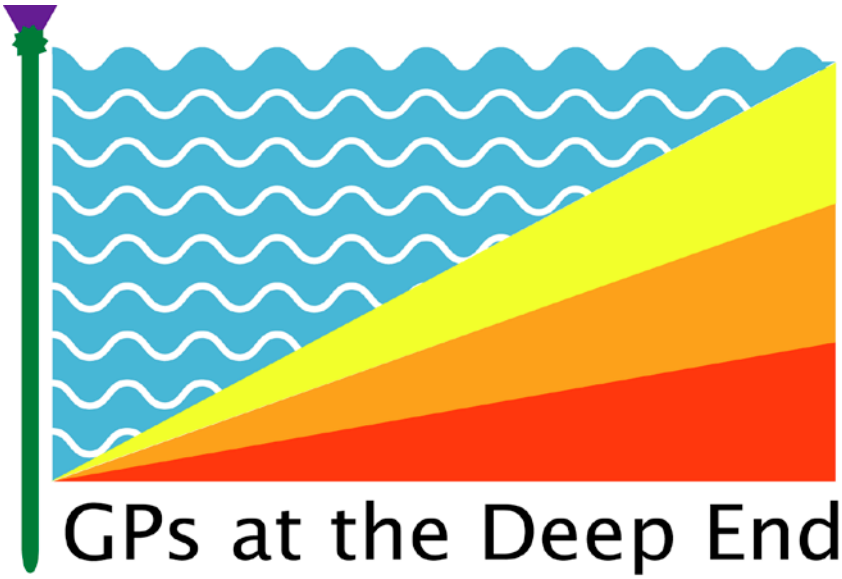

Deep End Report 18
Integrated care

This Deep End report addresses the practical implications of delivering integrated care in the most deprived communities in Scotland.

While the Scottish Government's current consultation focuses largely on the integration of current health and social care organisations, and how general practices may be represented within these new arrangements, this report focuses on what is necessary to provide integrated care for individual patients.

Mutuality, respect, long term relationships and shared responsibility are the watchwords for integrated care and require support and development at many levels:

- Between patients and professionals
- Between professionals working in teams
- Between professionals working in different organisations
- Between primary and secondary care
- Between general practices and community organisations
- Between leadership at area, locality and practice levels

The new structural arrangements on their own will not achieve the necessary cultural changes.

This report draws on research evidence, previous Deep End reports and discussion groups at the second national Deep End conference at Erskine on 15 May 2012.

SUMMARY

- To avoid widening inequalities in health, the NHS must be **at its best where it is needed most**.
- The arrangements and resources for integrated care should reflect the **epidemiology of multimorbidity** in Scotland, including its earlier onset in deprived areas.
- Better integrated care for patients with multiple morbidity and complex social problems can **prevent or postpone emergencies**, improve health and prolong independent living.
- Policies to provide more integrated care must address the **inverse care law**, whereby general practitioners serving very deprived areas have insufficient time to address patients' problems.
- Patients should be supported to become more **knowledgeable and confident** in living with their conditions and in making use of available resources, for routine and emergency care.
- The key delivery mechanism for integrated care is the **serial encounter**, mostly with a small team whom patients know and trust, but also involving other professions, services and resources as needs dictate.
- The intrinsic features of general practice in the NHS, which make practices the **natural hubs of local health systems**, include patient contact, population coverage, continuity of care, long term relationships, cumulative shared knowledge, flexibility, sustainability and trust.
- Health and social care professionals working in area-based organisations (e.g. mental health, addiction and social work services) should be **attached to practices**, or groups of practices, on a **named basis**.
- Practices should be supported to make more use of community assets for health via a new lay **link worker** role.
- The quality and timeliness of hospital discharge information should be a consultant responsibility and audited as a **key component of the quality of hospital care**.
- Practices needed **protected time** to share experience, views and activities, to connect more effectively with other professions, services and community organisations, to develop a collective approach and to be represented effectively.
- **Collective working** between general practices is best achieved with groups of 5/6 practices, as shown by the Primary Care Collaborative and Links Project. Larger groupings are less likely to achieve common purpose.
- **Locality planning arrangements** should be based on representation (not consultation), mutual respect and shared responsibility.

