The Future of GP Collaborative Working
There are opportunities and initiatives available throughout the UK to help GPs redesign services with this integration in mind. The governments of each of the four nations of the UK have introduced measures to encourage a more integrated health and social care system:

- In England, the Five Year Forward View sets out a number of proposed models of care that are intended to enable clinicians to take the lead in building new integrated care services, with various funding streams made available, either through the commissioning process, or through one off initiatives such as the Prime Minister’s Challenge Fund.
- In 2014, the Scottish government passed the Public Bodies (Joint Working) Act with the aim of integrating health and social care.
- In Northern Ireland the government is working to develop the Electronic Health Care Record – a single patient record which can be shared across the whole health economy, alongside the introduction of Integrated Care Partnerships (collaborative networks of care providers) covering the entire region.
- The Intermediate Care Fund was announced by the Welsh Government in December 2013 as a means to encourage integration between health, social care, housing and the voluntary sector.

This paper brings together case study examples of GPs taking the initiative and working in an integrated fashion, alongside secondary care physicians and the wider health and social care system, in order to redesign services to better meet the needs of their patients. The examples given show how it is possible to take advantage of the opportunities available and work within existing frameworks to create a service that responds flexibly to patients’ changing needs.

However, in order for clinicians to be incentivised to take these opportunities, consideration must be given to the challenges faced by GPs and other clinicians, both in changing their way of working, and everyday practice. The redesign of services is dependent on support or ‘buy in’ from local commissioners, providers and health authorities. In some cases this can be hard to achieve and maintain, leading to services being ‘let go’ over a period of time. In addition, many of the case studies cited the lack of available resources (both funding and staffing) as a significant barrier to the continuation of their service.

Despite the governments of the of the UK committing to build a more integrated health and social care system, there are serious concerns around the ability of legislation to deliver the change needed, with many government initiatives failing to take into account the central role of the GP in delivering patient care, and additional funding often falling far short of what is needed. These longstanding issues must be resolved, with legislation and funding levels built around the aspirations of GPs and the wider health service to provide the long term collaborative care that patients need.
One way to deliver integrated health care that works across traditional health and social care boundaries, is to create a new organisation with joint working at its core, that operates alongside traditionally provided services. This allows many of the barriers to integrated working to be 'designed out' of the provision of health care.

While creating a new service from scratch may seem like an impossible task for many, those providers that have achieved success did so in part by first building relationships with other health and social care professionals and patients, to ensure local support for and awareness of the service – in addition to building on, or taking inspiration from, existing services and initiatives.

Clinician leadership and willingness from local commissioners and health authorities to accept change are also a fundamental part of the creation of workable services of this type – as is the ability to recruit a workforce that is able to take on new roles and responsibilities, and to accept non traditional working patterns.

In addition, despite the fact that these initiatives are often designed to work alongside established services, integration with these pre-existing parts of the health service is often built into the design of the initiatives. For example underpinning the success many of these services, is their ability to share information about their patients care with GPs surgeries or secondary care, which allows these organisations to 'virtually' integrate with the wider health and social care system.

Overview

The @home service provides acute clinical care for patients within their home that would otherwise be carried out in hospital. Interventions are delivered in the usual place of residence via a multi-disciplinary team with GPs working collaboratively with hospital staff, nursing, pharmacy, and social care to deliver safe, quality healthcare within the patient’s own home.

The @home service also supports advanced discharge from hospital to help patients complete their treatment at home. The ethos of the service is that to deliver the best possible patient experience and outcomes, holistic integrated care should be delivered in an out of hospital setting.

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The service has two main aims:

- Allowing people to be given a high level of care in their own homes instead of being admitted unnecessarily to hospital.
- Allowing for advanced discharge out of hospital, so patients can recuperate in the comfort of their home while receiving high quality care.

The @home service is owned by Guy’s and St Thomas’ NHS Foundation Trust in London and has developed through close consultation with primary and secondary care doctors into a service that is designed to respond to the needs of both patients and an overstretched health service.

