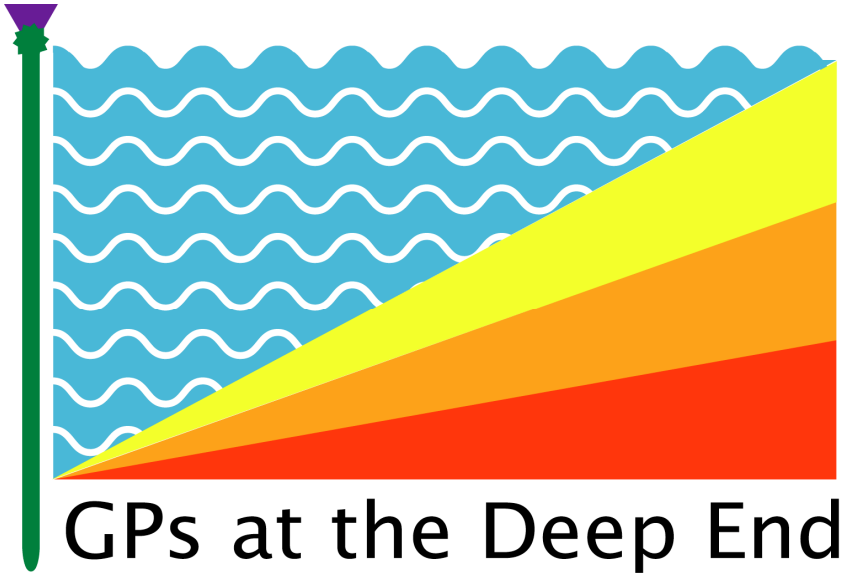


Deep End Report 2

Coping with needs, demands and resources

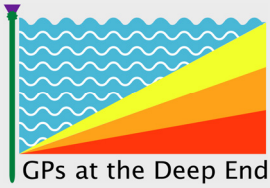
The second meeting of "General Practitioners at the Deep End"

22 January 2010

Nine GPs met on Friday 22 January 2010 at the University of Glasgow for a workshop on needs, demands and resources in general practice in very deprived areas.

SUMMARY

- Unmet need in deprived areas is huge and the demand on general practice seems unrelenting. Patients' medical needs are intimately inter-woven with emotional, psychological, financial and social problems. GPs strive to work holistically across the entire gamut of bio-psycho-social domains, often swimming against the tide and commonly feeling stressed, rushed, and exhausted.
- Complexity and multimorbidity are the norm rather than the exception in deprived areas and this occurs at a younger age than in the general population. The interface with secondary care is often problematic for a variety of reasons.
- GPs have an important advocacy role, as well as a generalist medical role, in helping their patients deal with their numerous and complex problems. This is possible because of the nature of general practice, and the values of the GPs who choose to work in deprived areas. Continuity of care provides 'constancy' to patients which is unique but requires active work and tenacity on the part of the GP.
- Potential ways forward include enhancing the primary care team based in the practice in order to address the mismatch of need and demand, and enhance efficiency of current services. For example having mental health staff, social workers, alcohol counsellors, financial advisors, etc based 'in-house' in the practice which would improve attendance rates of patients and inter-agency working.
- Ways of improving closer working with secondary care included joint GP/consultant clinics, consultant advice on difficult cases (to reduce referrals) and allocated times for telephone or email advice.
- Ways of enhancing the management of complex patients by the GP and primary care team include enhanced continuity and targeted longer consultations
- Professional support for GPs in deprived areas should include the establishment of a Deprivation Interest Group (DIG) across Scotland based on the Lothian model.
- Remuneration of GPs should include a deprivation weighting in the global sum, QOF and enhanced services that accurately reflects the context of working in a deprived area and the extra resources it takes to attain quality patient care.



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

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ATTENDING

Name	Location	Practice deprivation ranking
Margaret Craig	Allander Surgery, Glasgow	9
Geraldine Dunn	Bridgeton Health Centre, Glasgow	38
John Goldie	Easterhouse Health Centre, Glasgow	7
Zia Hussain	Port Glasgow Health Centre, Glasgow	85
Susan Langridge	Possilpark Health Centre, Glasgow	15
Stewart Mercer	University of Glasgow (Rapporteur)	n/a
Alan Millar	Arran Surgery, Glasgow	79
Catriona Morton	Craigmillar Practice, Edinburgh	29
Jim O'Neil	Lightburn practice, Glasgow	39
Petra Sambale	Keppoch Medical Practice, Glasgow	1

AIMS

This meeting aimed to:

- Discuss the ways in which the problems of patients living in very deprived areas are significantly different from those of the general population
- Examine the ways in which the delivery of care is more difficult in deprived areas
- Give examples of how practices can be more effective in coping with needs and demands of patients.
- Consider the types of external support which would be helpful
- Outline ways in which additional resource could best be provided and used.

