who lives alone. Recurring anaemia and rectal blood loss. Has had recent colonoscopy and UGD showing gastritis and diverticular change only.  
**Outcome:** copies of reports taken to patient and discussed. Further FBC taken and result given to patient with reassurance. Further supportive monitoring at home. Patient also contacts by phone as required. |
| 30 min | Review visit from 1 week ago. Patient A has moved to homeless accommodation.  
**Outcome:** very much brighter, self-caring and has established contact with his mum. Seen housing officer and has offer of permanent housing. Very keen to get back on his feet and out of the hostel. Anti-depressant unlikely to have had any material impact but continued meantime. Will attend for review 1 week. |
| 30 min | Planned review.  
**Outcome:** patient more settled and has contacted three housing |
associations and applied formally for rehousing. Physical concerns also addressed during consultation and investigations arranged. Reinforcement of support and of her accommodation.

| 45 min | Frail elderly patient with poor mobility and fall in bedroom several days before being seen at home following telephone contact with daughter. High falls risk. Virtually housebound and daughter has moved to stay with her mum who is not fit for independent living. Detailed background medical and social history taken. Daughter has no respite and daughter has personal health problems. Mum has long standing diarrhoea under investigation. Potentially nearing crisis and admission risk;  
**Outcome**: place on MDT list for discussion, referred to rehab team for input. Referred to Links Practitioner for carer support. Planned HV review 2 weeks. Aim to reduce risk of unplanned hospital admission or social crisis. |

**Outcome**: referred to Links Practitioner and offered advice via Money Matters Govan. Medication review and will be offered ongoing support via extended consultation process. |

| 45 min | Patient B mentioned in passing by her mum during routine appointment. Not been out of the house for several years. On no benefits and not been seen by practice for years before Project contact. This meeting is one of a series that have taken place at home. Complex needs and social and legal concerns surrounding lack of benefits, DWP not knowing that patient existed (and having an out of date address for the previous flat which was knocked down around 8 years previously), and mum having single occupant rates relief. Significant lack of resources, uncarpeted floorboards, financial stress. Local authority unaware that Patient I was in the house.  
**Outcome**: Links Practitioner input. Correspondence with DWP, establishment of ESA, fruitless contact with psychological services who visited once and have not returned. Ongoing support and major input from Links Practitioner is moving towards benefits being established, fine for rates relief being addressed and future support for psychological issues will be of long duration. |

| 2 hours | One home visit to a patient who was recently discharged;  
**Outcome**: requiring bloods, review of complex care needs, discussion about resuscitation and eKIS / ACP. |

| 60 min | One extended consultation with a patient who has multiple comorbidities and who repeatedly attends the practice and A+E;  
**Outcome**: medications review, eKIS, call to chemist and also had time to do a full memory assessment. |