CONTENTS

INTRODUCTION

This report captures the views and experience of General Practitioners at the Deep End on issues of joint working and integrated care.

The report draws on research evidence, previous Deep End reports and discussion groups at the second national Deep End conference at Erskine on 15 May 2012.

The report is for discussion and does not necessarily represent the views of all participants at the Erskine meeting, or of all Deep End practices.

THE GOVERNMENT CONSULTATION

Deep End GPs concur with the Consultation Paper's opening premise.

> *Many clinicians, care professionals and managers...describe two key disconnects in our system of health and social care. The first disconnect is found within the NHS, between primary care (GPs, community nurses, allied health professionals etc) and secondary care (hospitals). The second disconnect is between health and social care.*

Deep End GPs support the Government's stated aims:

(1) that health and social care services are firmly integrated around the needs of individuals, their carers and other family members;

(2) that they are characterised by strong and consistent clinical and care professional leadership;

(3) that the providers of services are held to account jointly and effectively for improved delivery; and

(4) that services are underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve – rather than the organisations through which they are delivered.

It is not clear, however, how these aims will be achieved by the proposed measures:

- Community Health Partnerships will be replaced by Health and Social Care Partnerships, which will be the joint and equal responsibility of Health Boards and Local Authorities, and which will work in close partnership with the third and independent sectors and with carer representation.
- Health and Social Care Partnerships will be accountable, via the Chief Executives of the Health Board and Local Authority, to Ministers, Local Authority Leaders and Health Board Chairs for the delivery of nationally agreed outcomes.
- Partnerships will be required to integrate budgets for joint strategic commissioning and delivery of services to support the national outcomes. Integrated budgets will include, as a minimum, expenditure on community health and adult social care services, and, importantly, expenditure on the use of some acute hospital services.

- A jointly appointed, senior Jointly Accountable Officer in each Partnership will ensure that partners' joint objectives, including the nationally agreed outcomes, are delivered within the integrated budget by Partnerships.
- The role of clinicians, social care professionals and the third and independent sectors in the strategic commissioning of services for adults will be strengthened.

Questions 1–14 in the consultation paper are concerned mainly with a second attempt at the structural integration of current local health and social care organisations. This is a challenging issue, as previous attempts at Community Health Partnerships have shown, but addressing this issue on its own is insufficient to deliver effective, integrated care for patients.

The questions appear to be driven by the assumption that the budgetary and accounting arrangements of senior managers are the key factors in enabling or preventing partnerships. In reality this superstructure rests of a foundation of human factors that are not given sufficient weight in these proposals.

> *As a GP the barriers that prevent me working more closely in partnership are factors such as excessive workload, uncertainty and anxiety over job security, high turnover of staff, short life span of community projects, bewildering array of services and pathways, lack of time and difficulty in getting hold of people, dysfunctional and overly large planning committees, incomprehensible and verbose communications from on high, abstract rationalist planning that disparages experience and organically developed systems, a remorseless rise in demand and expectations, a self-defeating emphasis on measurable factors that undermines the quality of interpersonal relationships and care.*

Questions 16–20 are concerned mainly with how general practices working in localities should be represented within these new arrangements. Before addressing these issues, however, it is important to consider the essential ingredients of care arrangements providing integrated continuity of care for large numbers of people.

> *Locality planning is not just about commissioning and budgetary planning but about organically growing trust, relationships and local systems that make integrated working and smoother decision-making possible. Front line staff and volunteers are the people who will or will not work as partners to make services more integrated and seamless for patients. However, they need to be given the resources to be able to do this, and not loaded with endless targets developed remotely. I hope this legislation will not be another missed opportunity to create the kind of organisational environment which makes it possible to grow this kind of trust and people-based system of care that patients expect and deserve.*

Groups of general practices should be supported as hubs of local systems, delivering integrated care in partnership with secondary care, area-based NHS services, social work and community organisations. Attached workers, lay link workers and protected time are needed to enable joint working. Local leadership needs respect, support and representation (not consultation) within locality planning.

THE EPIDEMIOLOGY OF MULTIMORBIDITY IN SCOTLAND

The people who are most in need for integrated care are those with multimorbidity.

The treatment burden of patients with multimorbidity is often substantial, and is unnecessarily and unacceptably complicated by fragmented care arrangements, involving multiple providers, discontinuity and poor coordination.

