GENERAL PRACTITIONERS AT THE DEEP END : LOOKING FORWARD

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ANNEXES

THE ROLE OF GENERAL PRACTICE IN ADDRESSING HEALTH INEQUALITIES

- The principal role of health care in deprived areas is to reduce the severity and slow the progression of established health problems.
- If this is done for all patients, based on their needs, health will improve and health inequalities will narrow.
- If resources and current ways of working are insufficient to deliver such care (e.g. as a consequence of the inverse care law), unmet needs accrue, problems progress more quickly, unscheduled services are accessed more often and inequalities in health widen.
- The inverse care law describes the tendency of the availability of good medical care to vary inversely with the need for it in the population served. The key difference is not between good and bad medical care, but between what practices can do and could do if appropriately resourced.
- The challenge for reducing health inequalities via general practice and primary care, therefore, is to increase the volume, quality and range of service provided for all patients, based on their needs (Annex A).

CURRENT SITUATION CONCERNING THE INVERSE CARE LAW

- There has been no real change since the first Deep End meeting.
- The nature of the inverse care law, as a cause of health inequalities in Scotland, is now well described in several official supports (See also Annex B)
- There has been no commitment by the Scottish Government to address the inverse care law as part of its policies to address inequalities in health
- An initial commitment to allocate part of "£40 million" to deprived areas disappeared by the time of the eventual funding announcement
- There has been no support from BMA Scotland in its input to GP contract discussions.
- There is no mention of the inverse care law in the RCGP manifesto for the 2016 Scottish general election
- A scientific paper entitles "General practice funding underpins the persistence of the inverse care law" is In Press with the BJGP and will appear in 2016.
- The Care Plus research findings, reporting the cost-effectiveness of extra time for consultations with complex patients, has been submitted to a journal
- Anne Mullin will represent the Deep End on the User Group established to comment on work to revise the Scottish Allocation Formula (SAF)
- Continued lobbying is required, directly to politicians, in the run up to the 2016 election

ADVOCACY

- Apart from continued advocacy concerning the inverse care law, the main area of advocacy by General Practitioners at the Deep End has concerned the UK Government's austerity and welfare reform programmes.
- Many patients need help in understanding and engaging with changes to the welfare benefits system, and how they operate.
- The work of helping such patients is concentrated in general practices serving very deprived areas, which are already hard pressed and which have no additional resource for this work.
- Closer links between general practices and financial advice services (for example, the embedded advisor schemes at Possil in Glasgow and, especially, Craigmillar in Edinburgh) offer a potential solution to this problem (see below, under ongoing projects).

CHALLENGES FACING GENERAL PRACTICE IN VERY DEPRIVED AREAS

General Practices in very deprived areas face many challenges, some of which are common to all general practices and some which are particular to very deprived areas.

All challenges have been exacerbated in recent years by relative disinvestment in general practice, whose share of NHS expenditure fell from 10 in 2005/06 to 8% in 2012/13.

The two common challenges are :-

- Redeployment of the work of general practitioners, so that best use is made of the likely reduced number of GPs, by developing new models of administrative, nursing, pharmacy and link worker support

- Improved joint working within local health systems, providing integrated care for people with multiple problems and shifting the balance between centralised, specialised and local, generalist services.

Both of these challenges must be met at least as well in the Deep End as elsewhere, or inequalities will widen.

Some challenges are particular to the Deep End, because of the nature or volume of problems being addressed.

- The high prevalence of patients with complex multimorbidity (defined not simply as "two or more diagnoses", but more broadly as the number, severity and complexity of health and social problems within families and households),

which typically occurs 10-15 years earlier in very deprived areas than in very affluent areas.

