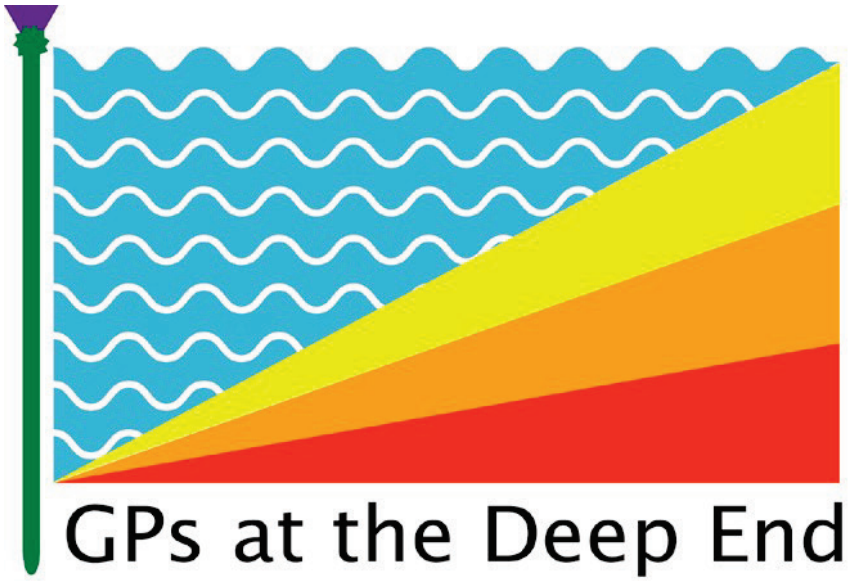


Deep End Report 29

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.

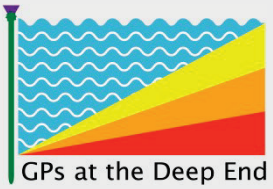
June 2016

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.*



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CONTENTS

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:

	Number of practices
GP partner	3
GP registrar	2
GP retainee	2
Salaried GP (SHIP locum)	3

Practice nurse	3
Nurse practitioner	1
Health care support worker	1

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[5], 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.

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ANNEX A
Extended consultations – patient contact and outcomes

Length	
20min	Patient with major depressive symptoms/suicide risk and substance misuse; **Outcome**: planning of future care and involvement of other organisations.
20 min	Patient with newly diagnosed depression and child protection issues; **Outcome**: during consultation likely COPD diagnosed referred for spirometry/smoking cessation.
20 min	Pregnant patient – major child protection concerns – background of domestic violence and drug misuse. **Outcome**: SW contacted and telephone discussion re planned case conference.
20 min	Poorly controlled diabetic who is reluctant to engage with services.
30 min	HV to newly diagnosed palliative care patient; **Outcome**: met with family and discussed management and DS1500.
20 min	Patient with h/o head injury personality change and depressive features very reluctant to accept input from support services.

25 mins	Planned palliative care discussion at home with patient and carer, non-cancer diagnosis. **Outcome**: clinical expectations discussed to allay fears over management. Linked with secondary care consultant by phone for agreement with treatment plan.
30 mins	Post hospital discharge visit in elderly lady with multiple co morbidities and polypharmacy; **Outcome**: medication review and link with social services and ACP planning.
30 min	Planned visit to elderly patient and carer with dementia and new diagnosis of advanced malignancy. **Outcome**: discussion over diagnosis, to some extent prognosis and palliative treatment. Linked into district nursing and palliative care team. ACP planning with carer.
20 min	Child < 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; **Outcome**: 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.