The Government's policies and plans for integrated care should reflect the epidemiology of multimorbidity in Scotland (1):

- Multimorbidity is the norm in Scottish patients over 50. Although multimorbidity is most common in older people, most people with multimorbidity in Scotland are under 65.
- Multimorbidity occurs most frequently in deprived areas, 10-15 years earlier than in affluent areas.
- For the top 40 chronic conditions, patients with only that condition are a small minority (less than 25%) for every condition except asthma. Most patients have more than one condition.
- There are only small differences between affluent and deprived patient groups in the prevalence of multimorbidity over 80 years of age.
- The most common co-morbidity in deprived areas is a mental health problem.

CONCLUSIONS FROM PREVIOUS DEEP END MEETINGS AND REPORTS

The following position statements are based on previous Deep End meetings and reports:

(A) The inverse care law
(B) General practice as the hub of local health systems
(C) Patients at the centre of serial encounters
(D) The importance of links
(E) Investing in social capital
(F) Making a difference

(A) The inverse care law

Deep End GPs welcome the statement in the Consultation Paper

> *In terms of GP engagement, we anticipate the need to consider workload issues, and therefore more availability of time to participate in locality planning, particularly in areas of high deprivation; and the recruitment and*

retention of GPs, particularly in areas with the poorest health outcomes. We have already begun a dialogue on the scope of the GMS Contract in Scotland, and we will continue to use that opportunity to consider how to give practical effect to these proposals for locality planning.

However, the problems of delivering integrated care in very deprived areas go far beyond GP engagement in locality planning, and while GP recruitment and retention in deprived areas are important, this is less of an issue in Scotland than it is in England.

The Government's vision of equitable, integrated care cannot be achieved if it does not address the inverse care law. On the contrary, if effective health and social care is not delivered equitably, inequalities in health will widen. The principal cause of the inverse care law in Scotland is the flat distribution of GP manpower which is independent of the steep social gradient in need (2).

- Deprivation increases consistently across deciles of the Scottish population with the largest step increase between the ninth and tenth deciles
- Independent health measures show a steep social gradient with greater than 2.5 fold variation across deciles of the Scottish population, from the most affluent to the most deprived.
- On average, deciles of the Scottish population comprise 535,015 people, served by 105 general practices including 353 whole time equivalent (WTE) general practitioners.
- The total WTE of general practitioners, including non-principals and doctors in training, was 11% higher (437.1 v 392.0) in the more affluent half of the population (deciles 1-5) than in the more deprived half (deciles 6-10)
- These data on WTE GPs date from 2003, the last occasion when it was possible to obtain such data based on a complete national sample.

Consequent to this mismatch of need and resource, consultations in general practices serving very deprived areas are characterised by (3):

- Multimorbidity and social complexity
- Shortage of time
- Less patient enablement, especially of patients with mental health problems
- Practitioner stress

(B) General practice as the hub of local health systems

General practices have the following features which make them natural hubs around which local health systems should develop:

- Practice teams have substantial, cumulative knowledge about patients, their circumstances and preferences.
- Practices are the service of last resort, providing virtually unconditional support for patients, whatever their health problems are.
- Continuity of contact with patients provides a robust and reliable context for long term care with multiple starting points for the improvement of care.
- Practice lists provide the basis for ensuring complete population coverage.

- Public opinion surveys consistently show high levels of trust in the general practitioner system.

No other part of the public service provides this combination of features.

(C) Patients at the centre of serial encounters

Patients need to be knowledgeable and confident in living with their conditions and treatments and in contacting and using available sources of support in both routine and emergency situations. In addition to specialist support for particular conditions and at special times, they mostly need unconditional, personalised, long term, continuity of co-ordinated care from professionals whom they know and trust.

Professionals need knowledge of the patient, and his or her problems, circumstances and preferences. They also need to know the patient's support network, including family, statutory and non-statutory services. Such knowledge can be lost when staff leave or are re-deployed.

Many of the problems of fragmented and inefficient care arise when patients are seen by professionals who lack such information.

Integrated care is generally a long haul involving serial encounters between patients and a range of professionals and services. Whether there is continuity between encounters, either via professional contact, or the availability of necessary information, depends on how care is imagined, organised and reviewed.