The @home service is currently operational within Lambeth and Southwark and works in collaboration with Guy’s and St Thomas’ NHS Foundation Trust and King’s College Hospital, as well as GP surgeries within the local area. The GPs who work for the @home service are full time.
Examples of integrated working

The ethos of the service is that to deliver the best possible patient experience and outcomes, holistic integrated care should be delivered in an out of hospital setting.

Key features

The @home service provides urgent and routine care to around 300 vulnerable patients a month, seven days a week from 7am to 11pm within their home, or in a few cases within the designated community ‘step down’ beds within hospitals in Southwark and Lambeth.

Patients are referred into the service by GPs, or as an early discharge from hospital as a means to avoid lengthy stays within hospital for conditions that could be managed within the community. In order for a correct referral to take place a medical summary must be emailed through to the service, and the person making the referral must have seen the patient within 24 hours.

The @home service also receives around 70 referrals a month from ambulance trusts. Once a referral has been made, a member of the @home team will visit the patient at home for an initial assessment and to explain the care that will be given. Patients will normally be seen within two hours of a referral from a GP.

An @home clinician will then be appointed who will be responsible for coordinating the patient’s care. Patients will be discharged from the hospital as a means to avoid lengthy stays within hospital for conditions that could be managed within the community. In order for a correct referral to take place a medical summary must be emailed through to the service, and the person making the referral must have seen the patient within 24 hours.

The @home service will take part in ‘post take rounds’ within A&E and medical admission wards in order to direct patients towards the service. This ‘in reach’ service is run 8am to 6pm five days a week in both Guy’s and St Thomas’ and King’s College Hospital.

The @home team is comprised of nurses, practice development nurses, therapists, pharmacists, social care workers, GPs, hospital consultants and physicians, who work together to provide holistic care for their patients.

Different disciplines will have different levels of input depending on the severity or type of condition. The team as a whole is coordinated by a matron who leads the team and the patient’s clinical care, and a GP provides clinical support and liaises with the patient’s own GP. In this way the service is able to ensure that the GP, as the expert medical generalist, remains at the centre of the care provided. The service as whole is supported by an administrative team.

The GPs who work for the service perform a very different role from many of their colleagues working within primary care, as the service in many ways operates as an emergency service, with a high turnover and greater level and severity of morbidity in the patients seen. This means that the GPs working for the service will make high level clinician decisions, where GPs working within a practice might normally refer to secondary care.

In addition, the service works proactively to treat and refer patients into their care. Nurses and GPs from the @home service do sessions within A&E in Guy’s and St Thomas’ and King’s College Hospital in order to try to direct patients towards the service, if it is judged that it would be better for the patient to be treated by @home. In addition, clinicians from the @home service will take part in ‘post take rounds’ within A&E and medical admission wards in order to direct patients towards the service. This ‘in reach’ service is run 8am to 6pm five days a week in both Guy’s and St Thomas’ and King’s College Hospital.

The @home team also undertakes a number of health promotion schemes and social care services as part of its care, including:

- Teaching self care techniques
- Medical reviews and support
- Mobility Support
- Activities of daily living support – for example providing help for patients with washing/dressing and meal preparation

The service is advertised through locality meetings and proactively by the @home team visiting local GP surgeries. All agencies who use the service are provided with guidance on when it is or is not appropriate to make a referral, and details of what conditions can be managed by the @home service.

Conditions and Interventions by the @home service include:

- Chronic obstructive pulmonary disease
- Heart failure
- IV antibiotics for wound infections, chest infections, cellulitis, UTIs
- Complex falls
- IV fluids for dehydration/Hyperemesis
- Hyper/hypotension, Hyper/hypoglycaemia
- Hyponatraemia
- Deteriorating renal function;
- Post operative
- Palliative care in partnership with other services

In addition, the service has developed a number of unique pathways based on common ailments and conditions.

