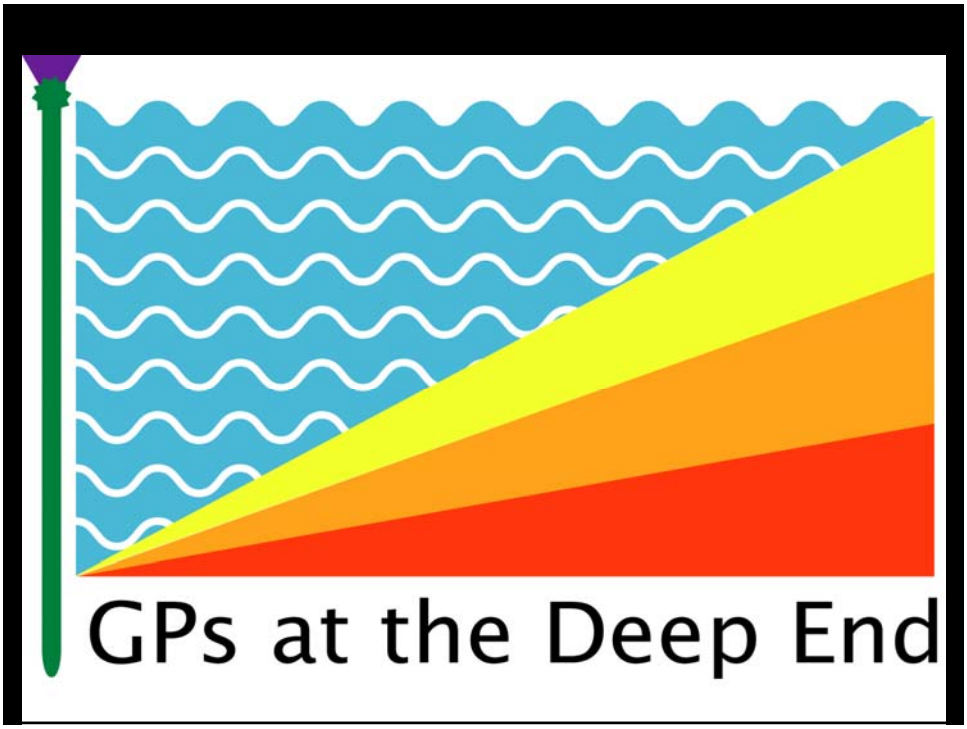



## PARTICIPATION IN DEEP END MEETINGS

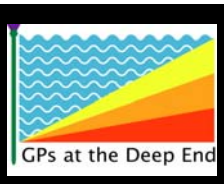
| | Always in the Deep End | Sometimes in the Deep End | Total | Participating (%) |
|---|---|---|---|---|
| Glasgow | 69 | 8 | 77 | 61 (79%) |
| Inverclyde | 5 | 5 | 10 | 1 (10%) |
| Rest of GG&C | 2 | 8 | 10 | 1 (10%) |
| Edinburgh | 3 | 3 | 6 | 5 (83%) |
| Dundee | 3 | 2 | 5 | 1 (20%) |
| Ayrshire | 3 | 4 | 7 | 1 (14%) |
| Lanarkshire | 0 | 3 | 3 | 0 (0%) |
| Aberdeen | 0 | 1 | 1 | 1 (100%) |
| Fife | 0 | 1 | 1 | 0 (0%) |
| TOTAL | 85 | 35 | 120 | 71 (59%) |

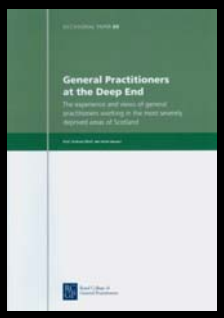
63 (74%) of the 85 consistent practices took part in at least one Deep End meeting
13 (37%) of the 35 occasional practices took part in at least one Deep End meeting

## WHERE ARE THE 100 PRACTICES?

| HSCP | No of top 100 practices IMD 2015 | | Attending today |
|---|---|---|---|
| Glasgow North East HSCP | 37 | ) | 15 |
| Glasgow North West HSCP | 21 | ) 75 | 15 |
| Glasgow South HSCP | 17 | ) | 13 |
| Inverclyde | 9 | | 3 |
| Edinburgh | 5 | | 6 |
| Dundee | 4 | | 2 |
| Ayrshire | 5 | | 1 |
| Renfrewshire | 2 | | 0 |
| TOTAL | 100 | | 55 |