| 60 min | Extended home visit to a complex patient;  
**Outcome**: discussion with carers, 2 further discussions with family, |
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Outcome/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>review of meds, bloods taken, epilepsy review, mental health review and review of old notes. eKIS entry done.</td>
<td></td>
</tr>
<tr>
<td>60 min</td>
<td>Extended home visit – complex patient; <strong>Outcome:</strong> medication review, anticipatory care, called her family, Discussed resuscitation, discussed future care needs with home.</td>
<td></td>
</tr>
<tr>
<td>30 min</td>
<td>Extra extended review was able to be slotted in for a patient with odd behaviour and a full memory assessment undertaken; <strong>Outcome:</strong> Called family, referred on to rehab and psychiatry as well as social work.</td>
<td></td>
</tr>
<tr>
<td>2 hours</td>
<td>Surgery of 6 x 20 minute extended consultations with 6 patients with significant diabetes related problems and complex co-morbidities; <strong>Outcome:</strong> aimed at improving engagement with medical management plans and improving sub-optimal diabetic control.</td>
<td></td>
</tr>
<tr>
<td>40 min</td>
<td>Consultation with new patient C. Single parent. Mother of 2 dependent children. Presented urgently, accompanied with 2 children – younger of which had apparent behavioural problems, with constellation of problems. ‘Urgently’ needed prescription for diazepam, tramadol and zopiclone. Benzos apparently started by psychiatrist from CMHT. Reports moved to area for her own safety because of threats of violence. <strong>Outcome:</strong> this consultation raised numerous concerns re child safety and need to liaise with psychiatry and SWD for clarification of facts and ongoing monitoring and supervision. The children as yet were not registered with the practice.</td>
<td></td>
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<tr>
<td>20 min</td>
<td>Multiple co-morbidities. <strong>Outcome:</strong> (1) several infected skin lesions (impetiginous appearance). Rx Fluclox + Fucidin H. (2) irritated eyes - conjunctivitis Rx Chloromycetin eye oint. (3) Drinking again - stressed by concern re mum and investigations she is undergoing. Discussion ++. Adv re-establish contact with alcohol support services. Has contact details. (4) Reports amenorrhoea.(mum had an early menopause). Has mild vasomotor symptoms. Cervical smear out of date. Will make appointment for smear.</td>
<td></td>
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<tr>
<td>20 min</td>
<td>Patient D attends with next of kin, has been self-harming. Hearing voices that direct her to 'cut herself'. Also sees visual hallucinations of deceased relative. Had contemplated taking an overdose several months ago but was held back by effect that this would have on her family. Had been attended by CMHT but lost to follow up when she failed to attend because of phobic anxiety symptoms. Has been binge drinking between half and a bottle of vodka weekly with alcohol free intervals between;</td>
<td></td>
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<tr>
<td>Time</td>
<td>Description</td>
<td>Outcome</td>
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<td></td>
<td><strong>Outcome</strong>: Rx diazepam 4 mg tid + thiamine tid –next of kin will supervise. Discussion +++ Refer CMHT. Appointment to be arranged via NOK.</td>
<td></td>
</tr>
<tr>
<td>20 min</td>
<td>Under major stress. Feels agitated and unsettled. Reports that he is living as main carer with his terminally ill relative (who is registered with another GP). Siblings help but are restricted by having young children. Ongoing GI symptoms with haemorrhoids ++. Has dyslexia and has had problems negotiating and explaining his absence from work to line managers. <strong>Outcome</strong>: explanatory comment added to med cert and 4 week review.</td>
<td></td>
</tr>
<tr>
<td>20 min</td>
<td>Under pressure because of benefits concerns re PIP. <strong>Outcome</strong>: advised to contact Money matters. Given a copy of medical summary. (2) Distressed+++ following recently unexpected death of sibling. Second sibling currently in hospital. Difficulty coming to terms with the bereavement. Discussion ++. Advised self refer CRUSE - given relevant information. Repeat medication reviewed.</td>
<td></td>
</tr>
<tr>
<td>30 min</td>
<td>We have one blocked 10 minute slot per surgery which I find invaluable as there will always be at least one consultation which runs much longer due to the complexity/ multi-mobidity of the patients we are seeing. This morning an example of this was a man who has been found to have cancer and was due to have surgery. Before he came in I checked on clinical portal and saw that his pre-op MRI had identified metastases and so when he came in I was already aware that his surgery would have been cancelled. He was very upset but with the longer time available I was able to discuss lots of future planning/family support/financial issues and complete a DS1500 for him. At the time he had made the appointment he was not expecting to have been given a poor prognosis and the flexibility of a blocked slot allowed a longer discussion without being concerned that the whole surgery was going to run very late.</td>
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<tr>
<td>30 min</td>
<td>Extended house call to assess elderly care home resident with recent diagnosis of malignancy. <strong>Outcome</strong>: updated AWI certification, KIS, DNACPR and ePCS.</td>
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<tr>
<td>30 min</td>
<td>Extended house call to renew AWI certification in care home resident. <strong>Outcome</strong>: completed formal assessment of memory to compare with baseline and reviewed medication.</td>
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<tr>
<td>30 min</td>
<td>Extended house call to review palliative care patient with complex pain issues. <strong>Outcome</strong>: discussion with patient and family re available options and initiation of parenteral analgesia, KIS/ePCS updated to reflect same.</td>
<td></td>
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<tr>
<td>20 min</td>
<td>Extended surgery consultation with school age child and mother due to behavioural problems at school stemming from Autistic Spectrum Disorder. <strong>Outcome</strong>: discussed support structures available through health, education and third sectors. Information regarding diagnosis and impact on family discussed at length. Management strategies discussed and agreed for both individuals with goal setting, etc.</td>
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<tr>
<td>Time</td>
<td>Activity</td>
<td>Outcome</td>
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<tr>
<td>40 min</td>
<td>Extended surgery consultation with patient bereaved in very unusual</td>
<td>Outcome: provided structured support regarding bereavement process</td>
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<td></td>
<td>circumstances. Previous input with patient had highlighted limited</td>
<td>and current mood difficulties. Explored coping strategies and reviewed</td>
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<td></td>
<td>services available locally to support patient's current difficulties</td>
<td>current medication provision. Dealt with incidental musculoskeletal</td>
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<tr>
<td></td>
<td>(due to gaps in mental health service provision and limitations on</td>
<td>complaint also.</td>
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<td></td>
<td>charitable resources).</td>
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<tr>
<td>10 min</td>
<td>Phone consultation with challenging patient with complex PMHx who</td>
<td>Outcome: negotiated more appropriate solution with offer of extended</td>
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<td></td>
<td>had initially requested emergency appointment regarding numerous ongoing</td>
<td>appointment at a later date within another Govan SHIP session in order</td>
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<td></td>
<td>issues.</td>
<td>to ensure ongoing continuity of care and de-escalation of acute situation.</td>
</tr>
<tr>
<td>30 min</td>
<td>Planned discussion of pain relief and long term conditions (including</td>
<td></td>
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<td></td>
<td>addiction issues).</td>
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<tr>
<td>45 min</td>
<td>Palliative care patient visited at home as an extended consultation.</td>
<td>Outcome: KIS and cancer care review complete. Discussed forward</td>
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<td></td>
<td></td>
<td>care planning and arranged a follow up review.</td>
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<tr>
<td>30 min</td>
<td>Extended consultation with patient with complex mental health issues.</td>
<td>Outcome: arranged re-referral to CPN.</td>
</tr>
<tr>
<td>10 min</td>
<td>Phone discussion with CPN and community psychiatry re application of</td>
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<td></td>
<td>MH act (patient E with marked physical health problems and chronic self-</td>
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</tr>
<tr>
<td></td>
<td>neglect, non-engagement with treatment and support services) and</td>
<td></td>
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<td></td>
<td>ways to determine patient capacity within the community.</td>
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<tr>
<td>40 min</td>
<td>Home visit.</td>
<td>Outcome: patient E admitted to hospital under EDC for treatment.</td>
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<td></td>
<td></td>
<td>Prolonged discussion with psychiatry re appropriate procedure for</td>
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<td>admission when capacity appears diminished. Discussion with Mental</td>
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<tr>
<td></td>
<td></td>
<td>Health Officer re necessity of EDC.</td>
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<tr>
<td>20 min</td>
<td>T1DM, benign intracranial hypertension, long history of low mood, serial</td>
<td>Outcome: 1. compliance poor in part due to confusion around</td>
</tr>
<tr>
<td></td>
<td>defaulter, poor compliance medication.</td>
<td>medication. Rationalised, pharmacist agreeable to dosette, rpt</td>
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<tr>
<td></td>
<td></td>
<td>medications amended to dispense weekly 2. review of mood and support</td>
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<tr>
<td></td>
<td></td>
<td>mechanisms. Recent change from fluoxetine to duloxetine (to rx both</td>
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<tr>
<td></td>
<td></td>
<td>neuropathy and depression) explained. Self referral to wellbeing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>services.</td>
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<td></td>
<td></td>
<td>Carer for husband with neurological problems and complex social</td>
</tr>
</tbody>
</table>
| **History** | Review in place as unexpectedly pregnant and s/b perinatal. However, miscarriage.  
**Outcome:** 1. antidepressant ISQ given pregnancy not continuing 2. support services available and aware patient group carer support. Signposted money matters to ensure carers benefits in place. |
| --- | --- |
| **Outcomes** | Released from prison and required med 3, antidepressants, review of chronic sinusitis and reported “first fit” witnessed by cell mate.  
**Outcome:** extra 10 min “unbooked” slot within surgery allowed time for 1. Medication review 2. First fit history, assessment, referral 3. Previous attendance at ENT – reinstatement of medication and technique demonstrated nasal spray. 4 Homeless. Offered and declined involvement with homeless. |
| **Outcomes** | Review of patient with multiple medical/social issues who had opted herself out of healthcare for many months.  
**Outcome:** review of all these issues (addiction, physical health, financial, housing, mental health, medication). Contacted her housing officer to clarify some of the issues raised and ensure being addressed as pt unclear. |
| **Duration** | 45min |
| **Outcome** | Assessment of patient with decompensated alcoholic liver disease. Multiple issues raised by patient and patient's partner regarding ongoing health issues, medication.  
**Outcome:** referred to DN for advice on pressure sores and continence pads. Needing weekly review at present. |
| **Outcome** | Home visit to housebound patient with mental health problems.  
**Outcome:** review of physical health but also whilst visiting found door entry system not working properly and therefore door not actually locking. Raised with social work and over the next week after speaking to 5 people this was eventually addressed. Would probably not have followed this up if I didn’t have extra time. |
| **Duration** | 1 hour |
| **Outcome** | Home visit to very elderly housebound pt. Recent A+E attendance after fall at home and cellulitis diagnosed.  
**Outcome:** declined admission. Arranged review after receiving A+E letter. Review of physical health, medication, pressure sores. Community rehab team involved and new walking aid provided. Update of pts next of kin/POA details. Referral to DN for skin care and provision of pressure cushion. Review for a week later arranged. |
| **Duration** | 1 hour |
| **Outcome** | Review of patient with dementia with carer after carer reported a deterioration in condition.  
**Outcome:** review of social issues including financial concerns and carer signposted to local carers centre. Review of medication, discussion about mental health and started on antidepressant and agreed to referral to CPN. Referred for continence pads. Carer advised to seek advice on guardianship as no current arrangements.  
**Outcome** | Home visit to patient with diagnosis of bowel cancer and who is housebound. |
| **Duration** | 45 min |
| 1 hour | Home visit to patient discharged from hospital to carry out review of medication, check on status now home and check managing as lives alone.  
**Outcome**: patient clearly struggling but denies further assistance. Updated records with current level of help, keysafe code for entry, next of kin details. Bloods taken due to meds change and poor hydration status. |
|---|---|
| 45 min | Home visit to patient with long history of chronic pain/mental health issues. Recent exacerbation of mental health problems and referred as emergency to psychiatry;  
**Outcome**: review of current status, review of change in meds and home circumstances. Also discussion regarding lifestyle issues and trying to get out more, discussed further exercise referral to encourage activity although declined at present. CPN follow up now in place. |
| 20 min | Polypharmacy review. |
| 20 min | Polypharmacy review. |
| 20 min | Polypharmacy review. |
| 40 min | Polypharmacy review (housebound patient). |
| 30 min | Polypharmacy review (patient with dementia). |