Outcomes and results:

- High patient satisfaction. Patients who responded to a patient questionnaire sent out by @home praised the professionalism and standard of care they are received.
- Reduced burden on secondary and primary care. By actively directing people towards care that can be provided within their own home, the @home service not only frees up bed days from secondary care, but also reduces the need for repeat GP appointments by treating the patient in a proactive fashion.
- Better patient outcomes. Patients often respond better to treatments if they are treated within their own homes, or a setting they feel comfortable in. By ensuring that they do not enter hospital unnecessarily the @home service can capture this aspect of good care.
Connecting Care for Children

GPs working with: Paediatricians, Social Services, Mental Health, and Health Visitors

Connecting Care for Children is an integrated paediatrician and GP service, created as a means to move care out of hospital into the community in response to relatively high outpatients and A&E attendances for children within the inner London area.

Overview

The department of paediatrics at St Mary’s Hospital, within Imperial College Healthcare London has developed an innovative service where paediatricians employed within the hospital work proactively with local GPs to deliver paediatric care within a primary care setting.

Although originating in concept within the hospital, the service design was developed from close consultation with clinicians across the whole health economy, patients, parents, charities and other non-professional groups.

Two pilot hubs were created in early 2014, with two further hubs launched later that year. Although a relatively recent service, it brings together a number of pre-existing initiatives within the local area, including a ten year old outreach service, where a hospital paediatrician saw children in a local GP practice, who would otherwise have been referred to a hospital clinic.

The service now runs across three London CCGs; West London, Central London, and Hammersmith and Fulham.

Key features

The service is organised around ‘child health GP hubs’. There are currently seven active hubs, each one covering around three to four GPs surgeries with a total of around 20,000 patients (4000 children). Each hub has its own administrator.

A hub contains three major components:

- **Specialist Outreach**: Once a month a joint clinic will be held between a GP and a consultant paediatrician within one of the GP practices within a hub. This session will be used to treat patients who could not be treated via the ‘open access’ aspect of the service, but whose condition is too complex to be treated solely within primary care. In addition, directly following or proceeding this meeting a multidisciplinary team meeting will be held within the GP surgery bringing together clinicians across the whole health economy (including school nurses, social workers, mental health workers, dieticians, community nurses, doctors in training, health visitors, GPs and paediatricians). The purpose of this meeting is for health professionals to feed into the design of the service, in addition to providing clinical support for difficult cases in a multidisciplinary setting. For example A&E doctors may bring children who are consistently attending A&E to the attention of the service through this meeting, as a means to move them away from A&E. As part of this meeting a short educational session will be run by a visiting consultant.

- **Open Access**: GPs working within the hubs have daily access by phone and email to the consultant paediatrician who visits their practice. The advice obtained either enables GPs to manage their patients better within primary care, or ensures that referral is made to the correct service. In addition, in order to be part of the ‘hub’ each GP practice must agree to provide same day paediatrics services within the surgery, including appointments with GPs or nurses either over the phone or in person.

- **Public and patient engagement**: A wide variety of patient involvement systems are built into the design of each hub. Each practice within the hub will have a network of around 20 patient volunteers known as ‘practice champions’ who feed back their experience of using the service and possible ideas for improvement, as well as having a role in encouraging self-care and peer support for patients. In addition, the service produces and actively promotes literature informing patients on the correct use of A&E and what options there are for paediatric care within their area.
Outcomes and results:

- Analysis by Connecting Care for Children of the first three hubs over the first twelve months of activity showed a decrease in referrals to secondary care of 161 patients (69%).

- An evaluation from April 2014 to March 2015 found that in one hub, which was working at near full capacity, 39% of new patient appointments were avoided altogether through the discussion and improved care coordination. In addition, there was a 19% decrease in hospital sub-specialty new patient appointments, a 17% reduction in paediatric admissions and a 10% decrease in A&E attenders to St Mary’s Hospital.