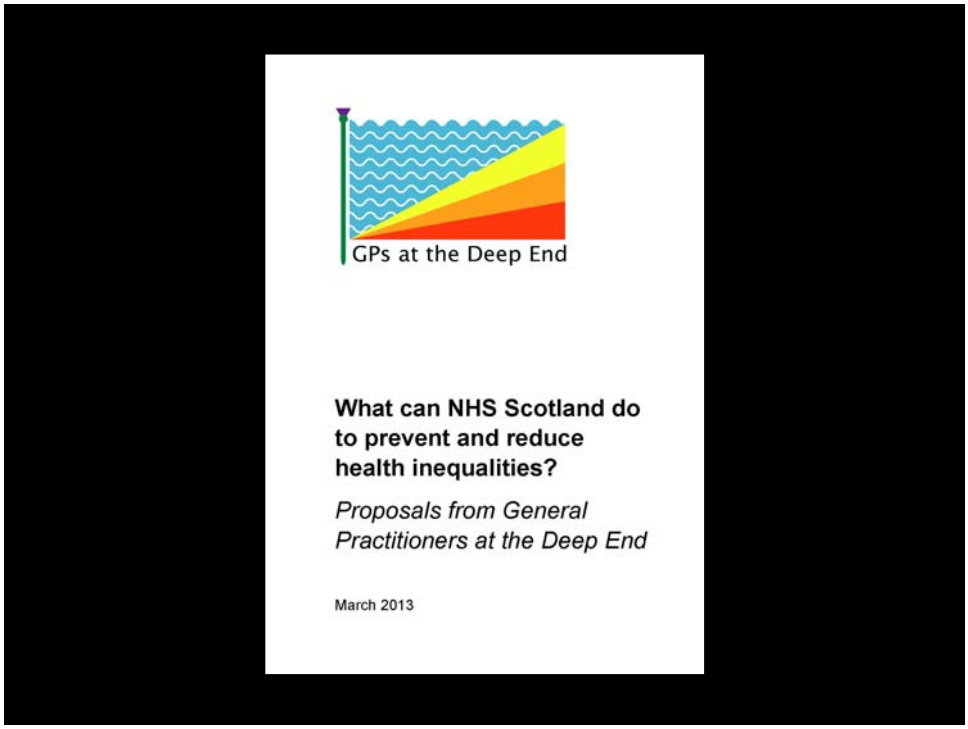
## DEEP END REPORTS




1. First meeting at Erskine
2. Needs, demands and resources
3. Vulnerable families
4. Keep Well and ASSIGN
5. Single-handed practice
6. Patient encounters
7. GP training
8. Social prescribing
9. Learning Journey
10. Care of the elderly
11. Alcohol problems in young adults
12. Caring for vulnerable children and families
13. The Access Toolkit : views of Deep End GPs
14. Reviewing progress in 2010 and plans for 2011
15. Palliative care in the Deep End
16. Austerity Report
17. Detecting cancer early
18. Integrated care
19. Access to specialists
20. What can NHS Scotland do to prevent and reduce heath inequalities
21. GP experience of welfare reform in very deprived areas
22. Mental health issues in the Deep End
23. The contribution of general practice to improving the health of vulnerable children and families
24. What are the CPD needs of GPs working in Deep End practices?
25. Strengthening primary care partnership responses to the welfare reforms
26. Generalist and specialist views of mental health issues

www.gla.ac.uk/deepend




## SIX ESSENTIAL COMPONENTS

GPs at the Deep End

1. Extra TIME for consultations (INVERSE CARE LAW)
2. Best use of serial ENCOUNTERS (PATIENT STORIES)
3. General practices as the NATURAL HUBS of local health systems (LINKING WITH OTHERS)
4. Better CONNECTIONS across the front line (SHARED LEARNING)
5. Better SUPPORT for the front line (INFRASTRUCTURE)
6. LEADERSHIP at different levels (AT EVERY LEVEL)