All my consultations are now extended to 15 minutes. This affords the time to deal with the presenting problem and ancillary issues, either on the patient’s agenda or my own. Examples below:

- Patient F. IVDA, methadone, depression, alcohol and psychological problems. Counselling on alcohol and relationship problems. Hoped for outcomes are empowerment, improved self-worth, reduced risk of risky behaviours/self-harm/relapse
- Patient G, IVDA, under increased stress, trying to find a job. Long history of grief associated with mother’s death. Hoped for outcomes are empowerment, employment, return to “normal” life, self-worth. Offered to act as character referee.
- Patient H, IHD, also has worries, COPD, smoking, dietary issues. Hoped for outcomes: lifestyle changes, with time to do it properly in an inclusive and non-condescending fashion.

45 min Extended visit. Triple consultation with niece and sister. Still concerned for mental health since death of mother two months ago. Not going out or to work. Abnormal grief reaction.

30 min Consultation for alcohol dependency. Young Mother. Husband sectioned and drinking again.  
**Outcome**: appointment arranged for support back to sobriety.
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<tr>
<th>Time</th>
<th>Description</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>45 min</td>
<td>Extended visit. Early HV at request of district nurse. New unilateral oedema in patient previously refusing any input at all.</td>
<td><strong>Outcome</strong>: now engaged with DN and GP. Vulnerable adult.</td>
</tr>
<tr>
<td>10 min</td>
<td>Emergency appointment.</td>
<td><strong>Outcome</strong>: bereavement counselling and support.</td>
</tr>
<tr>
<td>30 min</td>
<td>Patient with learning difficulties and support worker.</td>
<td><strong>Outcome</strong>: discussed abnormal CXR, ?cancer. Referred to chest clinic.</td>
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<tr>
<td>40 min</td>
<td>Home visit to elderly patient with dementia with heart failure. Optician has concerns.</td>
<td></td>
</tr>
<tr>
<td>30 min</td>
<td>Patient with mental health and drink problems turned up demanding to be seen.</td>
<td><strong>Outcome</strong>: at follow up, organised investigations and time to discuss and examine appropriately.</td>
</tr>
<tr>
<td>45 min</td>
<td>Home visit with district nurse to patient E with self-neglect, leg ulcer and mental health problems.</td>
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</tr>
<tr>
<td>1 hour</td>
<td>Further visit to same patient E who refuses to go to hospital in an ambulance. Several phone calls to ambulance HQ and hospital concerning this man.</td>
<td></td>
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<tr>
<td>35 min</td>
<td>Palliative care.</td>
<td><strong>Outcome</strong>: anticipatory care plan formulation with patient and daughter.</td>
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### ANNEX B