- Patient Reported Experience Measures (PREMs) used by the service found that nearly 90% of patients and carers said that having been seen in the outreach clinic within their registered practice, they would now be more likely than before to see the GP for future medical issues, and 100% would recommend the service to family and friends.

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1 Imperial College Health Care, What do our Patients Think: http://www.crc.imperial.nhs.uk/what-do-pts-think/

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Brighton and Hove Memory Assessment Service

The Brighton and Hove Memory Assessment Service is a dedicated dementia service built around a multidisciplinary team, whose function is to diagnose and treat patients with dementia within a primary care and home setting.

Overview

The service is run by BICS (Brighton Integrated Care Service – a social enterprise owned by all the GPs in the area) in partnership with Sussex Partnership Foundation Trust (the local mental health provider), the Alzheimer’s Society and the Carers Centre.

It was commissioned in 2013 via the local CCG, as a means to move dementia diagnosis out of secondary care services and into the community. The service was given MSNAP² accreditation by the Royal College of Psychiatrists in April 2015.

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² Memory Services National Accreditation Programme
The team is comprised of two GPs, one psychiatrist, three experienced community physiatrist nurses (CPNs) who have an expertise in elderly mental health, a carers assessment worker and dementia advisors – all of whom work part within this service and within other mental health or primary care services.

Patients will be referred to the service by GPs within the local area. A CPN nurse will then do the original assessment based on the referral from the GP, to decide if the patient needs to be assessed further or should be referred to another service. The patient may be sent for testing (including an MRI or a CT if required) to determine if they are suffering from dementia.

If the decision is made to progress with the patient’s care then their case will be brought before a weekly multidisciplinary team meeting (MDT) held within a GP surgery, involving all members of the team, where the patient’s notes and condition will be discussed, and a final diagnosis will be made.

Clinics will be run from within the GP surgery on the same day as the MDT where the CPN will deliver the diagnosis to the patient, once the diagnosis has been made (this process can take up to 12 weeks). If a decision could not be reached within the MDT then the patient may see the psychiatrist afterwards within this clinic to help determine if the patient’s case should go further. The clinics are held in a different GP surgery every month, and therefore many patients accessing this service may be seen at a GP surgery which is not their own.

Patients will be assessed and managed by the service over the period of one year, through medication reviews undertaken by the nurses within a GP surgery or within the patient’s home, and visits by a dementia advisor to the patient within their home. Throughout this process the CPNs and dementia advisors will be in close contact with the GP and psychiatrist who work within the service, who can prescribe medication if appropriate.

At the end of the year any patient on medication will be handed over to the Specialist Older Persons Mental Health team – based within the local hospital. If the patient has deteriorated or is in need social care they will also be passed over to this team who can offer a more intensive service. If the patient is not on medication and their situation has remained stable they will be referred back to their GP.

The service operates nominally on a nine to five basis, but given the nature of the patients they are seeing the team has the flexibility to work out of hours if needed.

Outcomes and results:

- Service delivered 400 diagnoses of dementia over the period of one year. A relatively high number in comparison to similar secondary care services.

- Moving care out of hospital into the community. The service was created to change dementia diagnosis within Brighton and Hove from a hospital based, to a community based service. This enables elderly and unwell people to receive the care that they need within their own home and reduces unnecessary hospital stays for vulnerable patients.
One of the most common and comparatively uncomplicated ways to encourage a more integrated way of working within general practice is for GPs to employ a secondary care physician, primary care clinician, or social care worker within the GP surgery. Many GPs have taken the initiative and have broadened the skill mix of their practice team, in order to help their patients receive the care that they need closer to home.

While diversifying the practice team can be one of the intended outcomes of GPs working together in a federated manner, it is also something that can be done easily without changing the overall working of practice. Therefore, in comparison to other forms of integration this model has the advantage of providing a relatively simple way to make a difference to patients’ lives and the practice’s way of working.