- The high prevalence of mental health problems (the commonest co-morbidity in deprived areas), problems of addiction (alcohol, tobacco, drug misuse) and their associated medical complications.
- The lack of consultation time with which to address fully the problems presented by patients.
- The need to work through problems slowly and steadily, developing long term relationships based on mutual knowledge, experience and trust.
- The need to engage with patients who may lack knowledge, motivation, aspiration, and agency (the "unworried unwell")
- The large scale transfer of clinical and paper work from secondary care, without commensurate resources.
- The concentration of problems related to welfare benefits, including applications, appeals, sanctions, and their effects, including poverty, distress and mental health problems.
- The concentration of migrants and asylum seekers, with undiagnosed conditions and language difficulties, requiring translators and additional consultation time
- The help that some patients need in engaging with a fragmented and often dysfunctional health and social care system.
- The need to establish and maintain links with community resources for health.
- Recruiting and retaining, for the long term, staff who are committed to working in a very deprived area

ONGOING AND PENDING DEEP END PROJECTS

The following ongoing and pending Deep End projects involve different combinations of the key elements of the Deep End Manifesto (Annex D)

- Additional clinical capacity
- Attached and/or embedded workers
- Links to community resources
- GP leadership
- Protected time and funding for service development
- Practices working in clusters
- External support

The **Link Worker Programme** involves :-

- SGHD funding for 5 years via the Health and Social Care ALLIANCE and General Practitioners at the Deep End
- Full-time community links practitioners embedded in 7 Deep End general practices
- A Deep End clinical lead
- Improved links to community resources for health
- Support for patients in accessing services
- Improved team working within practices
- External evaluation by Profs Stewart Mercer and Sally Wyke at Glasgow University

The **Govan Integrated Care Project** (SHIP) involves :-

- SGHD funding
- 4 Deep End general practices
- Additional clinical time, with two salaried GPs shared between 4 practices
- Two attached social workers
- Community links practitioners embedded in 2 practices
- Support for monthly practice multidisciplinary team meetings to review vulnerable families and frail elderly patients
- Protected time for GP leadership

Attached Alcohol Nurses

- Funded by the Glasgow Alcohol and Drugs Programme
- Alcohol nurses attached to 6 general practices

Pending projects

- Discussions are underway with the Scottish Association for Mental Health (SAMH) concerning a programme to link Deep End practices with local SAMH resources.
- Following three Deep End reports (16, 22 and 25) concerning the effects of austerity and welfare benefit reform on patients and practices, and two multidisciplinary meetings with members of the Glasgow Financial Inclusion Network, a programme of activities is being coordinated via the Glasgow Centre for Population Health to improve joint working to support people having problems with welfare benefits.

ESSENTIAL ELEMENTS OF GENERAL PRACTICE

Key determinants of professional satisfaction and output are autonomy, mastery and purpose, but these are only maximally effective when the essential elements of general practice are in place, including :-

- Adequate consultation time
- Efficient team working

- High quality record and communication systems
- Efficient interface with patients (reception, telephone, appointment system etc)
- Efficient referral systems to primary, secondary and community care, and community resources
- Adequate administrative, nursing and pharmacy support
- Professional, collegiate support
- Protected time for review and learning

Some of these aspects of practice depend on decisions made within general practices, while others require centrally coordinated support services. In general, the actions which can be taken forwards by general practitioners can be considered at several levels

A. By practitioners when they meet with patients
B. By practices working as multi-professional teams
C. By practices organising their resources (i.e. time, space, staff) to best effect
D. By practices working with similar practices within networks or federations
E. By practices working with attached staff from other services (e.g. health visitors, community nurses, mental health workers etc)
F. By practices working with other local services (e.g. health improvement, community care, social work, child health, voluntary sector)
G. By practices working collectively within a geographical area
H. By practices working as part of integrated local and national systems

RECRUITMENT ISSUES

- The Deep End has not had high profile GP vacancies, but this has changed with the publicity associated with the Balmore practice at Possilpark Health Centre
- David Blane's paper in the Scottish Medical Journal anticipates a problem in the Deep End, as a result of there being a higher proportion of GPs over 50.
- Three focus groups are being held with younger GPs, with the results to be presented at the National Deep End conference on November 24th
- The GP Fellowship proposal (Annex C) remains on the table.
- David Thomson has indicated that there may be an opportunity to pursue this as part of new primary care development funding

ATTRIBUTES REQUIRED BY GENERAL PRACTITIONERS WORKING IN VERY DEPRIVED AREAS

In addition to recruiting adequate numbers of general practitioners for work in the Deep End, it is important to prepare the future general practice workforce with the following attributes and skills :-