**Case record reviews (without the patient being present)**

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<tr>
<th>Duration</th>
<th>Description</th>
<th>Outcome</th>
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</thead>
<tbody>
<tr>
<td>35 min</td>
<td>Record review, telephone consultation patient and secondary care. Known malignancy, recent chemotherapy (completed 5 weeks prior). Ongoing symptoms due to anaemia. Complicated by current treatment with SC heparin for recurrent PTE;</td>
<td><strong>Outcome:</strong> discussion with patient and liaison with oncologist allowed for planned admission for transfusion and symptom control to oncology ward, thus preventing unscheduled admission through local A&amp;E.</td>
</tr>
<tr>
<td>20 min</td>
<td>Case review of child with child protection concerns;</td>
<td><strong>Outcome:</strong> liaison with health visiting team, school nurse and social work prior for update to forthcoming child protection meeting. New information received as a result of this triggered further social work contact with family.</td>
</tr>
<tr>
<td>1 hour</td>
<td>12 records. Case note review of patients with dementia not seen in 12 months;</td>
<td><strong>Outcome:</strong> resulted in planned invitation to surgery for 8 of these patients for extended consultation.</td>
</tr>
<tr>
<td>25 min</td>
<td>Patient in NH with CVA history.</td>
<td><strong>Outcome:</strong> medication review, seen as HV at NH and Adults with Incapacity Form updated and DNACPR assessed and also updated. Records and KIS amended and discussion with staff. Patient seen but much of this episode of care was with records and staff.</td>
</tr>
<tr>
<td>10 min</td>
<td>Patient with CVA and incapacity;</td>
<td><strong>Outcome:</strong> case record reviewed and KIS updated.</td>
</tr>
<tr>
<td>20 min</td>
<td>Review of notes regarding a complex patient and discussion with her carers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of previous GP’s short case summary re patient detailed above (Patient C) to ascertain veracity of current prescription request (for tramadol, diazepam and zopiclone),</td>
<td></td>
</tr>
<tr>
<td>20 min</td>
<td>Following 2nd house call above, noted diagnosis of glaucoma from summary of records but no medication for same or record of definitive Rx. Reviewed case records and establish patient lost to follow-up prior to registration with our practice;</td>
<td><strong>Outcome:</strong> contacted care home and arranged for community follow-up and assessment of intraocular pressures.</td>
</tr>
<tr>
<td>30 min</td>
<td>Review of patient’s case records in preparation for meeting with Mental Health Services (see below) to ensure that all necessary clinical records and correspondences were available for review and my information was up-</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Activity</td>
<td>Outcome</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>20 min</td>
<td>Review case records of vulnerable child (new patient);</td>
<td><strong>Outcome:</strong> name added to MDT.</td>
</tr>
<tr>
<td>90 min</td>
<td>Review of case records (vulnerable adult falling in between services);</td>
<td><strong>Outcome:</strong> summary letter sent to Mental health services and involved 3rd sector- high user of primary care (consulted 69 times last year, 20 times this year with GP) and A&amp;E services. GP request for an MDT with GP present (date to be confirmed but during protected GP project time.)</td>
</tr>
<tr>
<td>50 min</td>
<td>Re-coding and update of past medical history in summary sheet.</td>
<td></td>
</tr>
<tr>
<td>15 min</td>
<td>Polypharmacy review;</td>
<td><strong>Outcome:</strong> patient phoned. Changes discussed. Alterations made to medication as per pharmacist suggestions.</td>
</tr>
<tr>
<td>10 min</td>
<td>Polypharmacy review;</td>
<td><strong>Outcome:</strong> telephone consultation. 2 medications discontinued.</td>
</tr>
<tr>
<td>15 min</td>
<td>3 polypharmacy reviews looked at;</td>
<td><strong>Outcomes:</strong> appointments made for relevant patients.</td>
</tr>
</tbody>
</table>
## ANNEX C
### Correspondence

<table>
<thead>
<tr>
<th>Task</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing support letter.</td>
<td></td>
</tr>
<tr>
<td>Patient with CVA and incapacity. Telephone liaison with next of kin who has guardianship; <strong>Outcome</strong>: DNACPR discussed, agreed and Adult with Incapacity Form completed and provided to NH. Case record reviewed and KIS updated.</td>
<td></td>
</tr>
<tr>
<td>Results from Portal, letter with results to patient and liaison with secondary care about impending planned CT investigations.</td>
<td></td>
</tr>
<tr>
<td>Correspondence to parent of patient for use in addressing DWP and local authority issues.</td>
<td></td>
</tr>
<tr>
<td>Referral to SHIP social worker outlining events relating to patient patient ‘C’ with request for her to liaise with her SWD colleagues and establish contact with ‘C’. Letter to Riverside project psychiatrist re ‘C’.</td>
<td></td>
</tr>
<tr>
<td>2 Letters- fitness to drive for 1 patient with addiction issues. I letter to all professionals involved in the care of an adult with mental health problems ( 2 hours).</td>
<td></td>
</tr>
<tr>
<td>3 emails with psychiatry re vulnerable adult patient ( 20 mins).</td>
<td></td>
</tr>
<tr>
<td>Reply to Irish minister for responding to my letter previously completed in Govan time (worryingly would may not have done this if didn’t have extra time) re. missing girl who was taken to Ireland by possible parent (illegal immigrant) but not able to confirm she is safe.</td>
<td></td>
</tr>
<tr>
<td>Letter to psychogeriatrician outlining concerns regarding a patient with dementia.</td>
<td></td>
</tr>
<tr>
<td>90 min Reports for DHSS (ESA, Attendance allowance); phone calls to pharmacist to change Rx and drug boxes for vulnerable patients; phoned hospital.</td>
<td></td>
</tr>
<tr>
<td>90 min Phone calls to chemist concerning script and box changes; reports for DHSS (Attendance Allowance, DVLA, ESA); phoned dental hospital.</td>
<td></td>
</tr>
<tr>
<td>Telephone call from social worker regarding arrangements for forthcoming permanency meeting for vulnerable child.</td>
<td></td>
</tr>
</tbody>
</table>
### ANNEX D

**Reports**

<table>
<thead>
<tr>
<th>Duration</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Social work referral, psychiatry referral and rehab team referral.</td>
</tr>
<tr>
<td>30 min</td>
<td>Asylum and Immigration Service report completed (S4 Medical Declaration) – on a patient who has been denied asylum.</td>
</tr>
<tr>
<td>15 min</td>
<td>Discussion of isolated female vulnerable asylum seeker with LINKs worker to arrange follow up and support engagement with support services.</td>
</tr>
<tr>
<td>60 min</td>
<td>3 DHSS/ ESA reports.</td>
</tr>
<tr>
<td>40 min</td>
<td>2 Medical reports for ESA.</td>
</tr>
</tbody>
</table>

- Patient with a history of alcohol abuse and self-harm. Through support group secured place at residential detox. Attended with minister to reception. Needed paperwork completed ASAP to allow smooth admission from accommodation;

  **Outcome**: was able to do immediately as 10 min unbooked slot in surgery. On reviewing notes realised that defaulted from CT scan with “suspicious lesion” following admission with collapse. Also able to undertake new referral.