However, any change in working patterns requires both leadership from within the practice, as well as good working relationships with other parts of the health service to aid with any recruitment required. In addition, support from local commissioners or health authorities is necessary if the service is to be commissioned externally. If the clinician is to be employed directly from within the GP practice’s budget, this can necessitate a wider rethinking of the practice team. For example, a secondary care or primary care clinician may become part of the practice team instead of, rather than as well as, expanding the number of GPs employed.

The Old School Surgery in Bristol has adopted an innovative approach to meeting the changing needs of their patients, by employing a prescribing pharmacist as a partner within the GP surgery. This arrangement allows for patients with multiple long term conditions to be given medicine advice tailored to their unique needs.

In addition, the practice has a co-located pharmacy on site, employing a prescribing pharmacist who works closely with the surgery to help patients receive the right care for their needs, in addition to undertaking proactive care for the surgery’s most vulnerable patients.

Overview

The service is the brainchild of Dr Carole Buckley, a senior partner within the practice. The Old School Surgery was the first practice in England to employ a full time clinical pharmacist.

Rachel Hall had been working part time as a pharmacist within the practice since 2002, when it was suggested that she would be supported to become prescribing pharmacist (that is a pharmacist who has the ability to write prescriptions). Rachel has been working at the practice full time as a prescribing pharmacist since 2006 and as a partner since 2013.

This arrangement means that not only can Rachel treat and manage patients’ care within the surgery, but she also has a large influence over the strategic direction of the practice.

In addition, the Old School Surgery has a co-located pharmacy on site that works closely with the GP surgery to treat patients in a proactive fashion.
Examples of integrated working

Key features

Rachel has worked as a full time prescribing pharmacist within the surgery for nine years, both as member of staff and as a partner in the practice. Patients can be referred to Rachel by the GPs, nurses, receptionists at the triage stage, and the co-located pharmacy. Patients who have previously had an appointment with Rachel are able to make direct bookings with her.

The most common services that Rachel provides are medication reviews for those who have long term conditions such as diabetes. In addition, her experience as a prescribing pharmacist means that she has the ability to diagnose many common conditions and ailments and will prescribe medications, order blood tests, or refer the patient directly into secondary care, in the way in which their GP normally would. Blood test results will also trigger a consultation with her if medication is required.

Due to the nature of the patients she will see (elderly, with long term conditions) Rachel holds 20 minute as opposed to 10 or 15 minute consultations.

One major advantage of having a prescribing pharmacist within the practice is that Rachel can undertake all the medication reviews for the surgery, including reviewing requests for repeat prescriptions and any medicines included on hospital discharge letters. In addition, Rachel acts as a medicines expert for GPs within the surgery and will advise on what to prescribe, and speak to patients if they have a direct query about their medication.

Another innovative feature of the Old School Surgery is that in addition to having a prescribing pharmacist as a partner, the surgery employs a non-prescribing pharmacist within a co-located pharmacy.

In addition to patients presenting at this pharmacy in the normal way for a high street pharmacy, the GP surgery will refer patients into the pharmacy if they are judged to have a condition which can be easily addressed by a non-prescribing pharmacist. The pharmacist, Jonathan, can provide expert advice for minor ailments and 12 different conditions, and will provide over the counter medication. Medication is provided free of charge for those who would not normally pay for prescriptions (paid for by the CCG through the Pharmacy Minor Ailment Scheme). If once a patient has been triaged by the pharmacist he judges that more specialised care is needed, he can book the patient directly into the GP surgery via a shared EMIS system. To aid diagnosis the pharmacist can also access the patient’s notes with the patient’s consent via this shared system.

The GP surgery will also refer people into the pharmacy if they present for routine services such as stop smoking or the ‘morning after pill’. To facilitate this the opening hours of the pharmacy are the same as the GP surgery.

In addition, the co-located pharmacy manages a list of around 400 vulnerable patients on the GP surgery’s patient list, who suffer from long term conditions. Patients who are existing users of the community pharmacy will be placed onto this list through referral from the GP practice, the patient’s social worker or carer, or the pharmacy practice staff themselves.