- Ability to engage productively, initially and over the long term, with patients lacking health literacy and skills for self help and self management
- Competence and experience in dealing with prevalent problems, including drug and alcohol misuse, vulnerable families, asylum seekers and migrants, poverty and welfare benefits, previous sexual abuse, homelessness and complex multimorbidity
- Competence and pragmatism in the application of evidence-based medicine, little of which is based on studies of patients in deprived areas.
- Ability to remain optimistic, enthusiastic and engaged, in the face of multiple health and other problems presented in high volume.
- Ability to work productively with colleagues, within the primary care team, with other services in primary and secondary care and with community resources for health
- Commitment to the development of general practice as the hub of local health systems
- Collegiate working within local clusters of general practices
- Commitment to the principle that "the best anywhere" should become the "standard everywhere"

General practitioners also vary many discretionary aspects of general practice

- How broadly they identify the problems that general practice can help (e.g. the medical model or more widely).
- How high they "set the bar" in terms of the short, medium and long term objectives of patient care
- The length of a normal working day (with no more than average resources, practices can only increase the numbers of patients seen by shortening consultations or lengthening the working day)
- The number and type of practice staff to employ
- Whether to provide extra-contractual letters for patients seeking support for benefit applications and appeals.
- Whether to invest time in developing links with local community resources for health.
- Whether to take part in optional activities, including teaching, training, research or development projects
- Whether to pursue a leadership role in representing general practitioners
- Whether to adopt a leadership role in developing the local health system
- Whether to take part in advocacy, fighting against the conditions and policies which cause poor health in patients

FOR DISCUSSION

1. Can better use be made of GP time?
2. How can GP time be released for new tasks and roles?
3. What opportunities are there for new embedded or attached workers?
4. How can the link worker experience be rolled out to all practices?
5. How can general practices work better with secondary care?
6. How can experience and learning be shared more effectively between practices?
7. How can practices work better together in clusters?
8. What new infrastructure arrangements are needed to support general practice and primary care development?
9. What do GP leadership roles look like?
10. What would attract younger GPs to work in Deep End practices?

FOR ADVOCACY

1. Advocacy concerning the Inverse Care Law
2. Advocacy for the principle of embedding attached workers
3. Advocacy concerning austerity and welfare benefit reform
4. Advocacy concerning the results of the Care Plus Study
5. Maximising the opportunities provided by the Link Worker Programme
6. Maximising the opportunities provided by the Govan SHIP Project
7. Development of GP leadership roles which are appropriate for the Deep End
8. Recruitment and Development based on a new GP fellowship scheme

DEVELOPING RELATIONSHIPS (WITH WHOM AND HOW?)

1. Renewed contact with selected patients via longer consultations
2. Spreading GP workload via more administrative, nursing and pharmacy support
3. Enhanced use of community resources for health
4. Closer working with other primary and community care services, embedding their staff in practices or clusters of practices
5. Closer working with specialist colleagues
6. Closer working with unscheduled care services (OOH, A&E, discharge from emergency beds)
7. Collegiate working within groups of practices
8. Developing the capacity and relationships needed to transfer and share power, resource and responsibility

ANNEX A

THE ROLE OF GENERAL PRACTICE IN ADDRESSING HEALTH INEQUALITIES

By increasing the volume, quality and range of care provided for all patients, based on need, health care can improve population health and help narrow health inequalities.

The origins of health inequalities lie outside the health service, and are for politicians to address. General practitioners can inform and encourage politicians with advocacy based on first hand accounts of what is happening within communities on the front line of the NHS. Examples from General Practitioners at the Deep End include a joint letter to *The Herald* newspaper on minimal alcohol pricing, and three reports on the effects of austerity and welfare benefit reform on patients and practices.

General practice teams have continuing knowledge and contact with families, especially the wider family context in which children are born and brought up, including knowledge and contact with potentially "vulnerable families" before major problems arise. The virtual exclusion of general practice from national policies concerning young families (e.g. Getting It Right For Every Child – GRIFEC) means that this role is not recognised and is poorly supported

General practice deals mainly with the consequences of poor health (i.e. the health problems that patients have). General practice cannot turn back the clock, but it can slow the clock down, reducing the severity and slowing the progression of health problems. If such work is under-resourced where patient needs are greatest, the NHS becomes a cause of widening health inequality.