- SEA report – written up on patient who had polypharmacy review carried out by me after review of the notes by our support pharmacist.
ANNEX E
Case conferences

Planning discussion for conference re child protection in next week.

Attended a vulnerable young person’s case conference at Social Work offices (90 min).

There is no way I would ever have gone to a case conference without this time and it was quite a useful exercise for the family in question. Having extra time to manage patients with probable dementia is also really useful – not only does it take more than 10 minutes to assess cognitive function but invariably these patients have multiple comorbidities and require multiple referrals.

Extended meeting with Service Manager for MHDART and OOH CPN Service regarding a Significant Incident Review being conducted over events surrounding one of our patients who is currently on remand for a violent sexual offence. Gave an account of contacts with patient and events leading up to patient’s alleged offence and subsequent arrest. Discussed role of OOH CPN Service in assessing patient and input from other services who will subsequently contribute to the SIR. Authorised written account of events for inclusion in formal report.

Permanency meeting regarding vulnerable child – 2 hours.
### ANNEX F

#### Other meetings

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 hours</td>
<td>Chaired MDT meeting.</td>
</tr>
<tr>
<td>60 min</td>
<td>MDT meeting,</td>
</tr>
<tr>
<td>30 min</td>
<td>12.2.16: Discussion, phone calls and anticipatory planning regarding another complex patient who has been attending A+E repeatedly and calling out the DN repeatedly. eKIS done.</td>
</tr>
<tr>
<td>1 hour</td>
<td>Multidisciplinary meeting.</td>
</tr>
<tr>
<td>20 min</td>
<td>Met with police officers regarding patient noted above to provide authorisation of formal statement and provide authenticated copies of patient’s clinical records and records of hospital correspondences in our possession.</td>
</tr>
<tr>
<td>2 hours</td>
<td>Discussion and case planning in MDT with social work, DNs, HVs.</td>
</tr>
<tr>
<td>90 min</td>
<td>3 x housebound dementia reviews. Ensured that DNACPRs, section 47, covert medication pathways, POW, KIS details all in place.</td>
</tr>
<tr>
<td>30 min</td>
<td>Meeting with pharmacist to discuss medication reviews to date. Will expand to other groups e.g. dementia, with detailed breakdown of changes to date. Information on financial savings to be collated.</td>
</tr>
<tr>
<td>15 min</td>
<td>Contacted psychogeriatricians and CPN regarding patient with dementia and ability to contact help out of hours.</td>
</tr>
</tbody>
</table>
## ANNEX G
### Other activity

Involvement of redirection policy, planning in practice to present policy directly to secondary care to enhance engagement with secondary care and address any concerns they may have.

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 min</td>
<td>Phone call to patient C social worker – 10 min – unproductive – he was unavailable and his colleague was unable to provide information.</td>
</tr>
<tr>
<td></td>
<td>Visited 4 elderly housebound/nursing home patients to review medication and complete KIS/ACPs. Visited one new palliative care patient to update EPCS and give DNACPR form. Visited one patient just discharged from hospital following surgery for what was thought to be advanced ovarian cancer.</td>
</tr>
<tr>
<td></td>
<td>Late request for emergency appointment - adolescent with atypical facial abscess, arranged antibiotics and follow-up with GDP, Telephone discussion with patient with COPD regarding fitness to travel and standby medication – medication issued and collection by pharmacy arranged. Telephone discussion with rehab team regarding complex case of elderly lady with multiple morbidities who is resistant to input from services. Follow-up in surgery arranged.</td>
</tr>
<tr>
<td></td>
<td>Additions to MDT folder from A&amp;E and outpatient letters re child and adult patients (6 patients)- 40 min – out with session,</td>
</tr>
<tr>
<td></td>
<td>Meeting with HV lead- re vulnerable children identified in the MDT (due to current HV absent on sick leave)- 30 min,</td>
</tr>
<tr>
<td></td>
<td>Letter received re DNA London BPAS assessment for late termination. Patient in abusive relationship, previous child protection and maternal safety issues from previous relationship. Able to d/w HV prior to surgery who agreed to contact. Follow up t/c to patient confirmed that continuing with pregnancy and referred to antenatal services. HV discussed with SWD who advised partner has extensive h/o violence and possession of drugs. Patient has a pre-school child at home at present and considering allow partner to move in. Notification of concern sent to SWD. These various communications and outcome significantly enabled by extra time available.</td>
</tr>
<tr>
<td>15 min</td>
<td>Contacted practice pharmacist to arrange meeting to discuss future medication reviews.</td>
</tr>
<tr>
<td>12 hours</td>
<td>In depth analysis of practice deaths, by cause, place, predictability etc.</td>
</tr>
</tbody>
</table>
### ANNEX H

## GP leadership activity

- Attended steering group meeting, 90 min. Further informal discussion re-evaluation and project planning with other members of GP team.

- Lead role taken in coordinating approach to newly registered patient C and children, to ensure coordination between previous social worker and local SWD services, and with patient’s psychiatrist and to ensure that her children become registered with the practice and that potential ongoing needs of her children are assessed and addressed.

- Reviewed entries for MDT (30 min) – out with session.

- Preliminary meeting with senior Cordia staff to discuss better integrated working, especially in relation to palliative care.

- SHIP Project planning meeting – 2 hours.
  SHIP project email correspondence – 2 hours.

- Meeting with senior CHP staff to update them on the Govan SHIP project (90 min); telephone conversation with Professor Watt updating on outcome of Network meeting (15 min); Email correspondence on evaluation framework (40 min); 2 meetings with project manager in preparation for presentation to GPC and steering group (100 min).
ANNEX I

Comments on the use and perceived value of the additional time

The additional time available has been valuable in promoting:
- Patient centred care
- Health promotion
- Addressing multiple morbidity in timely manner
- Planning care
- Use of other organisations
- Liaising with colleagues HV and SW

With relation to the above work described, the key factor is in planning. Planned appointments for review allows for family members to be present. It also means the patient is prepared to have the difficult discussions that are needed in these complex clinical cases. Extended time for such consultations allows for patient’s concerns to be addressed and true shared planning for future care.