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.
30 min	50+ year old asylum seeker. Registered July 2014 with us. Headaches. Social history taken. Her dependent children still live in her country of origin. Cost prohibits much contact with her children. Speaks by phone about once per month. Had a part time job. HIV under treatment and PMH of probable meningeal TB. Known PTSD. **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.
	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,

	review of meds, bloods taken, epilepsy review, mental health review and review of old notes. eKIS entry done.
60 min	Extended home visit – complex patient; **Outcome**: medication review, anticipatory care, called her family, Discussed resuscitation, discussed future care needs with home.
30 min	Extra extended review was able to be slotted in for a patient with odd behaviour and a full memory assessment undertaken; **Outcome**: Called family, referred on to rehab and psychiatry as well as social work.

2 hours	Surgery of 6 x 20 minute extended consultations with 6 patients with significant diabetes related problems and complex co-morbidities; **Outcome**: aimed at improving engagement with medical management plans and improving sub-optimal diabetic control.
30 min	New first diagnosis of diabetes. Complex history of multimorbidity including hypertension previous perforated DU and COPD. Osmotic symptoms +++. HbA1c (235). Chol 2.8. BP 126/80 mmHg. eGFR >60. Microalbuminuria -ve (<5). Wt98.8kg. BMI 30.49. **Outcome**: ex-smoker Advised to arrange optician eye review (referred retinal screening retinal screening). Medication reviewed (polypharmacy). Already on statin. Satisfactory lipid control. Already on ARB - not for blood pressure control. Review 3/12 after repeat HbA1C. Advised +++ re lifestyle issues - diet and exercise.
40 min	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. **Outcome**: 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.
20 min	Multiple co-morbidities. **Outcome**: (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.
20 min	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;

	Outcome: Rx diazepam 4 mg tid + thiamine tid –next of kin will supervise. Discussion +++ Refer CMHT. Appointment to be arranged via NOK.
20 min	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. **Outcome**: explanatory comment added to med cert and 4 week review.
20 min	Under pressure because of benefits concerns re PIP. **Outcome**: 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.

	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.

30 min	Extended house call to assess elderly care home resident with recent diagnosis of malignancy. **Outcome**: updated AWI certification, KIS, DNACPR and ePCS.
30 min	Extended house call to renew AWI certification in care home resident. **Outcome:** completed formal assessment of memory to compare with baseline and reviewed medication.
30 min	Extended house call to review palliative care patient with complex pain issues. **Outcome**: discussion with patient and family re available options and initiation of parenteral analgesia, KIS/ePCS updated to reflect same.
20 min	Extended surgery consultation with school age child and mother due to behavioural problems at school stemming from Autistic Spectrum Disorder. **Outcome**: 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.

40 min	Extended surgery consultation with patient bereaved in very unusual circumstances. Previous input with patient had highlighted limited services available locally to support patient's current difficulties (due to gaps in mental health service provision and limitations on charitable resources). **Outcome**: provided structured support regarding bereavement process and current mood difficulties. Explored coping strategies and reviewed current medication provision. Dealt with incidental musculoskeletal complaint also.
10 min	Phone consultation with challenging patient with complex PMHx who had initially requested emergency appointment regarding numerous ongoing issues. **Outcome:** negotiated more appropriate solution with offer of extended appointment at a later date within another Govan SHIP session in order to ensure ongoing continuity of care and de-escalation of acute situation.

30 min	Planned discussion of pain relief and long term conditions (including addiction issues).

45 min	Palliative care patient visited at home as an extended consultation. **Outcome**: KIS and cancer care review complete. Discussed forward care planning and arranged a follow up review.
30 min	Extended consultation with patient with complex mental health issues. **Outcome**: arranged re-referral to CPN.
30 min	Extended consultation –patient with addiction issues and chronic patient. **Outcome**: review of current pain management and change of treatment plan.
10 min	Phone discussion with CPN and community psychiatry re application of MH act (patient E with marked physical health problems and chronic self-neglect, non-engagement with treatment and support services) and ways to determine patient capacity within the community.
40 min	Home visit. **Outcome**: patient E admitted to hospital under EDC for treatment. Prolonged discussion with psychiatry re appropriate procedure for admission when capacity appears diminished. Discussion with Mental Health Officer re necessity of EDC.