General practice makes a difference in two ways partly by delivering evidence-based medicine, as incentivised by the QOF, but also and more generally by what it does for all patients, delivering unconditional, personalised continuity of care, whatever problem or combination of problems they have.

General practice does not have a monopoly of contact, coverage, continuity, flexibility, long term relationships and trust, nor are these features consistent within general practice, but no other part of public or private service has then in such degree, which makes general practice the natural hub of local health systems.

Hubs on their own are insufficient. With links to other services, not only with secondary care, but also elsewhere in primary care, community care services and other community resources for health, hubs must be the centre of local health systems. By making better use of local resources, patients can be supported longer in the community, avoiding the fast track to out of hours, A&E and emergency beds.

These links are often dysfunctional and some do not yet exist. Local leadership is needed, from the bottom up, to improve joint working within local health systems

ANNEX B

THE CURRENT POSITION CONCERNING THE INVERSE CARE LAW

General Practitioners at the Deep End work in the 100 most deprived general practices in Scotland based on the proportion of patients living in the 15% most deprived Scottish data zones. Such patients comprise from 88-44% of Deep End practice list populations. Whereas most Scottish practices have some patients living in areas of socio-economic deprivation, Deep End practices see such patients in high volume.

Although the principal social determinants of health operate outside health care, health care mitigates the effects of poor health by reducing the severity and delaying the progression of conditions. Whether such care reduces or increases heath inequalities depends on the extent to which it is delivered in proportion to need across the socio-economic spectrum.

Most people need high quality care towards the end of their life, but in deprived areas where lives are shorter and harder, the NHS, and especially primary care, has an important but under-resourced role in improving health, increasing longevity and narrowing health inequalities.

When general practice is under-resourced relative to need, and unable to contain problems in the community, patients will make greater use of other front line services, including out of hours, A&E and acute hospital beds.

Men and women in the most deprived fifth of the Scottish population die 10.4 and 6.9 years earlier, respectively, than men and women in the least deprived fifth (See ISD data in table overleaf). The differences in health life expectancy (the estimate of how many years people are expected to live in a 'healthy state') are larger. HLE in men and women in the most deprived fifth of the population ends 20.8 and 20.4 years earlier than in the least deprived fifth. When HLE ends, men and women in the most deprived fifth of the Scottish population spend twice as long in poor health before they die than men and women in the least deprived fifth of the population (23.0 v 12.6 years in men; 25.7 v 12.1 years in women).

The Deep End comprises the more deprived half of the most deprived quintile. The point is that these issues are not confined to the Deep End, and need to be addressed pro rata across the social spectrum

A recent study found that levels of multimorbidity rose with practice deprivation (1). Practices in the most deprived decile had 38% more patients with multimorbidity

compared to the least deprived and over 120% more patients with combined mental-physical multimorbidity.

Practices in the most deprived decile had 20% more consultations per annum compared with the least deprived. There was no association between total practice funding and deprivation. Although consultation rates increased with deprivation, the social gradients in multimorbidity were much steeper. There was no association between consultation rates and levels of funding.

The study found no evidence that general practice funding matches clinical need, as estimated by different definitions of multimorbidity. Consultation rates provide only a partial estimate of the work involved in addressing clinical needs, however, and are poorly related to the prevalence of multimorbidity. In these circumstances, general practice in deprived areas is unlikely to mitigate health inequalities, while the general practice system as a whole may may increase them.

It is unlikely that consultation rates provide an adequate measure of the need for health care in very deprived areas. They provide no information on the content, duration, quality or consequences of consultations, nor do they account for the increasing amount of electronic and paperwork transferred to general practices from secondary care.

With a flat distribution of funding, deprived practices can only generate increased consultation rates by having shorter consultation times, or working longer hours. A study of 3000 consultations in general practice in the West of Scotland described the practical consequences for patients and practitioners (2). Consultations in deprived areas involve higher levels of multimorbidity and social complexity, shorter duration, lower expectations, less patient enablement, especially for patients with mental health problems, and higher practitioner stress. Basing funding on consultation rates simply institutionalises the inverse care law, to the detriment of the most vulnerable patients with complex problems.