Links Worker Programme

ATTACHED ALCOHOL NURSES

Govan SHIP Project

SAMH

## ADVOCACY

THE HERALD TUESDAY 15.05.2012 PAGE 9 NEWS

**Doctors warn austerity is damaging patients' health**

GPs in deprived areas see sharp rise in social issues

Large city hospitals 'are hubs for MRSA'

E.ON to freeze its prices

Daily Record AND SUNDAY MAIL

HOME NEWS SPORT ENTERTAINMENT LIFESTYLE TV

**Welfare cuts could see further 60,000 Scots kids being dragged into poverty, warn doctors**

A SCATHING report from the Deep End Steering Group and authorised by 360 GPs in deprived areas says the bed tax and work capability assessments are damaging the health and lives of the country's most vulnerable people.

DEEP END REPORTS 16, 21 and 25

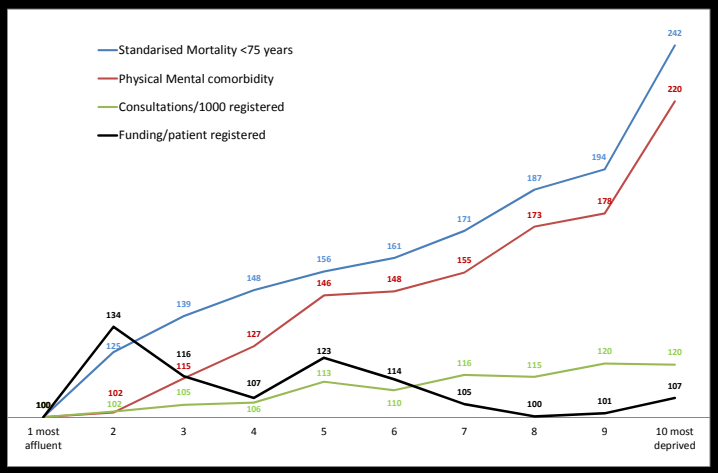
## LOBBYING

RCGP Scotland Time to Care
Audit Scotland
Public Audit Committee
Health and Sport Committee
Parliamentary Questions
Member's Debate
2016 Scottish election?

SGHD 20/20 Vision Statement
RCGP Compendium of Evidence
English Primary Care Workforce Review 2015

BMA input to the new 2017 Scottish GP contract
RCGP Scotland manifesto for the 2016 Scottish election

Figure 1 : % Differences from least deprived decile for mortality, comorbidity, consultations and funding

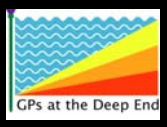


## GENERAL PRACTICE FUNDING PER PATIENT

| DECILE OF DEPRIVATION | TOTAL PRACTICE FUNDING PER PATIENT £ | | ESSENTIAL CONTRACT PAYMENTS £ | QOF PAYMENTS £ | ENHANCED CONTRACT PAYMENTS £ |
|---|---|---|---|---|---|
| 1 (most affluent) | 111.5 ) | | 84.8 | 22.3 | 4.3 |
| 2 | 142.3 ) | | 114.9 | 23.5 | 4.2 |
| 3 | 126.7 ) | | 98.3 | 24.0 | 4.3 |
| 4 | 120.4 ) | £126.9 | 91.2 | 25.0 | 4.2 |
| 5 | 133.7 ) | | 104.4 | 25.0 | 4.2 |
| 6 | 126.9 ) | | 97.5 | 25.3 | 4.1 |
| 7 | 117.4 ) | | 90.0 | 24.3 | 4.0 |
| 8 | 114.6 ) | | 85.3 | 25.3 | 4.0 |
| 9 | 116.2 ) | £117.2 | 86.7 | 25.7 | 3.9 |
| 10 (most deprived) | 120.4 ) | | 91.1 | 26.0 | 3.3 |
| Total | 123.3 | | 94.6 | 24.7 | 4.0 |

