

June KF Meeting

SLIDE 1

The Deep End is a Scottish Project but there are similar projects established in Yorkshire/Humber, Greater Manchester and Ireland.

If all GP practices in Scotland are ranked by deprivation (approximately 1,000 practices), the most deprived 100 practices are termed as “GPs at The Deep End”. The GPs at the Deep End is an internationally recognised brand, with Glasgow GPs at the forefront of developing initiatives to tackle the Inverse Care Law and reduce health inequalities. **This is the principle that the availability of good medical or social care tends to vary inversely with the need of the population served.**

Of the 100 Deep End practices in Scotland, 85 are in GGC, and 80 in Glasgow City HSCP. (37 in NE, 24 in NW, and 19 in South). These 80 practices cover a population of 357,000 patients.

SLIDE 2

Govan is in the Southside of Glasgow- a historic part of Glasgow that been a trading community from the Viking era onwards. It has a historic industry -shipbuilding has been on the River Clyde in some form for 1000 years. At the height of modern ship building were three great yards Stephens, Fairfields and Harland and Wolff fronting the River Clyde. Govan was the cradle of the labour, co-operative and trades union movements in Scotland and is associated with individuals who fought for social justice - Mary Barbour, Jimmy Reid.

And it is also has an association with football, and comedy (not necessarily linked) - famously Sir Alec Ferguson, Sir Billy Connolly .Govan has been used as a film set, has launched many famous ships and continues to evolve its identity.

SLIDE 3;

The Govan SHIP project, which launched in April 2015, was initially funded through the Scottish Government Primary Care Development Fund to explore opportunities for integration and collaboration between General Practice and newly formed Health & Social Care Partnerships. It had been developed with the support of the South CHP and Social Work management, the local GP Committee and academia from Glasgow University.

The collective aims of the project are that it is

- Person Centred

A universal approach based on need and not condition or criteria

- Develops Integration / Collaboration

Getting extra value from more joined up management and better use of existing health and social care and community resources and services.

- Shifts Demand

Involving right person, right time, right place to create capacity for the GPs to see the more complex patients (ties with realistic medicine aims). This is achievable through a variety of interventions to reduce downstream activity.

The exit strategy for the project is that there is no exit point- only entry points for other practices -we want it to be scaled up and normalised within mainstream general practice. This reflects core GP working that has a long term focus and aims to retain patients for continued (but mostly intermittent) support.

SLIDE 4;

A helpful way to think about any journey of change in complex structures is by Horizon Planning. It also helps us understand why change can be so challenging for established systems.

Horizon1 in 2015 was the status quo, a place that we wanted to leave for all the reasons that you can see. Some of our ideas were old ideas that were being re-worked and some ideas were very novel.

We have been travelling to Horizon 3 which has not been at times an easy journey, certainly not straightforward. But we have managed in a remarkably short period of time for a project of such complexity to innovate, change patient behaviour and the use of health services, collect a reasonably convincing data set, have the project externally evaluated, improve recruitment and retention within the participating practices and enlarge our network of partners from statutory and 3rd sector agencies. **In that sense we are connected to policy frameworks that moves beyond ‘talking’ to ‘doing’.** We have met the conditions of collaboration, communication, culture and connectivity of realistic medicine.

SLIDE 5; The main resources apart from professional buy in was time and money.

Aligned Social Care Workers & Community Teams

The project started with fully qualified social workers and as part of the learning at the end of year one the skill mix was changed to social care workers who were less focussed on higher level statutory work and more able to support earlier intervention / signposting.

Additional time for GPs

This absolutely key and a non-negotiable element of the project design. Protected time creates effective GP capacity within the system. GPs can organise in-depth consultations up to and over 40 minutes if necessary, for example, longer time to support diagnosis and identification, anticipatory care planning, continuity of care for palliative patients (all documented in DE report 29). The protected time is used for;

- Polypharmacy reviews to ensure appropriate drug regime
- Case reviews- e.g. multi-morbidity, frequent attenders of service

- An Outward facing component - ability to attend and/or provide better quality information for case conferences (e.g. CP, ASP, AWI)
- Developing GP leadership

Structured MDTs

Providing structure to previously informal links with health professionals AND including social work care to ensure a broader understanding - adding social support (if known) to the health information - and vice versa

SLIDE 6

Development of coding and data templates has been a major workstream of the project. These have been created within Emis (our IT system) but there are separate codes that are unique to the project population.