REFLECTION

Problems in deprived areas and effects on delivery of care

The group discussed several ways in which they felt the problems of patients living in deprived areas were different from those of the general population, and how this made the delivery of care more difficult. The group reflected that 'need seems infinite' because patients in deprived areas have so many problems to cope with. Medical needs cannot be separated neatly from the context of peoples' lives, and thus GPs and primary care staff must deal with the whole gamut of problems across bio-psycho-social-spiritual domains.

The group discussed the major problems of multiple morbidity and complexity in their patients, which occur not just in the elderly but in those of working age. This was regarded now to be the norm rather than the exception in their daily work.

Specific issues were raised concerning the burden of alcohol and drug addiction, mental health, social problems, housing, polypharmacy, palliative care, and bereavement. With such high death rates in deprived areas, GPs are faced on a daily basis with bereaved families. These were some of the areas that the GPs felt were different – or at least vastly more intense - in deprived areas compared with the general population.

GP considered themselves as having a strong and important advocacy role in the lives of their patients, who were often marginalised due to their various problems. "Tenacity" was required of GPs and the primary care team to enable patients to engage in services. They saw their role as often providing 'constancy of care' in the patient's life; other relationships came and went, as did other services, but the GPs (and staff employed by the GP) remained relatively constant.

In terms of service delivery, the group described the intensity of need and demand as 'unrelenting' with more need and demand in every area of care, and in all modes of service delivery –face-to-face consultations, telephone encounters, and house calls. Everything takes longer, as patients have more problems, and often less ability to understand the issues, and self-care. The patient population has a high illiteracy rate, thus explanations take longer and need to be tailored to the individuals' level of understanding. Thus consultations are very different in deprived areas.

Because of multiple and complex problems, single-disease guidelines and payments (via the QOF for example) seemed often to be misplaced in these circumstances. Patient often miss their pre-booked routine chronic disease management appointments with the practice nurse and thus when they do attend the GP with an urgent problem, much of this 'anticipatory care' work needs to be fitted in to the consultation in addition to the reason for consulting. In addition, patients are often on multiple prescribed drugs, requiring increased vigilance (for example, by prescription reviews). The term "semi-housebound patient" was used to describe a patient group with mental health problems, high morbidity, and/or economical problems resulting in a non-attendance at the health centre. This group often requires more intensive engagement with general practice.

The inter-face with secondary care was considered to be often very problematic. The loss of the secondary care general physician means that GPs have problems knowing where to refer complex multi-morbid patients who are too young for Care of the Elderly specialists. Some hospital investigations are referred back to the GP for the results to be explained to the patient, which again has time implications. Patients who do not attend their first hospital appointment (DNA) are usually not given a second appointment. Patient care is delayed and suboptimal and GP workload increases with high re-referral workload.

IDEAS AND POTENTIAL SOLUTIONS

In terms of solutions, there were 4 key issues that emerged as overarching principles or themes:

- **Flexibility is the key to dealing with complexity**
  The group were clear that, in the context of general practice and primary care in deprived areas, there can be no 'one-size-fits-all' approach. Because of the complexity and multimorbidity of patients' lives and problems, there must be flexibility in how people are dealt with. This has implication for training, for anticipatory care, and for how the system is organised.
- **Solutions, once established, need to be 'systematised'**
  Numerous examples exist of 'good projects' that have been led by enthusiastic individuals only to die a death once the pilot funding dries up, often without rigorous evaluation of impact. The group felt that new projects should receive funding for research and evaluation in advance, and that an exit strategy should also be planned in advance. Ideas and innovations that are shown to work must then be incorporated into the system.
- **In terms of general practice and primary care, 'in-house' works best**
  This was a strong overall conclusion. The more that primary care and associated services can be delivered within general practice, and ideally under the direct financial and managerial control of the practice, the better the chances are of success
- **Continuity – or constancy – of care is essential**
  This was regarded as a vital ingredient of any potential solution.