The build up of shared knowledge, confidence and trust takes time. New developments in care must address not only the start of the process (e.g. by needs assessments) but also its continuation and coordination. Fragmented care begins when there are poor connections between serial encounters.

(D) The importance of links

General practice hubs are often insufficient to address patients' problems and need to be complemented by links to other professions, services and resources. Key interfaces are with secondary care, area-based NHS primary care, social work and community organisations.

In general, the links between general practices and hospital services are poor, with each part of the service pre-occupied with its own problems.

A consistent conclusion of Deep End discussions is that if referral routes to other professions and services are not local, timely and familiar, they are less likely to be taken up by patients in very deprived areas. Practice-attached workers are a key component, therefore, of integrated care.

For general practices serving areas of blanket deprivation with high prevalences of many health problems, area-based services (e.g. social work, mental health and addiction services) should attach named workers to practices, or groups of practices.

A new role of lay link worker is also needed to develop and maintain links between general practices, other services and community organisations

(E) Investing in social capital

Integrated care depends on multiple relationships

- Between patients and practitioners
- Between practitioners working in different professions and services
- Between general practices and area-based NHS and social work services
- Between general practices and community-based organisations
- Between general practices and hospitals
- Between leadership at area, locality and practice levels

The social capital within a local health system comprises the sum of all the relationships within it.

Research in the west of Scotland on patients' perceptions of practitioner empathy (4) has shown the importance of the relationship between patients and practitioners. While empathy may be reported by patients in the absence of enablement, enablement never occurs in the absence of empathy.

Similar considerations apply to relationships between health and social care practitioners. The cardinal features of effective joint working between professions and services are:

- Regular contact between people who know each other's names
- Understanding and respect of each other's roles and constraints
- Effective communication when it matters
- Positive experiences and confidence in joint working

Attention should also focus on the relationship between service organisations. In a Canadian trial of the effect of key workers in keeping frail elderly people out of hospital (which involved neither additional resources, nor restructuring, but a commitment to joint working at every level, especially the top), the extent of joint working was defined, measured and monitored as (5):

0 No awareness: program or services are not aware of other programs or services.

1 Awareness: discrete programs or services in the community are aware of other programs or services, but they organise their own activities solely on the basis of their own program or service mission, and make no effort to do otherwise.

2 Communication: programs and services actively share information and communicate on a formal basis.

3 Cooperation: programs of services modify their own service planning to avoid service duplication or to improve links among services, using their knowledge of other services or programs.

4 Collaboration: programs or services jointly plan offered services and modify their own services as a result of mutual consultations and advice.

A similar approach is needed to assess and quantify the level of joint working between potential collaborators in integrated care.

By its novelty, productivity and speed, the Deep End project has highlighted the previous lack of NHS infrastructure allowing practices to share experience, views

and plans. Key elements of the project have been protected time and central support. The NHS should provide such infrastructure on a continuing basis.

Both the Government consultation paper and Deep End meetings have commented on the "disconnect" between primary and secondary care. With notable exceptions, relations between NHS staff in primary and secondary care lack mutuality, understanding and respect.

At the second national Deep End meeting, "there was feeling among GPs that neither Health Boards nor external agencies have sufficient knowledge of how primary care actually works or the scale of the day to day contact with patients".

In all these areas there is a need for investment in and monitoring of social capital, in terms of the joint working relationships which are needed for the delivery of integrated care.

(F) Making a difference

Better integrated care can prevent or postpone emergencies, improve health and prolong independent living. The evidence for this is at present is indirect but substantial, being based on the premise that impersonal, partial, poorly organised and fragmented care, lacking continuity and coordination and delivered by professionals with neither prior knowledge of the patient nor a commitment to what happens in the future, is a potent recipe for premature and expensive use of emergency services. The question is **not whether** better integrated care can prevent or postpone emergencies **but by how much**. In the future, the challenge will be to achieve such outcomes as efficiently and using as few health professionals as possible.