Another recent study found that 54% of Scotland's GPs work in the most affluent 50% of practices, compared with 46% who work in the most deprived 50% of practices (3). The most deprived decile had the oldest GPs, with 37% aged 50 and over, and 6% aged 60 and over. Although there is not currently a problem in filling GP vacancies in the Deep End, it is only a matter of time before the retirement of older GPs causes a recruitment challenge.

1. McLean G, Guthrie B, Mercer SW, Watt GCM. General practice funding underpins the persistence of the inverse care law. BJGP. In press
2. Mercer S, Watt G. The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland. Ann Fam Med 2007; 5:503-10.
3. Blane D, McLean G Watt G. Distribution of GPs in Scotland by age, gender and deprivation. Scottish Medical Journal. http://scm.sagepub.com/cgi/reprint/0036933015606592v1.pdf?ijkey=w7P44N27unlMwx0&keytype=finite

ANNEX C

A FELLOWSHIP SCHEME FOR GENERAL PRACTITIONERS AND OTHER HEALTH PROFESSIONALS WORKING IN VERY DEPRIVED AREAS (THE DEEP END)

Although most general practices in Scotland include some patients living in very deprived circumstances, the greatest concentrations of such patients are found in Deep End practices, with substantial implications for patients, practices, the NHS, public health and health inequalities.

This proposal, based on Deep End Report 20 *What can NHS Scotland do to prevent and reduce health inequalities?* envisages a partnership between Deep End practices, NHS Education in Scotland (NES), NHS management and the University of Glasgow to address the following issues in very deprived areas :-

- Adding clinical capacity (addressing the inverse care law)
- Recruiting the next generation of general practitioners
- Releasing experienced practitioners for leadership roles in primary care development
- Addressing the education and training needs of "Deep End practice"
- Strengthening local health care around general practice hubs
- Development of collective working by general practices
- Development of evidence-based practice

The proposal, which is illustrative rather than prescriptive, needs to be discussed with all parties, but could include :-

- 12 three year fellowships, split 60:40 between clinical work and professional development
- Part-time university study (Master of Primary Care degree at the University of Glasgow, or similar, including work-based evaluation projects)
- Release of experienced GPs for collective work on service development
- Coordinator roles for clinical, service and academic development
- Alignment with NHS needs, i.e. addressing health inequalities, supporting the integration of health and social care, caring for an increasingly multi-morbid population, and encouraging recruitment and retention of GPs in deprived areas.

The Deep End Fellowship Scheme: a solution to many problems?

This is a proposal to expand the current NES Health Inequality Fellowship Scheme (three posts, total of 2.0 WTE) to 12 WTE posts, to address several problems facing

primary care in the most deprived areas of Scotland in an integrated cost-effective way.

Background

The NHS in Scotland should be at its best where it is needed most. For GPs at the Deep End, serving the 100 most severely socio-economically deprived populations in Scotland, there are many challenges to overcome.

1) ***The inverse care law***, which states that "the availability of good medical care tends to vary inversely with the need for it in the population". Put simply, there is a lack of clinical capacity in general practice in deprived areas. Deep End GPs can only scratch the surface of healthcare needs in the populations they serve.

2) ***The challenge of integrated care***. General practices are the natural hubs of local health systems, based on their intrinsic strengths of contact, coverage, continuity, flexibility, long-term relationships and trust. Their potential has yet to be fully realised, however, and more can be done to improve links, both *within* primary care and *between* primary care and other services, including community resources. This will result in reducing use of unscheduled (and expensive) care – OOH, A&E, and emergency hospital admissions.

3) ***The need to develop the leadership role of general practitioners***. It is recognised that many GPs already carry out leadership roles within practices, leading on different areas of quality improvement and service development. At present, however, this evolves in a haphazard, ad hoc process, with little peer or institutional support or coordination. Furthermore, there is a lack of time and funding for GPs to engage with expert groups (e.g. SIGN) or Health Board initiatives.

4) ***The disaggregated nature of general practice***. Most GPs work in small to medium sized practices, and there are still many singlehanded GPs. There is considerable potential to share learning and resources more effectively between practices.