The longer appointments allowed by the SHIP programme give a capacity for ‘one stop shop’ assessment of needs and a bringing together of community services in a pre-emptive way that has the capacity to contribute to an anticipation of social or medical crises. The patients represented are able to give an in depth background history that would be difficult and fragmented in usual 10 minute consultations. This understanding of the prodromal health and social factors allows more logical and hopefully more effective interventions and support. Combined with Link Practitioner services, this permits a more rounded provision to patients, where social and medical needs can be better supported.

It is clearly difficult to objectively gauge the degree to which this change allows more efficient resource use and patient satisfaction, but experience of the contacts thus far seems very positive.

I simply would not have had the time to try to properly review these patients and try to avoid A+E attendances without this extra time.

Additional time allowed the opportunity to address concerns raised by presentation of a complex patient and her children with vulnerabilities without, because of the additional supported time, compromising the care provided to other patients’ health care needs.

I find the additional 10 minute blocked slot invaluable and reduces the stress of trying to keep to time which is becoming increasingly difficult due to our high levels of deprivation and multimorbidity.

The 4 housebound patients had not been seen for some time and rarely called us. They are very frail and on visiting them in addition to completing medication review and KIS other new medical problems were identified and treated. For example one was found to have an exacerbation of her COPD requiring oral steroids and another
had marked conjunctivitis.

Having the capacity to undertake this protected time allows coordinated and planned review of patients with complex needs, such as those with cognitive impairment in care homes or receiving palliative care. By seeing them on a planned basis, it is easier to prepare for these consultations and ensure that they are conducted in a holistic manner as well as ensuring that additional activities (such as KIS, ePCS etc) are completed thoroughly, adding value for OOH practitioners and others who may access them.

Being able to schedule a lengthier appointment was invaluable to the mother of the child with Asperger's Syndrome as it allowed his mother to inform him about this in advance, minimising his distress at attending the surgery and ensuring that all parties were prepared to raise the issues most pressing to their agenda in a way that would not be possible for a same-day or shorter appointment. I was also able to prepare for this consultation and have resources regarding sector agencies to hand.

The structured review of patients also highlighted something that would not normally be noted in an emergency house call, namely the lack of follow-up in secondary care for a chronic condition. This ensured better and safer treatment for this patient where such issues are often only identified at crisis points.

Having the “extra capacity” in the surgery meant that I was also able to review the child with the facial abscess more quickly (rather than an emergency appointment at the end of a busy surgery and therefore could arrange follow-up within normal office hours), and also coordinate with community staff regarding complex patients with rehab needs directly.

Having the additional capacity of a Govan SHIP session on this occasion allowed me to complete work which would normally have required remote access from home due to a large volume of referrals and correspondence from a busy morning surgery. It allowed me to complete this work sooner and to a higher standard (due to better recall of the subtleties of each case).

Additionally, this session allowed me to plan contact with both mental health services regarding a very unfortunate incident involving one of our patients and later with police who are currently investigating this case. Planning these interactions not only served to reduce my anxiety in dealing with this difficult case but also allowed better coordination with these other agencies and ensure that we were not interrupted during our meeting due to competing clinical commitments.

Finally, having the capacity to offer prolonged appointments allowed me to offer more holistic support to my bereaved patient who has found that she falls within a gap in services for support within the community and has been struggling with the loss of her husband. Simply being able to listen for a longer time than normal appears to have been beneficial for this patient, forming a better therapeutic relationship and hopefully assisting her in this difficult time. These are all undertakings which are impossible within the constraints of a 10 minute consultation, booked at short notice and in which we must also hope to undertake health promotion, QOF, etc.

Extended consultations are extremely useful for complex patients there are a number of issues to address and could not be undertaken within a 10 minute consultation in a busy surgery.

Time to review case records- this can be a very lengthy process for complex patients but allows improved case planning and liaison with other services/specialties

Time to think and consider management of patients without the stress of being rushed
and trying to fit this during very busy surgeries.
Some of the time spent in connection to Govan SHIP is out with the allocated GP session – which is inevitable when following up patients. However knowing that we have a protected session allows a more planned approach to writing up, reviewing patients at a GP consultation or HV and gives a sense of some control over our working environment – otherwise we are constantly firefighting.

Prevention of crisis admission to hospital of patient ‘E’ who has multiple medical problems and a history of chronic self-neglect. The protected time allowed me to ensure that psychiatry was informed and that the process of admission was appropriately followed. This patient has been repeatedly discussed at our MDTs and it is clear that he falls in between services with no one service taking the lead in management despite multiple agencies being involved.

Time to discuss care plan with a palliative care patient – this is time consuming and challenging to do within the usual GP working day – the session allows a more appropriate time to spend with the patient.

Additional time makes some accommodation for the co-morbidity compounded by poor social capital/resources that are a large part of every Deep End surgery. It allows for an extra phone call with the intention of aiding medication compliance, following up on a hospital DNA or explaining a complicated hospital discharge prescription and so aiming to reduce medication error through better understanding.

Allowed me time to deal with some patients whom I either struggled with in a normal surgery (and arranged for them to come back in my protected time) or carry out home visits which I wouldn’t have otherwise had the time to do and involve the patient more in the decisions as I had the time. I was also able to follow up on the issues above (missing child and broken door entry system) as I had the time, otherwise I often just find myself superficially dealing with things and not following up on them or assuming that someone else should be dealing with it.