## ISSUES ESPECIALLY PREVALENT IN THE DEEP END

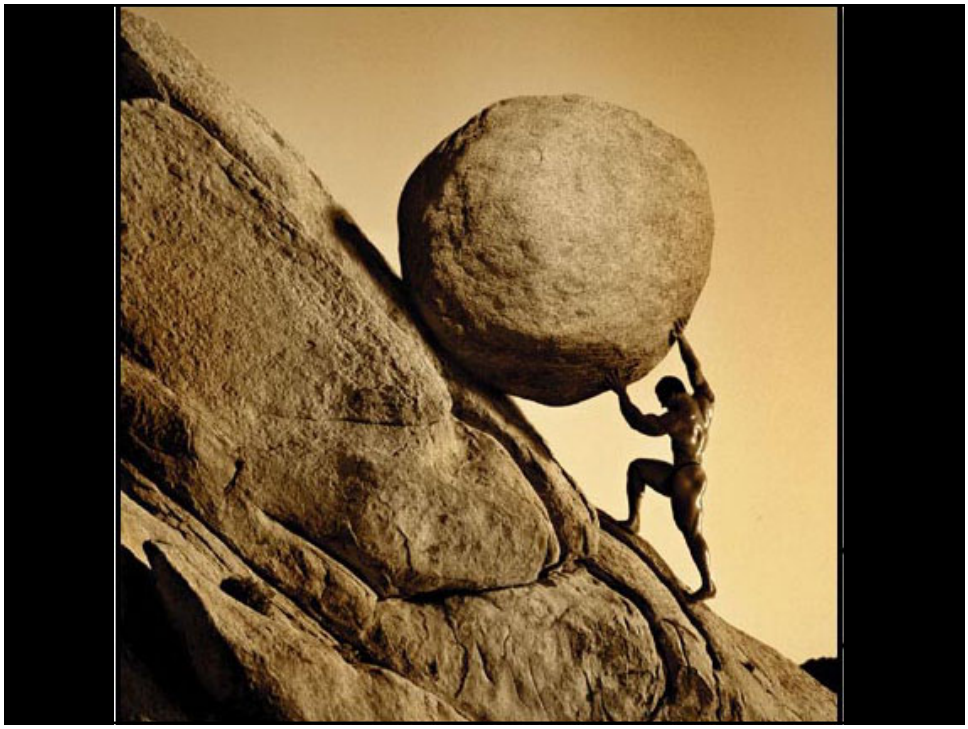
Mental health problems
Drugs and alcohol
Material poverty
Vulnerable children and adults
Migrants, refugees and asylum seekers
Fitness to work
Sexual abuse history
Homelessness




## GENERIC ISSUES

How to engage, with patients who are difficult to engage
How to deal with complexity in high volume
How to apply evidence

DEEP END REPORT 24





| | HEALTHY LIFE EXPECTANCY years | YEARS IN POOR HEALTH years | TOTAL LIFE EXPECTANCY years |
|---|---|---|---|
| MEN | | | |
| RICHEST 10% | 76 | 5 | 81 |
| POOREST 10% | 57 | 11 | 68 |
| DIFFERENCE | 19 | 6 | 13 |
| WOMEN | | | |
| RICHEST 10% | 78 | 6 | 84 |
| POOREST 10% | 61 | 15 | 76 |
| DIFFERENCE | 17 | 9 | 8 |

## INVERSE CARE LAW

"The availability of good medical care tends to vary inversely with the need for it in the population served".

Not the difference between good and bad care, but between what general practices can do and could do with resources based on need.

The Herald

FOUNDED ON MONDAY JANUARY 27, 1783

Give care services more resources

GPs at the Deep End

Our health service should be at its best where it is needed most

SCOTLAND has an admirable record of providing comprehensive health care which is free at the point of use, and has been steadfast in protecting its NHS from the ravages of market competition, which continue to threaten the NHS in England.

However, as the continuing statistics on health inequality show, NHS Scotland has still to address the inverse care law, whereby the availability of good medical care tends to vary inversely with the need for it in the population served.

While NHS resource distribution formulae and general practitioner contracts have recognised for a long time the increased health problems, multiple morbidity and needs for care of elderly populations, they have been much less effective in providing resources to meet the increased health problems, multiple morbidity and social complexity of younger patients living in very deprived areas.

As general practitioners working in the 100 most deprived general practices in Scotland, we are the front line of the NHS in Scotland as it battles with health inequality. We are in daily contact with large numbers of patients, with unrivalled levels of continuity and coverage, and have substantial experience and knowledge of the health problems of people living in Scotland's poorest communities, including vulnerable children, and those struggling with mental health and addiction problems, in addition to physical ailments.