RESPONSE TO QUESTIONS 16–20 IN THE CONSULTATION

QUESTION 16 *It is proposed that a duty should be placed upon Health and Social care Partnerships to consult local professionals, including GPs, on how best to put in place local arrangements for planning service provision, and then implement, review and maintain such arrangements. Is this duty strong enough?*

- This duty is insufficient, because it maintains the centralisation and concentration of power, decision-making and responsibility, with limited ability to influence what happens at ground level.
- While broad principles and decisions on resource allocation can only be taken centrally, many aspects of joint working can only be determined locally, based on local resources of knowledge, staff, premises, links etc.
- Integration of care requires mutuality, understanding and respect between those responsible for care at central and local levels, and a re-deployment of central resources to support decision-making at a local level.
- Decision-making at a local level (within large practices or groups of practices) needs to be supported (devolving some central support functions) and represented (not "consulted") within the planning system.

- Following the example in South Glasgow, GP representation on locality planning groups should be on the basis of election rather than appointment.

QUESTION 17 *What practical steps would help to enable clinicians and social care professionals to get involved with and review planning at local level?*

- Named social workers should be attached to large practices, or groups of practices, so that productive professional relationships can be developed, based on regular contact, shared experience, mutual respect, understanding and trust.
- Protected time is needed to establish and develop these relationships, to share and review experience, and to provide a basis for representation within locality planning arrangements.

QUESTION 18 *Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?*

- Experience of the Scottish Primary Care Collaborative (6), and also the LINKS Project (7), shows that general practices can work productively and collectively in groups of five or six practices.
- A grouping of 20 practices is too large, as there are too many differences between this number of practices to enable joint approaches.
- A feature of both the SPCC and the LINKS project was external support for groups of practices working on joint activities, including protected time to agree common objectives and to review progress.
- The LINKS project also had the key feature of protected time for a GP lead who could represent the group centrally and in dealings with external contacts.

QUESTION 19 *How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?*

- Needs-based resource allocation can only be carried out centrally. In general, general practices do not wish to have responsibility for area-based commissioning.
- Locality planning is necessary to ensure that area-based services and general practices work effectively together, in service of the local population.
- Local practice arrangements can only be determined at practice level, based on local knowledge, but practices should be supported (with protected time, information, professional development activities) to share experience and activities within clusters of practices.

QUESTION 20 *Should localities be organised around a given size of local population e.g. of between 15,000–25,000 people, or some other range? If so, what size would you suggest?*

- Experience of the Scottish Primary Care Collaborative and the LINKS project is that groups/clusters of five/six practices provide a practicable basis for joint working.
- Larger groupings involve too many differences between practices to enable a joint approach.

- Each cluster should have an elected GP lead with protected time to support joint working between practices and to represent their cluster within locality planning arrangements.

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ANNEX A

Discussion points from the 2nd National Deep End Conference

57 GPs and eight observers met on Tuesday 15 May 2012 at the Post House Erskine Hotel for the second national Deep End meeting, during which breakout groups addressed the issues of joint working for integrated care, as raised by the Scottish Government's consultation on Adult Health and Social Care.

(1) Participants
(2) Improving links between primary and secondary care
(3) Improving links between general practice and social work
(4) Improving links between general practices and local community resources.
(5) Improving links between general practices
(6) Strengthening general practice as a collective system

(1) Participants

General practitioners

Glasgow unless stated otherwise

Name	Location	List size	Deprivation ranking
Ian Aitken	Crail Medical Practice	4100	27
Mahammoud Akhtar	Eglinton Medical Practice	2875	86
Wilma Best	Gorbals Health Centre	6059	60
Roger Boyle	Springburn Health Centre	1359	44
Georgina Brown	Springburn Health Centre	7187	44
Peter Cawston	Drumchapel Health Centre	5310	43
Louise Churches	Bridgeton Health Centre	2846	36
Margaret Craig	Allander Surgery	4167	12
Davinder Dhami	Easterhouse Health Centre	1629	16
William Doak	Arran GP Surgery	10670	80
Alex Dowers	Townhead Health Centre	12990	159*
John Dunn	Muirhouse, Edinburgh	10942	75
Carolyn Gillies	Govan Health Centre	3893	32
John Goldie	Easterhouse Health Centre	9241	6