5) ***The need to recruit and retain the next generation of general practitioners working in very deprived areas***. This has not been as big an issue in Scotland as it has been in many inner city practices in England, but there is evidence that this is changing. There has been a recent shortage of locums to cover shifts in many practices, but those in very deprived areas have struggled most.

The components of the proposal

We envisage the new Deep End Fellowship scheme to include the following components, providing opportunities for leadership across practice clusters at two levels: the new cadre of Fellows; and the more experienced GPs who will have protected time released by the clinical commitment of the Fellows.

a) Funding for 12 whole time GP fellows, appointed for three years, spending 6 sessions per week in clinical work and 4 sessions on professional and service development (including the Master of Primary Care degree at the University of Glasgow, or similar)

b) Release of 2 sessions per week per practice for established practitioners to focus on service development

c) One of the released practitioners to coordinate the cadre of GP fellows, focusing on the clinical challenges of patient engagement, mental health problems and maintaining therapeutic optimism (see Deep End Reports 22 and 24)

d) One of the released practitioners to support the cadre of experienced GPs (based on the "GP lead" model, developed by Dr Peter Cawston, for the Link Worker project

e) Each released GP to lead practice developments in a chosen area, including links to other services, on behalf of all practices

How the programme will work

a) Added clinical capacity will relieve pressure on Deep End practices

b) Fellows will develop individual projects, to MPC standard, within the themes of "improving patient care in Deep End practices" and “strengthening primary care around general practice hubs”, and adding to the primary care evidence base

c) Released GPs will also work as a coordinated cadre, also engaged in primary care development

d) Fellows will obtain substantial, supported, clinical experience; a Masters degree; experience of primary care development and evaluation

e) Development of leadership experience in established GPs

f) A model of collective working between practices

ANNEX D

SUPPORTING THE DEVELOPMENT OF GENERAL PRACTICE IN VERY DEPRIVED AREAS (SUMMARY OF REPORT NO 20)

Deep End Report 20 *What can NHS Scotland do to prevent and reduce health inequalities?* (http://www.gla.ac.uk/media/media_271030_en.pdf) in March 2013included the following summary points :-

- General Practitioners at the Deep End are NHS Scotland's front line in areas of severe socio-economic deprivation.

- They have patient contact, population coverage, continuity, flexibility, long term relationships, substantial knowledge and experience and the trust of patients.

- These characteristics make general practices the natural hubs around which local health systems should develop.

- But Deep End practices lack the time, links to other services, NHS support and leadership roles needed to maximise what NHS Scotland can do to prevent and reduce inequalities in health.

- The Deep End Project has been unusually successful, with Scottish Government support, in engaging with general practices, in capturing and communicating their experience and views, and in harnessing their commitment to the Links, CarePlus and Bridge Projects.

- It is time to move beyond advocacy, and small projects, however, and to make a real difference to inequalities in health.

- By recognising the causes and consequences of the inverse care law, NHS Scotland can help to prevent poor health and life chances in young families, improve the health and life expectancy of patients with established conditions and prevent the further widening of health inequalities in adults.

- Additional clinical capacity is required, on a pro rata basis, providing one extra GP session per week per 1000 patients living in very deprived areas.

- The principles of co-production, including mutuality and respect, should be applied to serial encounters in general practice and primary care, enabling

patients to become more knowledgeable and confident in living with their conditions and in making good use of available resources.

- The principles of co-production should also be applied to the joint work of general practices and area-based services, including attached workers (from social work, mental health, addictions and child health services), on a named basis.

- The lay link worker role should be developed to link practices and patients with community-based services and resources.

- Building on the Deep End Project, practices serving very deprived populations need regular opportunities to share experience, views and activities.

- NHS Scotland should re-deploy its substantial support systems (including information, research and development, training, continuing professional and leadership development) to provide more effective, integrated support for practices in the front line.

- These proposals should be applied together, as a demonstration of integrated care for patients with multimorbidity, an antidote to health service fragmentation and a model for NHS Scotland in the future.

- NHS Scotland should be seen at its best in areas of greatest need, or inequalities in health will widen. A new partnership with General Practitioners at the Deep End can show the way.