Under this scheme patients will be issued repeat dispensing prescriptions for 28 days rather than the usual 56. Once a month Jonathan will undertake a review of this medicine, where he rings each patient to check on their general health and if they taking their medication.

If medication concordance is poor, this enables Jonathan to readjust the patient’s medication if needed, and help the patient try and improve how they take their medicine. If a patient’s medication has to be reset on three consecutive occasions then the pharmacy team highlight their concerns to the surgery so that they can review the patient. In addition, the pharmacy team can refer any vulnerable patient back to the surgery for assessment, at anytime.

Jonathan will consult with Rachel throughout this process and she will make the final decision on whether to change or stop the medicine, or if the patient needs a further appointment with Rachel or a GP.

Through this initiative Jonathan is therefore able to ascertain if the patient is not taking their medicine, or if their condition has worsened, but they have not yet been to the doctor, thereby facilitating early interventions for the practice’s most vulnerable patients.

Outcomes and results:

- Better use of medication – having a prescribing pharmacist work full time within the practice has improved prescribing as a whole within the surgery. Both by designating the majority of the prescription work to Rachel, and through Rachel’s role as a ‘medicines expert’ within the team. In addition, the medicines review scheme run by the co-located pharmacy to identify how vulnerable patients are taking their medication has increased the proper use of medicines for this cohort.

- Increased whole person care – the medicines review scheme run by the co-located pharmacy has increased the number of early interventions undertaken by the surgery by identifying patients who are in crisis.

- Increased speed of access – diversifying the practice team has allowed for patients to be directed towards the correct discipline for their unique needs, leaving more time free for GPs to undertake proactive care, and decreasing duplication of services.
The psychotherapist will see a wide variety of people with depression or anxiety disorders, low level psychosis, anger management problems, substance dependence, eating disorders, and relationship problems, among other issues. For those who are feeling suicidal or suffering from a serious psychological conditions, he will discuss a referral with the crisis team or secondary mental health services within the local hospital. He cannot prescribe medication, and will refer patients back to the GP if medicine is needed.

The psychotherapist is trained in integrative psychotherapy—which gives him an awareness of a variety of different techniques—using CBT (Cognitive Behavioural Therapies), TA (Transactional Analysis) and person centred counselling—amongst others. Once the patient has had an initial appointment the psychotherapist will then, in consensus with the patient, decide on how to proceed with their treatment. The treatment which is applied depends on the patient, and the most effective treatment has its basis in a trusting relationship between the psychotherapist and the patient.

There is no standard number of consultations per patient, but it is unusual for a patient to be treated within one session, and further sessions can be booked directly by the patient with the psychotherapist once they have attended one session. The psychotherapist never truly discharges a patient in the way that a GP will never completely discharge theirs, and if a patient feels the need to see the psychotherapist they can readmit themselves directly back into the service.

In addition to face to face consultations the psychotherapist can give phone consultations in an ad hoc manner if needed.

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The Thornbrook surgery, in Derbyshire, has diversified its practice team by employing a mental health worker in order to give patients the opportunity to access mental health services in a timely and convenient manner.

**Overview**

The Thornbrook surgery has been employing a mental health practitioner within its surgery, one day a week for around ten years, as a means to provide care for patients with mental health conditions within a primary care setting. The intention of this appointment is to increase access to services and treatments which many patients may be uncomfortable accessing within a traditional secondary care setting.

The service was designed by GPs within the GP surgery and is commissioned via the CCG.

**Key features**

The Thornbrook surgery currently employs a psychotherapist to work one day a week within the GP surgery, providing a range of psychotherapy treatments for registered patients.

Patients can be referred into the service by GPs within the surgery, or the patient can request to be readmitted if they have seen the psychotherapist in the past. The psychotherapist is able to access the patient’s records while in the practice.