Name	Location	List size	Deprivation ranking
Richard Groden	Tollcross Medical Centre	6776	76
Gordon Guthrie	Torry, Aberdeen	5819	83
Alyson Hee	Balmore Surgery	3375	3
Sinclair Holland	Crewe Road, Edinburgh	8979	97
Robert Jamieson	Bridgeton Health Centre	2846	36
Gillian Kidd	Midlock Medical Centre	8343	65
Yasmeen Kousar	Eglinton Medical Centre	2857	86
Neil Lafferty	Wallacewell Medical Centre	1901	70
Susan Langridge	Possilpark Health Centre	2165	18
Carolyn Linton	Riverside, Ayrshire		
Wiliam MacPhee	Parkhead Health Centre	4971	17
Pauline McAlavey	Glenmill Practice	6113	29
Alan McArthur	Braidcraft Medical Centre	6875	40
Veronica McBurnie	Springburn Health Centre	3201	49
Clare McCorkindale	Kelso Street Surgery	3382	57
Chris McHugh	Townhead Health Centre	12990	159*
Kerry Milligan	Homeless Families Health Care, Glasgow		
John Montgomery	Govan Health Centre	5885	34
Anne Morgan	Drumchapel Health Centre	2861	15
Catriona Morton	Craigmillar, Edinburgh	8353	20
Anne Mullin	Govan Health Centre	8476	79
Kerri Neyton	Maryhill Health Centre	5990	61
Michael Norbury	Craigmillar, Edinburgh	8353	20
Deirdre O'Driscoll	Springburn Health Centre	3201	49
Jim O'Neil	Lightburn Medical Centre	3117	28
Anne Pettigrew	Springburn Health Centre	3116	54
Allison Reid	Balmore Surgery	3375	3
Petra Sambale	Keppoch Medical Centre	3085	1
Nicola Smeaton	Mill Practice, Dundee	9365	85

Name	Location	List size	Deprivation ranking
David Willox	Croftfoot	7123	145*
Andrea Williamson	Homelessness Health Service, Glasgow		
Marie Wilson	Easterhouse Health Centre	2462	4
Axel Winkler	Dalmellington, Ayrshire	3625	89

**Practices 145 and 159 were in the top 100 practices based on the 2006 classification of the Scottish Index of Multiple Deprivation (SIMD), but not based on the 2009 classification. Both practices are relatively large and have over 2000 patients living in the 15% most deprived Scottish data zones.*

Note takers (all general practitioners)

David Blane, Sarah Capewell, Emma Fardon, Bhautesh Jani, Lynda Fenton, Mike Norbury, Sumi Roy, Andrea Williamson

Academic GPs

Stewart Mercer	University of Glasgow
John Robson	Queen Mary, University of London
Graham Watt	University of Glasgow

Others attending

Max Brown	Scottish Government Health Department
Roderick Duncan	Scottish Government Health Department
Christine Hoy	Scottish Government Health Department
Sue Laughlin	Greater Glasgow and Clyde Health Board
Sheena MacDonald	Scottish Government Health Department
Frank McGregor	Scottish Government Health Department
Richard Simpson *MSP*	Scottish Parliament
Frank Strang	Scottish Government Health Department

(2) Improving links between primary and secondary care

Problems

- Hospital admissions are often managed on a narrow medical basis, not taking into account the complex needs of multimorbid patients, especially from deprived areas.
- Discharge information is often “too late and too little” to allow continuity of care in the community.
- Hospital doctors and general practitioners tend to work (“embattled”) within the constraints and pressures of “their part of the system”, without knowing or caring for the working of the system as a whole.
- Hospital doctors and general practitioners tend not to meet; in consequence their professional relationships often lack the mutual understanding and respect that is necessary for “seamless care”.
- Medical Receiving and Medicine for the Elderly seem to be the only specialities interested in joint working with GPs.
- Markers of disrespect have been unilateral changes to hospital services (e.g. the relocation and centralisation of services, reallocation of practices to different localities) with substantial implications for general practitioners and their patients
- Data on outpatient referrals are thought to be inaccurate, with poor data leading to poor decisions.
- Junior doctors in the hospital front line often have insufficient information about patient circumstances to do anything other than admit patients as emergencies.
- Secondary care colleagues are not routinely present at Local Medical Committee meetings.