20 min	T1DM, benign intracranial hypertension, long history of low mood, serial defaulter, poor compliance medication. **Outcome**: 1. compliance poor in part due to confusion around medication. Rationalised, pharmacist agreeable to dosette, rpt medications amended to dispense weekly 2. review of mood and support mechanisms. Recent change from fluoxetine to duloxetine (to rx both neuropathy and depression) explained. Self referral to wellbeing services.
	Carer for husband with neurological problems and complex social

	history. Review in place as unexpectedly pregnant and s/b perinatal. However, miscarrying. **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.
	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.

45min	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.
1 hour	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.
1 hour	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.

1 hour	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 DNs for skin care and provision of pressure cushion. Review for a week later arranged.
45 min	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.
1 hour	Home visit to patient with diagnosis of bowel cancer and who is housebound.

	Outcome: discussed at MDT as part of Govan SHIP and realised no contact with pt for some time and had had correspondence from hospital re ?recurrence. Polypharmacy review and bloods taken.
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.

45 min	Extended visit. Early HV at request of district nurse. New unliteral oedma in patient previously refusing any input at all. **Outcome**: now engaged with DN and GP. Vulnerable adult.

10 min	Emergency appointment. **Outcome**: bereavement counselling and support.
30 min	Patient with learning difficulties and support worker. **Outcome**: discussed abnormal CXR, ?cancer. Referred to chest clinic.
40 min	Home visit to elderly patient with dementia with heart failure. Optician has concerns.
30 min	Patient with mental health and drink problems turned up demanding to be seen. **Outcome**: at follow up, organised investigations and time to discuss and examine appropriately.

45 min	Home visit with district nurse to patient E with self-neglect, leg ulcer and mental health problems.
1 hour	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.

35 min	Palliative care. **Outcome**: anticipatory care plan formulation with patient and daughter.

ANNEX B
Case record reviews (without the patient being present)

35 min	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; **Outcome**: 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&E.
20 min	Case review of child with child protection concerns; **Outcome**: 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.
1 hour	12 records. Case note review of patients with dementia not seen in 12 months; **Outcome**: resulted in planned invitation to surgery for 8 of these patients for extended consultation.

25 min	Patient in NH with CVA history. **Outcome**: 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.
10 min	Patient with CVA and incapacity; **Outcome**: case record reviewed and KIS updated.

20 min	Review of notes regarding a complex patient and discussion with her carers

	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),

20 min	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; **Outcome:** contacted care home and arranged for community follow-up and assessment of intraocular pressures.

30 min	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-

	to-date and accurate.

20 min	Review case records of vulnerable child (new patient); **Outcome:** name added to MDT.
90 min	Review of case records (vulnerable adult falling in between services); **Outcome:** 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&E services . GP request for an MDT with GP present (date to be confirmed but during protected GP project time.)

50 min	Re-coding and update of past medical history in summary sheet.

15 min	Polypharmacy review; **Outcome:** patient phoned. Changes discussed. Alterations made to medication as per pharmacist suggestions.
10 min	Polypharmacy review; **Outcome:** telephone consultation. 2 medications discontinued.

15 min	3 polypharmacy reviews looked at; **Outcomes** : appointments made for relevant patients.

ANNEX C
Correspondence

	Housing support letter.
	Patient with CVA and incapacity. Telephone liaison with next of kin who has guardianship; **Outcome:** DNACPR discussed, agreed and Adult with Incapacity Form completed and provided to NH. Case record reviewed and KIS updated.

	Results from Portal, letter with results to patient and liaison with secondary care about impending planned CT investigations.
	Correspondence to parent of patient for use in addressing DWP and local authority issues.

	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'.

	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).
	3 emails with psychiatry re vulnerable adult patient (20 mins).

	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.

	Letter to psychogeriatrician outlining concerns regarding a patient with dementia.