**Outcomes and results:**

- Greater patient satisfaction—the service as a whole has a very low number of ‘do not attends’, in comparison to similar secondary care services. In addition, responses to patient feedback surveys give nearly entirely positive ratings.
- Reduced ‘stigma’—ensuring that patients can be seen closer to home, within their GP surgery rather than a designated mental health clinic or hospital means that patients are less likely to refuse treatment if they are uncomfortable about undergoing counselling.
- Fewer referrals to mental health secondary care services than other GP surgeries within the local area.
In addition to secondary care physicians working within general practice, many GPs choose to work within secondary or social care, either as a GP in clinics within hospital or care homes, or by taking on a new ‘expanded’ role that allows them to work as secondary care physician on a part-time basis. This form of integration allows the skills of the general practitioner to be taken outside of the general practice surgery, whilst simultaneously bringing the expertise of a secondary care physician into the surgery.

While GPs are trained in detecting and treating a wide variety of illnesses and conditions, in order to provide more specialised so-called ‘secondary care’, it is often necessary for GPs to undertake extra training or education. Many GPs may choose to become a GP with a Special Interest (GPwSI) or take other qualifications which allow them to work within the secondary care discipline of their choosing.

Given the restricted ability of many GPs to take on additional responsibilities even if there is a desire to do so, many services such as these are dependant on ‘buy in’ and support from not only secondary and primary care, but also those who have responsibility for planning and designing the health economy – who can ensure that GPs are given the time and resources to change their knowledge and way of working.

The Livingston Experiment

The Livingston Experiment was the name given to the unique way of providing medical services which operated over the majority of the population of the new town of Livingston in West Lothian, Scotland, from the start of the new town in the 1960s until the early 2000s.

The service was set up on the principle that all GPs working within the area would be appointed to conjoined posts, working in both primary and secondary care, as a means to embed integration into the provision of all health services within the town.

Overview

When Livingston new town was founded in the 1960s the opportunity was taken to establish a new way of providing medical services, with the aim of improving services by bringing primary care, hospital, and local authority run parts of the health service closer together.

The object of this service was not just to bring the skills of secondary care into the GP surgery, enabling GPs to provide a more complex level of care to their patients, but also to bring the skills of the GP into the hospital, thereby encouraging a more holistic patient-centred culture within secondary care. The system worked in part due to the support from medical and local authorities, as evidenced by the fact that a medical director was appointed with the specific remit of promoting the service.

Some doctors used the experience gained in the Livingston scheme to move on to academic or other posts. Others continued useful and fulfilling careers in combined practice in Livingston. However, when these doctors moved on or retired, they more and more came to be replaced by GP’s appointed to work in traditional ways, as support for the service from the medical and local authorities decreased, and the new GPs were no longer required to take up a second discipline. Once the final GP appointed to a conjoined post retired, the service in effect stopped operating.
GPs who worked in a secondary care discipline were initially appointed to ‘Medical Assistant’ and later to ‘Hospital Practitioner’ grades, working within consultant led teams.

Outcomes and results:

- **Shared learning between primary and secondary care** – the service enabled the transfer of knowledge between primary and secondary care, both in terms of medical knowledge and ways of working.

- **High patient satisfaction** – the fact that patients could potentially be seen by the same doctor in a number of different settings increased the continuity of care that was available and consequently, patient trust in the service.

- **The Livingston Experiment inspired early data sharing and medical computer systems.** Several doctors and others who worked in the Livingston scheme went on to work on the design of these programmes.

**Key features**

All GPs employed within Livingston New Town (and therefore within the Livingston scheme) were required to be trained in both general practice and one other speciality, such as: paediatrics, psychiatry, general medicine, geriatrics, public health, anaesthetics, occupational health, or obstetrics and gynaecology. Around 20 GPs were involved in total, at various times throughout the life of the scheme.

There was a need to recruit doctors into the town but there were few recruits available in the 1960s and 1970s who already had sufficient training both in general practice and another specialty. Therefore, dedicated three year training programmes were developed incorporating different disciplines as required. In one case, a fully qualified and experienced anaesthetist undertook GP training in order to work within the scheme.