Potential solutions

- A sustained programme of measures is needed to enhanced mutual understanding, respect and joint ownership of problems between health professionals working in primary and secondary care within defined localities.
- Could hospitals develop a sense of corporate identity, generating a feeling of responsibility for services for the local population, recognising, supporting and rewarding services which make a difference?
- Identify areas of secondary care where relationships are felt to work well (e.g. rheumatology); arrange meetings between general practitioners and consultants to identify how and why relationships work well, with the aim of spreading good practice to other specialities.
- Multidisciplinary locality meetings are needed to discuss particular issues e.g. delayed hospital discharge letters. An example was described in which each local practice was provided with two hour locum cover for one GP per practice. With funding, protected time and feedback, such meetings are valuable in giving local practices a collective voice.
- Offer hospital doctors a period of time working in general practice (although when this was tried in Tayside, there was no uptake).

- One to one telephone calls between GPs and a known consultant could provide the “low level” communication needed to facilitate integrated care.
- Emergency admission of elderly patients could be avoided by providing rapid access to rehabilitation teams for increased support at home (a successful example of this was described in Edinburgh) and direct access out of hours to beds in care homes for patients who are not safe at home but who do not require an acute bed.
- The age cut off for “elderly” should be reduced by 10 years in the most deprived areas, due to the earlier onset of multimorbidity
- In Edinburgh, a consultant geriatrician has been funded to provide a single point of contact for all Medicine of the Elderly issues during GP opening hours in an area of the city. The consultant visits patients at home, arranges urgent medical outpatient appointments, day hospital visits or fast track secondary care-based tests and investigations, keeping GPs informed of progress throughout.
- Senior hospital doctors should be responsible for the content, quality and timeliness of discharge letters.

(3) Improving links between general practice and social work

Problems

- GPs recognise that the social work service is overstretched, with high turnover.
- Many GPs could not name their “lead social worker”.
- Communication can be poor e.g. a GP looking after a family with two young children was not informed of the outcome of a social work case conference.
- CHCPs were thought to have been too big, and concerned with NHS/Social Work relationships at a high level rather than promoting helpful interaction between health and social work practitioners.
- Many practices described having “lost” previously good links with social work.
- GPs expressed concern about the training and quality of some staff delivering social care e.g. “family workers” rather than trained social workers.
- Continuity is a key issue. There are problems in sharing information, for example, when new or relatively transient families move into an area. Cross-over of data can be slow.
- GPs are happy to pass on responsibility about a patient but want to know that the problem is definitely being addressed, and not put on hold. Better communication might allay such concerns.
- It was noted that there is nothing novel about calls for better communication between heath and social services. The continuing challenge is to make this happen. Reorganisation and restructuring provide no guarantee that patients will receive integrated care.

Potential solutions

- Rather than new measures, it was felt that measures which had worked previously should be used again e.g. practice-based social workers.
- Having face-to-face contact with a known individual is seen as important, as is the ability to discuss both individual cases and neighbourhood level issues at regular meetings.
- A named social worker, or small team of social workers, should be attached to a practice or small network of practices.
- Where possible, closer configuration of Social Work areas and GP lists would be helpful.
- Additional resource is needed to build in the time needed for professional groups to meet and speak with each other.
- General practice could provide an important gateway to social work services e.g. benefits advice.
- GPs felt that it would be hugely beneficial to have a long term working relationship with a linked social worker to develop consistency and trust.
- Proximity is a key determinant of the many formal and informal contacts needed to develop and maintaining trusting professional relationships.

(4) Improving links between general practices and local community resources

Problems

- General practices need to be better networked locally, knowing what services are available which could be helpful for patients.
- In recent years, the imperatives, incentives and pressures caused by the GP contract have caused practices to become inward looking and to lose contact with what is happening outside.
- Shortage of time is the key constraint in establishing local networks.

Potential solutions

- Community development and social prescribing are important parts of the future. Many GPs see this as a return to the “core business” of general practice.
- Websites collating useful local information should be helpful, providing they are easily accessible, provide the necessary information quickly and are kept up to date.
- One GP cited the positive effect of the ALISS project which carried out asset mapping in local areas and helped GPs to find out for their patients what services are available in the voluntary sector.
- Open days could provide “marketplace” opportunities to find out what local resources and services are available.
- Attached lay workers could act as social prescribing facilitators, developing and maintaining links between services, helping patients to make use of links and checking for continuity. The example was given of a practice receptionist carrying out this role in a limited way.