The inverse care law in Scotland is not a matter of good medical care in affluent areas and bad medical care in deprived areas. It is the difference between what general practice and primary care can currently achieve, in meeting the needs of patients in very deprived areas, and what could be achieved if the service were better resourced to address levels of need.

The major issue which must be addressed, and whose solution requires political action, is the shortage of time within consultations to address a patient's needs in very deprived areas. Although other measures are needed, without this essential building block, the NHS will continue to fail in its attempts to narrow health inequalities.

Longer consultations are needed to work with patients on their problems, to take a preventive approach and to instigate links to other services.

The NHS has many challenges to face, but should be at its best where it is needed most. We call on political parties contesting the forthcoming election to commit themselves to eliminating the inverse care law in Scotland. Their first step should be to provide general practices in the front line with additional time for patient consultations.

**Members of the Deep End Steering Group: Georgina Brown, GP, Springburn Health Centre; John Budd, GP, Edinburgh Homeless Practice; Peter Cameron, GP, Drumchapel Health Centre; Margaret Craig, GP, Possil and Springburn; Susan Langridge, GP, Possilpark Health Centre; Stewart Mercer, Professor of Primary Care Research, University of Glasgow; Catriona Morton, GP, Craigmillar Health Centre; Anne Muffin, GP, Govan Health Centre; Jim O'Neill, GP, Lightburn Medical Centre; Euan Paterson, GP, Govan Health Centre; Petra Sambale, GP, Keppoch Medical Centre; Graham Watt, Professor of General Practice, University of Glasgow; Andrea Williamson, GP, Glasgow Homeless Health Services.**

*BRIEF ENCOUNTER*

*SERIAL ENCOUNTER*

## BARBARA STARFIELD ON PRIMARY CARE

1. Health services with strong primary care systems are more efficient
2. Social differences in health are greater for manifestations of illness severity (including mortality) than for occurrence of illness
3. The major impact of health services is on the severity and progression of ill health
4. Equity of access to health services, by itself, is not a useful strategy in industrialised countries. What matters is *use of appropriate* health services

## NOT ONLY

Evidence-based medicine (QOF, SIGN)

## BUT ALSO

Unconditional, personalised, continuity of care, provided for all patients, whatever problems they present.

## RELATIONSHIPS WITH PATIENTS

Initially face to face, eventually side by side

Julian Tudor Hart
A NEW KIND OF DOCTOR

*SCHEHEREZADE*

*TELLING 1001 TALES*

Balancing

the needs and demands of the worried well, with longevity

with

The needs of the unworried unwell, who lack longevity

## CONSULTATIONS IN DEPRIVED AREAS

Multiple morbidity and social complexity

Shortage of time

Reduced expectations

Lower enablement (especially for mental health problems)

Health literacy

Practitioner stress

Mercer SM, Watt GCM

Annals of Family Medicine 2007;5:503-510

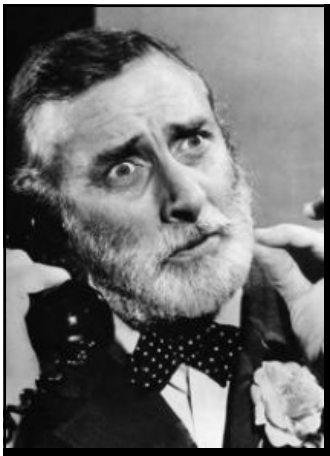
## IS THE NHS FAIR?

| | |
|---|---|
| In providing emergency care | YES |
| In providing non-emergency care | NO |
| In providing primary care | NO |

Patients and caregivers are often put under enormous demands by health care systems

Frances Mair, Carl May

BMJ 2014;349:g6680 doi: 10.1136/bmj.g6680 (10th November 2014)



I'VE JUST INVENTED A MACHINE THAT DOES THE WORK OF TWO MEN.