SLIDE 7

The MDT meeting happens on a monthly basis, some time is spent on preparing the register for the MDT. To overcome disconnect of data systems social workers and GPs each bring their own laptop and this allows us to share information about the patient or client which is a practical solution to having separate EMIS and Carefirst systems. **This is a really important function of the project because data protection is an often used inadvertently as a barrier to sharing vital information.** Patient consent is always where practical and possible obtained from the patient or responsible NOK and it is our experience that generally patients DO give their consent to discuss their management at our MDTs. **Trust is a very strong element of the project- patient trust, trust between professionals, trusted management colleagues.**

Work streams were developed under a number of themes and included the following approaches:

Children & Families

- Additional capacity and MDT structure allows for greater GP involvement in child safeguarding procedures
- Early / anticipatory approaches, linking with 3rd sector family support (e.g. Home Start) which was previously underutilised

Frail & Elderly

- In-reach collaboration with Elderly Medicine (Acute) resulting in improved communications with elderly medicine and better understanding of service needs
- Testing escalation protocol to avoid admission through; telephone advice, better use of day hospital (planned and rapid access) and ultimately improved information quality through eKIS in the event of presentation to hospital

Unscheduled Care

- Collaboration with Emergency Department and GEMS in the development of a framework and protocol on how GP practices could respond to out of hours

redirection. Varying issues resulted in no redirections - but potential system was established.

Information Management / Evaluation

- Development of a data framework, including new and customised searches / extracts from local GP electronic systems for quantitative evaluation
- Commissioning of qualitative evaluation focusing on the different way of working

Development

- Collaboration - with other sectors and organisations including mental health, housing and education
- **Leadership** - engaging different GPs to lead on each work stream and lead officer participation in NES/RCPG/Scottish Social Service Council 'You as a Collaborative Leader' programme
- Expansion (Year 3) - Other initiatives in Scotland are testing embedding the roles of Pharmacy and MSK physiotherapy in general practice in relative isolation. These professionals were included in the SHIP project to evaluate any additional benefit through being part of a collaborative multi-disciplinary approach and in the context of high deprivation and the associated incidence of multi-morbidity at a younger age.

SLIDE 8

- Our population of interest, patients that we actively engaged with - either visiting at home, arranging extended surgery consultations tended to be in the younger and over 65 age groups, and who are more socioeconomically disadvantaged, multimorbid. Trends in the SHIP population indicate that
 - **They were previously higher than average users of health services**
 - **Their level of demand was increasing over time**
 - **Their demand peaked over the period of intervention**
 - **Their demand levelled or declined after intervention**

SLIDE 9

1,466 identified to the SHIP since inception

1028 still registered at end March 2018

7% of (14,087) practice population

SLIDE 10

Monthly MDT Activity

Burst of activity over first 9 months in terms of identifying and managing need and risk.

Generally settles after then.

On average 36% of cases are social work related - hence the need for their explicit involvement

The majority of the patients are not known to social work nor are they SW related issues. But we needed to have the function of the MDT to discover this. In the context of vulnerability this is what unmet need looks like

1050 current SHIP patients = approx 7% of overall total of 14,200 (**we suggest 10% extra GP capacity as a pragmatic figure for addressing unmet need**)

SLIDE 11

Chart shows the average of 4 six month cohorts overlaid and their demand 12 months prior to and 12 months post cohort period

For SHIP project patients - Trend of patients shows historically higher than average users, increasing need/demand, being brought back towards previous levels when compared to baseline (all non-SHIP patients within the practices)

SLIDE 12

For overall practice demand:

For the comparator practices there have been two periods of significant increase since August 15.

For Govan there has been no significant increase throughout and from April 17 there is a significant downward shift.

Demand = More than just surgery appointments - is GP interactions/entries to Practice management systems (including letters, results, home visits, telephone and in-practice consultations)

The GPs involved in the project would suggest that this is a result of the approach to using some of the additional GP time to proactively visit targeted patients instead of reacting to events. **And as of May this year the demand reduction = double the rate of the comparator practice.**

SLIDE 13

Continuation

King's Fund indicates that success in most projects of this nature have taken six to seven years to achieve the desired changes

Short term

Assess Return On Investment

Continue qualitative evaluation

Develop physiotherapy / pharmacy specific evaluation

Publish findings

Develop 4th practice involvement to test reproducibility

Expand to Govanhill (awaiting response re. separate funding)

Develop options to extend

Medium Term

Govan SHIP and offshoot project (GP Pioneers) have demonstrated possible to recruit and retain GPs in areas of deprivation and highest need. Locums staying long term and/or becoming partners. No vacancies in SHIP / Pioneer practices bucking the national trend.

Primary Care Transformation funding?

Explore further Scottish Government funding

Review of on going activity (physiotherapy, pharmacy, longer term data)

Small scale rollout

Long Term

Rollout programme to Deep End (plus?) Practices

Slides 14-16

Our exit strategy is that there isn't one. The project becomes an entry point for other GP practices in the DE and beyond, that it becomes embedded in GP working and primary care structures, that we continue to evolve and explore new horizons in our integrated care model. Govan SHIP is just one, partial expression of the Deep End manifesto - Links, Pioneer and the Parkhead project are other expressions with differing purpose. A key point of Govan SHIP is addressing uncoordinated care (as a result of the inverse care law), by re-assessing needs and "driving" integrated care from the bottom up, the essence of general practice.

It is bucking the trend of rising patient demand (which often reflects unmet need in the community) and recruitment and retention issues within general practice. Both need to be meaningfully addressed. General practice and the wider primary care team contain many of the solutions if resourced and supported adequately.