EXAMPLE OF FUNDING REFLECTING GPS' WORKLOAD IN AREAS OF DEPRIVATION

Some funding streams were welcomed reflecting the workload in deprived areas with certain patient groups:

- National Enhanced Service for patients suffering from drug misuse
- Vulnerable families East Lothian Local Enhanced Service

- Section 17 c funding to one of the most deprived practices in Scotland enabling specific services tailored to the needs of the population like a vulnerable families project and a complex patient project with extended consultation times.
- Changes to the prevalence adjustments from 2009/10 that apply in the calculation of the Quality and Outcomes Framework with a reflection of the relative incidence of long term conditions in local communities. There was some fear that this effect will be lost due to the planned removal of the correction factor for practices.

In terms of specific ideas, examples were given of successful pilots that had been stopped, and ideas about how services could be developed or re-configured were raised. Some examples are shown below:

- In drug addiction (methadone maintenance), the shared-care schemes that operate in some areas of Glasgow were seen to be very effective. In these schemes, the social worker comes to the practice and sees the patient directly before or after the GP (and sometimes with) so that associated problems can be dealt with seamlessly. In Edinburgh, there is an enhanced service for methadone prescribing, so that GPs get extra payments to see patients twice every three months as a minimum, with a holistic assessment carried out once per year by a healthcare assistant within the practice.
- National Enhanced Services for patients suffering from drug misuse.
- In terms of addiction and mental health, there was a call to have 'in-house' mental health workers or CPNs attached to the practice. One participant recalled that such a pilot had been carried out in Edinburgh, and had worked well, but funding was stopped.
- The primary care-secondary care interface was also discussed and ideas proposed included having a specialist visit the practice regularly to review cases with the GPs and multidisciplinary team, rather than seeing the patient directly (based on the Cuban model). Another solution was to have specialists carrying out clinics in the practice and building in time to meet with and talk to the GPs as well as consulting patients. This happens is some areas but not others. A third idea was to have 'telephone time, when the GP knew they could phone and speak to the consultant or email advice. In terms of DNAs it was suggested that hospital clinics should adopt different rules for patients in deprived areas so that missing one appointment does not lead to a need to re-refer. Another suggestion was active engagement prior to the appointment e.g., "a friendly telephone voice reminding the patient a day prior to the appointment to attend."
- Longer consultations times for patients with complex problems. The example of the Keppoch practice, which was a PMS (section 17 c) practice, was given in which extra funding had been negotiated with the health board to employ a part-time salaried GP. This has freed up the time of the other partners so that now patients who require longer consultations on the day can be given an extra 10 minutes. This has been shown to improve consultation outcome with higher levels of patient enablement and lower GP Stress (see Mercer et al *BJGP* 2007, 57: 960-966)

In terms of practice level solutions, having protected time for inter-practice meetings of the top 100 practices was considered to be essential. This could mirror the arrangement that rural GPs already have. The example of the Lothian Deprivation Interest Group (DIG) was seen as something that could be usefully extended across Scotland. With the CPD needs of GPs on the horizon, this could be a timely development. It was also recognised that many of the top 100 are single-handed GPs, and special effort should be made to engage with these GPs.

The group recognised the need for joined –up services not only within healthcare but across all agencies. However CHPs and CHCPs were not considered to be an effective management structure, and the group felt the previous LHCCs worked better.

BACKGROUND

This section describes some aspects of workload, unmet needs and funding regulations for practices serving deprived populations.

50 to 55 percent of a practice's current fees and allowances are accounted for by the global sum. Other resources via the GMS contract are the Quality and Outcomes Framework, Enhanced Services, the Minimum Practice Income Guarantee and payments towards premises and IT. In addition there are seniority payments contributing to individual general practitioners' incomes.

Some of the additional workload for practices delivering services in areas of deprivation is acknowledged in the Scottish Allocation Formula, which determines how the global sum is distributed to practices in Scotland. There is also weighting towards new registrations on a UK level recognising additional workload for practices with a fluctuating population.

Since the introduction of nGMS, general practice has undergone a transformation resulting in new challenges to service delivery. Not all changes have been evaluated regarding their effects on deprived populations resulting in a lack of information concerning the true cost impact for general practice in these areas.

The following examples highlight the workload impact in deprived areas voiced by general practitioners.

THE CHANGING PRIMARY-SECONDARY CARE INTERFACE

- **Increasing specialisation**

  Patients from a deprived background frequently present with complex psychosocial problems and multi-morbid conditions. Increased specialisation of hospital services has led to the loss of General Physicians. GP's may receive complex and sometimes conflicting advice for treating individual patients. The work of making sense of this for patients is complicated by high illiteracy rates and lower levels of self-management skills and puts added pressure on the limited consultation time available.