(5) Improving links between general practices

Problems

- Current organisational structures are too large and act against the development of local networks of practices.
- The small and dispersed nature of may practices premises (with little investment in the last five years) has compounded problems of isolation and communication.
- Practices which see themselves as "doing OK" may be reluctant to team up with other practices.
- There are often cultural differences between practices which need to be acknowledged and worked through.
- The current management structure is seen as too rigid, with a tension between health board/government priorities and those of GPs.
- "Ten CPD meetings used to be held annually but the funding has now stopped."
- GP continuing education has become individualised and dissociated from practice activities and needs.

Potential solutions

- Local networks should be small (5-6 practices) and well resourced (dismantling central resources to achieve this). They will not be effective as an "optional, extra activity".
- Groups should be small scale, independent, dynamic and well-supported. One size doesn't need to fit all.
- Ideally, services should be practice-linked but in the current economic climate, it was agreed that "buddying up" with neighbouring practices to share resources made more sense.
- The Primary Care Collaborative (PCC) approach was effective and acceptable in engaging with 67% of Deep End practices.
- Network managers should be appointed from the "bottom up" with GP involvement.
- Not all practices need to engage from the outset. If a model is established with attainable goals and these are achieved, the benefits will be evident and initially reluctant practices are more likely to join. Pilot groups should find the way forward.
- Notwithstanding the independent contractor status of GPs and their need to look after their own fiscal interests, "all agreed" that it would be helpful to have a network for better communication between practices within a locality to assess needs and plan services accordingly.
- Informal networking (e.g. shared coffee breaks) helps to build relationships and share best practice, in addition to formal CPD sessions.

(6) Strengthening general practice as a collective system

Problems

- There was feeling among GPs that neither Health Boards nor external agencies have sufficient knowledge of how primary care actually works or the scale of the day to day contact with patients. In consequence, there is little awareness of the potential high volume and speed with which referrals could be made in core areas such as mental health.
- The attitude of some CHCPs was seen as a barrier to GP involvement, being too bureaucratic, top down and not engaged with the primary care agenda. Other CHCPs had fostered positive relationships between practices in a supportive environment.
- Accountability and governance had been incorporated in the CHCP legislation but had not been enforced (as highlighted in the Audit Scotland report). Early accountability and transparency in shifting funds between services is essential.
- Contracts and targets focus attention on national public health issues rather than encouraging creative solutions to local issues.
- GPs are keen to be involved in local planning, but time is the key limiting factor, especially when GP colleagues have to provide backfill for GPs involved in locality planning.
- Previous experience of important changes being driven through without consultation had damaged trust.
- There is concern that some of the mistakes of CHCPs will be repeated, and that joint working at a local level will not receive the necessary attention
- GP workload is becoming unsustainable. There is recognition that a good management structure is needed to plan services and align budgets.

Potential solutions

- The South Glasgow GP Committee provides an example of an elected approach which allows GP voices to be heard on issues of common concern, such as better access to local services.
- GPs would like to be involved in directly planning services and aligning budgets but not to have entire responsibility for budgets.
- Locality working would be a good way of ensuring that the available resources are in the right place for patients.
- GPs are well placed to comment on where savings can be made.
- Locality groups should have some decision-making powers, but not necessarily commissioning responsibility.

POSTSCRIPT

> *Another example – an 87 year old with mild dementia who falls at home and is found to have a chest infection on home visit. I know she doesn't need admission and could stay at home with adequate provision from the appropriate community team. For years, time and time again, the experience seems to be the same – several phone calls, a visit for assessment agreed, patient found not to meet some criteria, patient ends up in hospital anyway – a result that I could have achieved at a fraction of my time. I am left feeling that the NHS and social services seem to have become a National Assessment Service, rather than a service to deliver care.*

A locality GP cluster should be large enough to collate data on experiences such as these but small enough for this to be meaningful and remain under the direct control of the clinicians involved, to be able to identify problems, fix them, and communicate quickly and in a simple fashion. This section of the proposals does not give enough weight to the importance of effective local working together to solve small but important problems like this, which lie at the true heart of dysfunctional partnerships. Locality groups need to be allowed to be effective, nimble, grounded in reality and develop clear locally relevant goals rather than being encumbered with a false inclusivity or being used as levers for senior managers. GP practices need to play a central part in these, but locality planning must be focused on enabling links and personal relationships between different sectors to grow as well as dealing with systems of care.