UNFORTUNATELY, IT TAKES THREE MEN TO WORK IT

SPIKE MILLIGAN

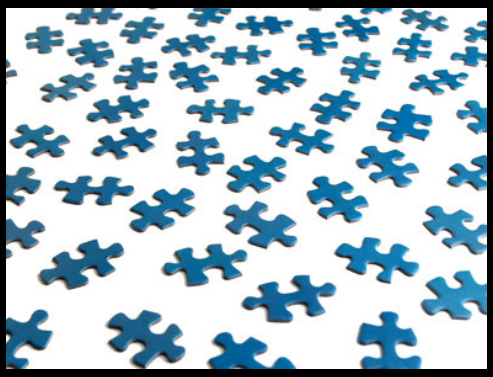
## FRAGMENTATION

Dysfunctional consultations

Discontinuity

Poor coordination

Gaps in coverage



## INTRINSIC FEATURES OF GENERAL PRACTICE

Contact

Coverage

Continuity

Coordination

Flexibility

Relationships

The essence of General Practice

An invitation to create the future

# INVENTING THE WHEEL

HUB

Contact
Coverage
Continuity
Comprehensive
Coordinated
Flexibility
Relationships
Trust
Leadership

SPOKES + RIMS

Keep Well
Child Health
Elderly
Mental Health
Addictions
Community Care
Secondary Care
Voluntary sector
Local Communities

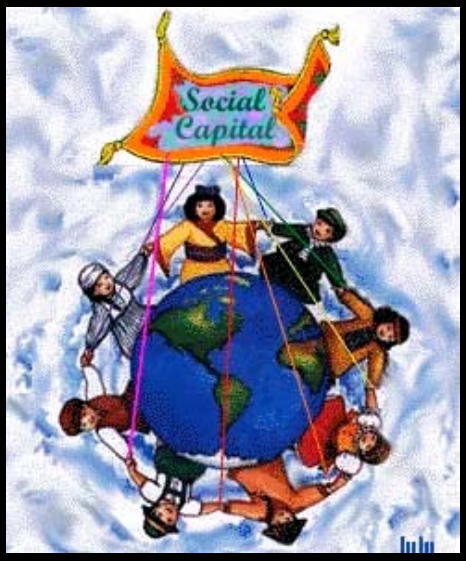
INTEGRATED CARE DEPENDS ON MULTIPLE RELATIONSHIPS

Health practitioners need to ask
not only "What do I do?"
but also "What am I part of?"

Don Berwick
Head of US Medicare and Medicaid

RESOURCE POOR

PEOPLE RICH




RESOURCE RICH

PEOPLE POOR

LEADERSHIP OF HUMAN RESOURCES

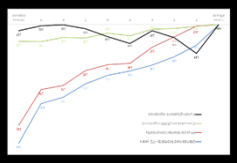
A NEW BUILDING PROGRAMME FOR INTEGRATED CARE