- **Eighteen Week Referral To Treatment Pathway**

  With the introduction of the 18 week referral to treatment target in Scotland, secondary care policies have changed to discharging patients after their first missed appointment. Patients from the most deprived areas have the highest non attendance rates at hospitals (see web link). Treatment delays, loss of follow

up of patients and re-referral result in higher workload for GP's working in deprived areas and poorer patient outcomes.

http://www.drfosterhealth.co.uk/features/outpatient-appointment-no-shows.aspx

Health becomes a lower priority when basic needs are difficult to meet – particularly concerns regarding finances or problems with housing. If employed, our patients tend to be in lower paid positions where they may be less likely to be able to take time off to attend appointments. Our patients need a second chance.

A "DNA" should not be considered an acceptable conclusion to a referral. Need to use some other endpoint that demonstrates efforts made to enable access.

- **Example of good practice**

  The Colposcopy Service in Glasgow makes efforts to follow up DNAs. Contact is actively sought by the service. More relevant outcome measured (not often that that is possible).

RESTRUCTURING OF SERVICES

- **Centralisation**

  Lack of transport or finances, gang culture boundaries and a higher threshold to attend unknown areas result in low uptake of centralised services for deprived patients and higher demand for general practice in these areas.

- **Withdrawal of services**

  Restructuring of community services can create access barriers for deprived patients. Withdrawal of chronic disease blood sampling in treatment room settings removed a drop-in service that was tailored to the needs of the local population. Global Sum calculations based on historical practice workforce have not been adjusted to account for the transferred additional workload to practices.

- **Health visiting for the elderly**

  The withdrawal of a practice based health-visiting service for the elderly has a detrimental affect for a vulnerable deprived population. GPs report loss of continuity of care and preventative intervention, higher hospital admission rates and increased workload for GPs

- **Patient pathways**

  Restructuring of mental health and addiction services in some health board areas have led to a loss of clear patient pathways for mental health patients with addiction comorbidity with a high impact on workload for General Practice.

CHANGING DEMOGRAPHICS

A steep rise of a non-English speaking patient population has affected practices in some deprived areas in Scotland considerably. Longer consultation times with interpreters are currently not considered in the global sum allocation.

ECONOMY OF SCALE

High prevalence of conditions can be rewarding for practices if contacting patients and attendance rates are not problematic. High illiteracy rates, lack of telephone landlines, changing mobile phone numbers and non attendance rates at appointments are well known challenges for practices engaging with patients from a deprived background.

QUALITY AND OUTCOMES FRAMEWORK (QOF) AND ADDITIONAL SERVICES

Deprivation is not factored into remuneration for achievements under the quality and outcomes framework. Practices in Glasgow have received support by a heart failure pharmacy specialist to initiate beta blockers in patients thus working towards QOF achievement. Attendance rates in 3 practices with high deprivation were 63.64% (99 appointments), compared with 85.53% (83 appointments) in an area with up to 1% deprivation. Attendance rates are further reduced to 60 % if 2 practices with a percentage of more than 84% of deprived practice population are looked at (75 appointments). Administrative costs and GP workload in deprived areas need to be higher to achieve good patient care as incentivised via the quality and outcomes framework. In addition the QOF payment per point system varies when a practice is above or below the “contractor population index”, which is the average list size of a practice. The average list size in October 2007 was 5317 – 67 practices of the top 100 had a list size of less than 5000 in 2009.

ENHANCED SERVICES

Enhanced Services do not acknowledge additional workload in deprived areas, and some enhanced services do not consider disease prevalence in their specification. The recent H1N1 vaccination programme in Scotland is an example with the incentive towards lower threshold for QOF indicators PE7 and PE8 linked to a vaccination target percentage but no intelligence on prevalence or consideration of hard to reach patients.

KEEP WELL

Keep Well practices have many newly ascertained high risk patients for primary prevention but without adjustment of the global sum for extra long term costs (e.g. recall of hard to reach population, blood sampling, interpretation of results, admin costs, prescribing work, medication reviews etc)

RECRUITMENT AND RETENTION

Continuity of care and teamwork within the primary health care team are paramount for supporting vulnerable families. Attached staff turnover is high in deprived areas. There are no recruitment and retention initiatives for health visiting teams working in deprived areas. Thus supporting vulnerable families in a general practice environment becomes an insurmountable task.

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