The initial concept was of a 50:50 time split between general practice and the additional specialty, but in the course of time this became more flexible, with GPs within this service designing their working hours and the manner of working in conjunction with input from secondary care services and the wider health economy. The hours worked could vary from a few sessions a month as required, to up to 50% of the GP’s working hours depending on need.
THE FUTURE OF GP COLLABORATIVE WORKING

Example of integrated working

GPwSI in Paediatrics in the Child Health Clinic in Lerwick, Shetland Islands

GPs working with: Paediatricians and Psychiatrists

In Lerwick, in the Shetland Islands, a local GP with a Special Interest (GPwSI) has designed a unique role for herself within the local hospital on the Island, as a response to the lack of available consultant paediatricians within the area.

Overview

In 2004 the local hospital in Lerwick, Shetland was having problems recruiting a full time consultant paediatrician. As a solution the Director of Public Health decided that the hospital would try and recruit a GPwSI to work in paediatrics. One of the GPs within the local area who had previous training and experience working within paediatrics was approached to fulfil this role.

Given the relative remoteness of the local hospital and the lack of consultant paediatric support within the local area, before taking on this role the GP approached the local paediatrics department in the (teaching) hospital in Aberdeen – in order to both undertake training to raise her up to the GPwSI level, and to gain input from the paediatric consultants into the design of a series of pathways and a system of governance, that would ensure that the GPwSI is supported to work in an integrated fashion within her role by specialist consultants on a day to day basis.

In addition, as the service had not had a permanent consultant paediatrician for some time, it suffered from poor administration and badly defined protocols. Therefore, when the GPwSI began work, she took steps to redesign the entire paediatrics team by introducing many of her GP practice protocols, specifically those that deal with the handling of results and correspondence, in addition to the unique protocols developed in conjunction with the paediatrics department in Aberdeen. The team also operates a number of patient feedback and audit mechanisms introduced by the GPwSI to make the department more efficient as a whole.

By both taking on the role and actively designing many of the aspects of the service, the GPwSI is able to both bring the skills of general practice into the hospital and the knowledge of a paediatrician into the general practice surgery.
The GPwSI is subcontracted to work within the multidisciplinary paediatrics team within the local hospital eight sessions (four days) a month. The GPwSI provides a unique GP focussed service, rather than a traditional consultant service.

The paediatrics team contains a number of different disciplines, such as nurses, visiting general paediatric consultants, specialist visiting consultants, speech and language therapists, and paediatric occupational therapists and physiotherapists, in addition to the CAMH team – which includes a visiting psychiatrist.

Different disciplines will work within different sub-teams on different days within the department. However, periodically everyone who works within the service will meet to discuss the strategic direction of the team and share knowledge and experience over the whole department. This allows the GPwSI the opportunity to play a role in the strategic direction of the service, and to represent the views and experience of general practice within secondary care.

Patients are referred into the service by local GPs, hospital medical consultants, health visitors, or social workers. Patients will mainly be seen within a designated clinic within the local hospital, however, occasionally the GPwSI is asked to see children in the medical ward if they have been admitted prior to being sent to the paediatric ward in Aberdeen.

Key features

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Outcomes and results:

- Improved integration and communication with external hospital services. The fact that GPwSI worked in conjunction with the paediatric consultants in Aberdeen to built a series of protocols that ensure that they are in close communication with each other, not only builds integration and continuity into the design of the service, but also ensures that the paediatric consultants are aware of and support its design.

- Improved auditing and patient feedback mechanisms. The GPwSI redesigned the service’s way of working, including instituting patient feedback mechanisms and auditing processes, that improve the efficiency and outputs of the service as a whole.

- Better integration between primary and secondary care. Having a single GP work both within secondary and primary care facilitates skill transfer, by bring the skills of the GP into secondary care, and the expertise of a paediatrician into the primary care setting. In this way the GPwSI is able to either give patients the care that they need within the GP surgery, or ensure that they access the correct secondary care service.