2 visits carried out as I knew I had time to do them. The man who had attended A+E I wouldn’t have otherwise seen although I thought it would be useful due to lack of time that he hadn’t requested a visit. The patient just discharged needed a visit but had I not had this time I would have usually just done this review by telephone which would not have allowed me to see how poorly the patient is coping, poor hydration status and therefore I wouldn’t have checked her bloods and arranged follow up. The same for the patient who had a diagnosis of bowel cancer. For the patient with mental health problems being able to spend a bit more time and to visit him at home enabled me to get a better understanding of some of his difficulties regarding his health as well as his home circumstances.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACP</td>
<td>Anticipatory Care Plan</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>ARB</td>
<td>Angiotensin II Receptor Blockers</td>
</tr>
<tr>
<td>AWI</td>
<td>Adults with Incapacity</td>
</tr>
<tr>
<td>BPAS</td>
<td>British Pregnancy Advisory Service</td>
</tr>
<tr>
<td>CAT</td>
<td>Community Addiction Team</td>
</tr>
<tr>
<td>CHP</td>
<td>Community Health Partnership</td>
</tr>
<tr>
<td>CMHT</td>
<td>Community Mental Health Team</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>CPN</td>
<td>Community Psychiatric Nurse</td>
</tr>
<tr>
<td>CRUSE</td>
<td>Bereavement Counselling Agency</td>
</tr>
<tr>
<td>CT</td>
<td>Computerised Tomography</td>
</tr>
<tr>
<td>CVA</td>
<td>Cerebrovascular Accident (stroke)</td>
</tr>
<tr>
<td>CXR</td>
<td>Chest Xray</td>
</tr>
<tr>
<td>DHSS</td>
<td>Department of Health and Social Security</td>
</tr>
<tr>
<td>DN</td>
<td>District Nurse</td>
</tr>
<tr>
<td>DNA</td>
<td>Did Not Attend</td>
</tr>
<tr>
<td>DNACPR</td>
<td>Do not attempt cardiopulmonary resuscitation</td>
</tr>
<tr>
<td>DS1500</td>
<td>A form completed by a GP, Consultant, hospital doctor or specialist nurse, which enables someone who is terminally ill to claim Disability Living Allowance (DLA) or Attendance Allowance (AA) under what the DWP calls “Special Rules”.</td>
</tr>
<tr>
<td>DU</td>
<td>Duodenal Ulcer</td>
</tr>
<tr>
<td>DVLA</td>
<td>Driver and Vehicle Licensing Agency</td>
</tr>
<tr>
<td>DWP</td>
<td>Department of Work and Pensions</td>
</tr>
<tr>
<td>EDC</td>
<td>Emergency Detention Certificate</td>
</tr>
<tr>
<td>ENT</td>
<td>Ear, Nose and Throat</td>
</tr>
<tr>
<td>eKIS</td>
<td>Electronic Key Information Summary</td>
</tr>
<tr>
<td>ePCS</td>
<td>electronic Palliative Care Summary</td>
</tr>
<tr>
<td>ESA</td>
<td>Employment Support Allowance</td>
</tr>
<tr>
<td>GDP</td>
<td>General Dental Practitioner</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>GHC</td>
<td>Govan Health Centre</td>
</tr>
<tr>
<td>GPC</td>
<td>General Practice Committee</td>
</tr>
<tr>
<td>HV</td>
<td>Health Visitor</td>
</tr>
<tr>
<td>IHD</td>
<td>Ischaemic Heart Disease</td>
</tr>
<tr>
<td>IVDA</td>
<td>Intravenous Drug Abuser</td>
</tr>
<tr>
<td>MDT</td>
<td>Multidisciplinary Team</td>
</tr>
<tr>
<td>MH Act</td>
<td>Mental Health Act</td>
</tr>
<tr>
<td>MH DART</td>
<td>Mental Health Homeless Discharge and Resettlement Team</td>
</tr>
<tr>
<td>NH</td>
<td>Nursing Home</td>
</tr>
<tr>
<td>NOK</td>
<td>Next of Kin</td>
</tr>
<tr>
<td>OOHCPN</td>
<td>Out of Hours Community Psychiatric Nurse</td>
</tr>
<tr>
<td>PMHX</td>
<td>Previous Medical History</td>
</tr>
<tr>
<td>POA</td>
<td>Power of Attorney</td>
</tr>
<tr>
<td>POW</td>
<td>Power of Welfare</td>
</tr>
<tr>
<td>PTE</td>
<td>Pulmonary Thermo-Embolism</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
</tr>
<tr>
<td>QOF</td>
<td>Quality and Outcome Framework</td>
</tr>
<tr>
<td>SEA</td>
<td>Significant Event Analysis</td>
</tr>
<tr>
<td>SIR</td>
<td>Significant Incident Review</td>
</tr>
<tr>
<td>SWD</td>
<td>Social Work Department</td>
</tr>
<tr>
<td>T1DM</td>
<td>Type 1 Diabetes Mellitus</td>
</tr>
<tr>
<td>UGD</td>
<td>Upper Gastro-Duodenostomy</td>
</tr>
<tr>
<td>WTE</td>
<td>Whole Time Equivalent</td>
</tr>
</tbody>
</table>
The Govan SHIP Project
(Social & Health Integration Partnership)

Appendix to the main report

APPENDIX J - PATTERNS OF HEALTH CARE USE AT GOVAN HEALTH CENTRE
PATTERNS OF HEALTH CARE USE AT GOVAN HEALTH CENTRE

The Govan Social and Health Integration Partnership (SHIP) is a Deep End Project, which began on 1st April 2015, based in the four General Practices at Govan Health Centre, serving the 16th, 28th, 30th and 32nd most deprived practice populations in Scotland.

This research project is the first preliminary evaluation of the Govan SHIP, focusing on frequent health care and their involvement in the SHIP Project.

Sampling method

- The 4 practices had a combined total of 18,139 patients in 2014, including 73% who consulted a GP during the year, either in the practice or a home visit, with an average of 4 contacts per patient.
- 1270 patients consulted a GP between 12-26 times in 2014, comprising 7% of all patients and accounting for 28% of all GP contacts in 2014.
- This group was defined as “frequent users” on the basis of contacting a GP between once a fortnight (26 times) and once a month (12 times) in 2014.
- 100 frequent users were sampled from each practice, comprising 58%, 35%, 26% and 26% of frequent users in the four practices.
- The sample from each practice included about 50 patients who consulted once a fortnight and 50 who consulted once a month.
- The study excluded frequent users who died during 2015.
- Data were collected from EMIS and Docman for their health care contacts in 2015.
- The number of different community care contacts was recorded for frequent users of GP consultations, but could not be obtained for other patients at the health centre.

The study population

- The modal age group of frequent users was 45-64 years; 65% were female.
- 50% of patients were prescribed antidepressants (excluding amitriptyline for neuropathic pain).
- 8% of patients were prescribed methadone; 72% of these were also prescribed antidepressants.