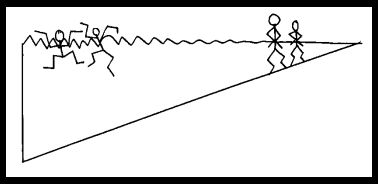
PATIENT STORIES

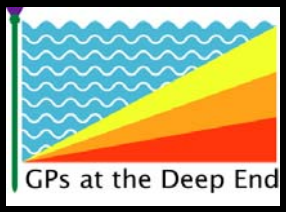
LOCAL HEALTH SYSTEMS

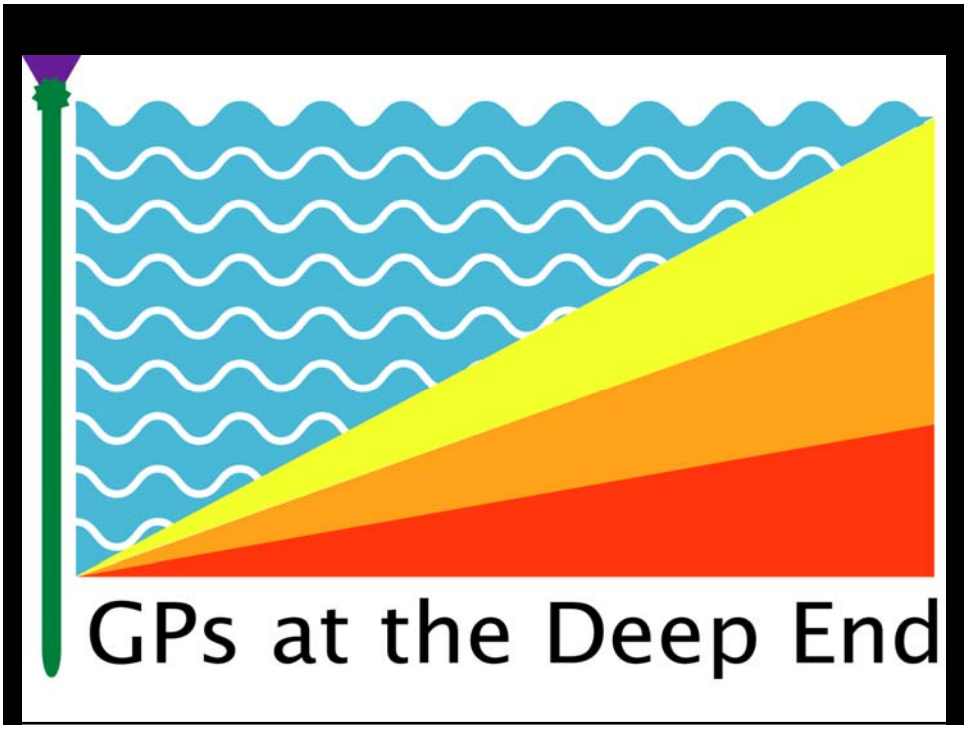
MACHINES THAT DO THE WORK OF TWO MEN

## GENERAL PRACTITIONERS AT THE DEEP END








LONDON 2012

PRODUCTIVE LOCAL SYSTEMS

A SOCIAL REVOLUTION IN HEALTH CARE

## A LEARNING ORGANISATION

Committed to the principle :

that “the best anywhere should become the “standard everywhere”

SHARING

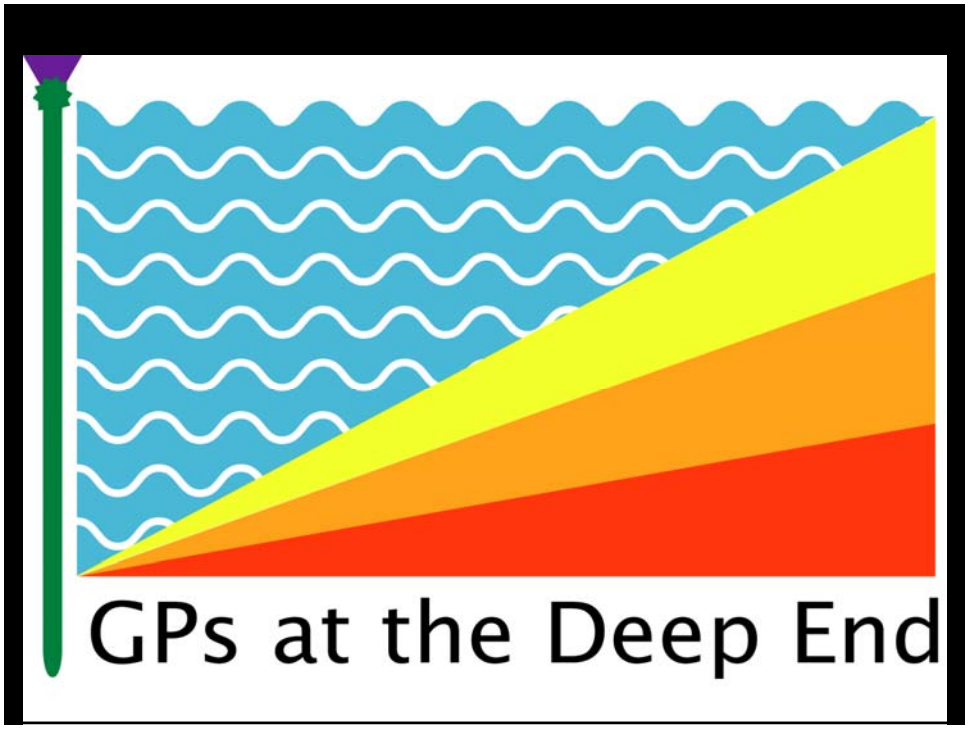
Knowledge

Information

Evidence

Experience

Values


GPs at the Deep End