90 min	Reports for DHSS (ESA, Attendance allowance); phone calls to pharmacist to change Rx and drug boxes for vulnerable patients; phoned hospital.

90 min	Phone calls to chemist concerning script and box changes; reports for DHSS (Attendance Allowance, DVLA, ESA); phoned dental hospital.

	Telephone call from social worker regarding arrangements for forthcoming permanency meeting for vulnerable child.

ANNEX D
Reports

3	Social work referral, psychiatry referral and rehab team referral.

30 min	Asylum and Immigration Service report completed (S4 Medical Declaration) – on a patient who has been denied asylum.
15 min	Discussion of isolated female vulnerable asylum seeker with LINKs worker to arrange follow up and support engagement with support services.

60 min	3 DHSS/ ESA reports.

40 min	2 Medical reports for ESA.
	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

2 hours	Chaired MDT meeting.

60 min	MDT meeting,

30 min	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.

1 hour	Multidisciplinary meeting,

20 min	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.

2 hours	Discussion and case planning in MDT with social work ,DNs ,HVs.

90 min	3 x housebound dementia reviews. Ensured that DNACPRs, section 47, covert medication pathways, POW, KIS details all in place.

30 min	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.

15 min	Contacted psychogeriatricians and CPN regarding patient with dementia and ability to contact help out of hours.

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.

10 min - Phone call to patient C social worker – 10 min – unproductive – he was unavailable and his colleague was unable to provide information.

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.

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.

Additions to MDT folder from A&E and outpatient letters re child and adult patients (6 patients)- 40 min – out with session,

Meeting with HV lead- re vulnerable children identified in the MDT (due to current HV absent on sick leave)- 30 min,

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.

15 min	Contacted practice pharmacist to arrange meeting to discuss future medication reviews.
12 hours	In depth analysis of practice deaths, by cause, place, predictability etc.

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 car.

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.

ABBREVIATIONS

ACP	Anticipatory Care Plan
A&E	Accident and Emergency
ARB	Angiotensin II Receptor Blockers
AWI	Adults with Incapacity
BPAS	British Pregnancy Advisory Service
CAT	Community Addiction Team
CHP	Community Health Partnership
CMHT	Community Mental Health Team
COPD	Chronic Obstructive Pulmonary Disease
CPN	Community Psychiatric Nurse
CRUSE	Bereavement Counselling Agency
CT	Computerised Tomography
CVA	Cerebrovascular Accident (stroke)
CXR	Chest Xray
DHSS	Department of Health and Social Security
DN	District Nurse
DNA	Did Not Attend
DNACPR	Do not attempt cardiopulmonary resuscitation
DS1500	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”.
DU	Duodenal Ulcer
DVLA	Driver and Vehicle Licensing Agency
DWP	Department of Work and Pensions
EDC	Emergency Detention Certificate
ENT	Ear, Nose and Throat
eKIS	Electronic Key Information Summary
ePCS	electronic Palliative Care Summary
ESA	Employment Support Allowance
GDP	General Dental Practitioner

GHC	Govan Health Centre
GPC	General Practice Committee
HV	Health Visitor
IHD	Ischaemic Heart Disease
IVDA	Intravenous Drug Abuser
MDT	Multidisciplinary Team
MH Act	Mental Health Act
MH DART	Mental Health Homeless Discharge and Resettlement Team
NH	Nursing Home
NOK	Next of Kin
OOHCPN	Out of Hours Community Psychiatric Nurse
PMHX	Previous Medical History
POA	Power of Attorney
POW	Power of Welfare
PTE	Pulmonary Thromo-Embolism
PTSD	Post Traumatic Stress Disorder
QOF	Quality and Outcome Framework
SEA	Significant Event Analysis
SIR	Significant Incident Review
SWD	Social Work Department
T1DM	Type 1 Diabetes Mellitus
UGD	Upper Gastro-Duodenostomy
WTE	Whole Time Equivalent