Comparison between 2014 and 2015

- The sampled patients had an average of 11 GP consultations in 2015, which was lower than the average of 15 GP consultations in 2014.
- It appears that frequent consulting is not a stable characteristic, which needs to be taken into account when evaluating interventions to reduce rates of use.

Total health care contact in 2015

- The average number of health care contacts per patient in 2015 was 23
- 72% were in primary care, 19% involved scheduled secondary care and 9% involved unscheduled care.

GP and primary care contacts in 2015

- GP contact accounted for 85% of primary care contacts and 60% of all health care contacts.
- GP contacts comprised practice-based consultations (70%), telephone consultations (21%) and home visits (9%).
- 3% of GP contacts were DNAs.
Scheduled uses of secondary care (outpatient referrals, elective admissions)

- 248 patients (62%) had a referral to outpatients in the study year.
- Patients attended 636 new and 677 return outpatient consultations.
- 16% of outpatient appointments were DNAs.
- 46 patients (12%) had elective hospital admissions, with an average of 4 elective admissions each.

Uses of unscheduled care (out of hours, A&E, emergency admissions)

- 179 patients (45%) had unscheduled uses of care, including 239 contacts with NHS 24, 29 out-of-hours walk-in contacts and 264 visits to A&E.
- 28% of NHS 24 and out-of-hours walk-in contacts needed no further action.
- 65% of A&E attendances were discharged.
- 53 patients (13%) had emergency admissions to hospital, with an average of 2 admissions each.
- GPs referred 12% of unscheduled admissions.

Hospital bed use

- The 167 elective and 104 emergency admissions generated 1613 hospital bed days. The average length of each admission was 6 days.

Community care

- 33% of patients had contact with 2 or more different types of community care and 5% had more than 5 different types.
- 83 patients (21%) had contact with mental health services, which was the most common type of community contact. 81% of these patients were prescribed an antidepressant.

Allocation of patients to the SHIP project

- 50 of the 400 study patients received SHIP intervention(s) in 2015
- 31 (62%) of these patients were female and 16 (32%) were aged 45-64 years.
- The 50 patients comprised 13% of the study population (50/400) but accounted for 18% of the primary care contacts, 20% of scheduled secondary care and 23% of unscheduled care.
- 27 patients (54%) were taking antidepressants and 4 (8%) were taking methadone.
- They comprise 6% of all patients selected for SHIP interventions between April and December 2015 (n=837).
- As the study population was an approximately one third sample of frequent users, it may be estimated that about 18% of patients receiving SHIP interventions were frequent users of GP consultations.

SHIP interventions

- 43 patients (86%) had 1-3 SHIP interventions (5 patients had 0, 19 had 1, 14 had 2, 10 had 3, 1 had 4 and 1 had 5).
- Of the 50 patients, 7 received extended consultations, 3 had additional home visits, 16 were referred to professional colleagues (to the SHIP social workers, a health visitor or voluntary worker), and 29 had multidisciplinary team (MDT) reviews.
• These interventions comprised 6% of all patients receiving SHIP interventions in 2015 (50/837), 6% of all extended consultations, 6% of the additional house visits, 10% of referrals 8% of the social work contact and 6% of MDTs.
• They also comprised 30% of all palliative care reviews carried out as part of the SHIP project.
• In the two practices with a community links practitioner (CLP), 15 of the 27 patients receiving a SHIP intervention were referred to the CLP. 6% of patients had at total of 93 CLP contacts.

Potential impact of SHIP interventions

• Although the long term aim is to improve health outcomes, intermediate aims of the SHIP Project are to reduce the number of GP contacts (either absolutely or by involving other colleagues) and to reduce uses of unscheduled care.

Potential impact of SHIP on GP contacts

• 29 SHIP patients (58%) had more than 26 contacts with any health care professional in 2015 and 7 (14%) had more than 52 contacts.
• 6 patients (12%) had more than 26 GP contacts in 2015.
• 9 patients (18%) made up 32% of SHIP primary care contacts.
• These figures indicate the potential to reduce large numbers of GP contacts involving small numbers of patients.

Potential impact of SHIP on unscheduled care

• The 50 SHIP patients had 29 unscheduled OOH, NHS 24 and A&E care contacts.
• 6 patients (12%) accounted for 54% of these contacts.
• 4 patients had more than 12 unscheduled care contacts.
• 4 SHIP patients (8%) had 66% of SHIP unscheduled care emergency admissions.
• These figures indicate the potential to reduce unscheduled care use by targeted interventions to the small numbers of patients who are making the most use of unscheduled care services.

Comment

• The characteristics of frequent consulters were similar in the four very deprived practices, with a high proportion of middle-aged, female patients.
• Over half of the patients were taking antidepressants indicating a high prevalence of mental health illness. 21% of patients had been referred to mental health services. There appears to be scope for additional mental health support for these practices.
• The majority of health care was delivered in primary care and by a GP.
• Nearly half of those who consulted the GP more than 26 times received a SHIP intervention. Their primary care contacts were higher than in the study sample as a whole, whereas unscheduled contact was low.
• A very small number of patients accounted for two thirds of unscheduled emergency admissions by SHIP patients.
• Identifying frequent users of GP consultations is inefficient, however, as a method of identifying frequent users of unscheduled care. Initiatives to reduce the use of unscheduled care should target frequent users of unscheduled care (i.e. A&E attendances, emergency hospital admissions) directly.
• Patients who had extended consultations as part of the SHIP Project had low rates of unscheduled care.
• It was striking that 40% of SHIP patients and that half of those patients discussed at MDT meetings had no recorded uses of unscheduled care.
• As data were not collected on the timing of SHIP interventions, it is not possible to attribute cause and effect. However, the data are consistent with SHIP interventions, such as extended consultations and MDT reviews, reducing the need for other types of care. This needs further evaluation.
• MDT reviews were most often used for palliative care patients. There is scope to target SHIP interventions to other groups, for example, middle aged women.
• In general, it appears that referral of patients for SHIP interventions is based on the urgency of current problems rather than patterns of frequent use of GP encounters.

Alice Harry, Medical Student
Graham Watt, Professor of General Practice
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