GPs at the Deep End

Deep End Report 30

A role for Members of the Scottish Parliament in addressing inequalities in healthcare in Scotland

Inequity in general practice funding, described as the Inverse Care Law, is a major feature of NHS Scotland and a contributing cause of Scotland having the widest health inequalities in Western Europe.

Over a third of Scottish MSPs have constituents who receive less time with a general practitioner, despite higher levels of physical, psychological and social problems.

This report reviews recent evidence concerning the Inverse Care Law in Scotland, and the political and professional responses.

The support of Scottish politicians is needed to address and abolish the Inverse Care Law in Scotland.

November 2016

SUMMARY

- At least a third of Members of the Scottish Parliament represent constituents who receive less time with their GP, despite higher levels of psychological problems, more multimorbidity and more chronic health problems.
- This situation arises as a result of the Inverse Care Law, whereby steep social gradients in premature mortality and multimorbidity are associated with a flat distribution of GP funding.
- The Inverse Care Law applies not only to socio-economically very deprived areas at the edge of Scottish society, but also to over 2 million Scots living in the 40% most deprived areas.
- Underfunding of general practice in deprived areas results in unmet need, GP stress and complications of patients' conditions occurring sooner, with increased pressure on out of hours, accident and emergency and acute hospital services.
- In 2015, Scottish Government Ministers pledged to address the issue via revision of the Scottish Allocation Formula (SAF) which allocates funding to general practices via the national GP contract.
- The Ministerial commitments replace years of denial, vague commitment and weak resolve concerning the Inverse Care Law.
- It is not clear whether a suitably revised SAF is achievable with a formula based on data which take no account of unmet need.
- If a suitably revised SAF is not possible, another solution must be found.
- Additional clinical capacity for general practices serving deprived areas is essential, in order to address the needs of patients with varying combinations of physical, psychological and social problems.
- The Care Plus Study shows that additional consultation time for patients with complex problems in deprived areas is a cost-effective use of NHS resources.
- Additional help from nurses, pharmacists and link workers can complement but not substitute for the medical generalist role.
- Policies for primary care transformation must not leave the Inverse Care Law intact.
- Redistribution of resources within general practice has not been feasible when general practice funding was reduced as a proportion of the NHS budget, putting all general practices under pressure and leaving many GP vacancies unfilled.
- The Scottish Government's recently announced commitment to increase primary care funding introduces the possibility of addressing the Inverse Care Law via a policy of differential growth, in which no practice loses funding.
- Patients in deprived areas in Scotland have lost out in the competition for NHS resources, as a result of the poor understanding, representation and advocacy of their needs.
- If the NHS is not at its best where needs are greatest, inequalities in health will widen.
- Very deprived areas are the main testing and proving ground for the equitable intentions and policies of NHS Scotland.
- With new funding for Scottish general practice, there is a historic opportunity to address and abolish the Inverse Care Law.
- MSPs must not let their constituents down.

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"General Practitioners at the Deep End" *work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Scottish Government Health Department, the Royal College of General Practitioners, and General Practice and Primary Care at the University of Glasgow.* www.gla.ac.uk/deepend

GPs at the Deep End

INEQUALITIES IN HEALTH IN SCOTLAND

The 73 Scottish parliamentary constituencies may be considered in three groups, from most affluent to most deprived, as determined by the proportion of data zones within constituencies which belong to the 15% most socio-economically deprived data zones in Scotland. (Annex A)

The average proportion of datazones in this deprived category ranges from 1.9% (range 0-4%) in the 24 most affluent constituencies, to 10.5% (range 4-18%) in the middle group of 25 constituencies and 32.1% (range 18-62%) in the 24 most deprived constituencies.

All 24 of the most deprived constituencies are represented by SNP MSPs, including the First Minister, representing Glasgow Southside (9th most deprived), and the Cabinet Secretary for Health, representing Dundee City East (13th most deprived).

The 15-fold difference in the prevalence of deprivation between groups of constituencies is associated with a 3.9 year difference in life expectancy in men (79.0 v 75.1 years) and a 2.7 year difference in life expectancy in women (82.6 v 79.9 years). Data from the NHS Scotland Information Services Division show that earlier deaths in deprived groups are preceded by periods of poor health before death which are twice as long as in the most affluent areas. (1)

Although larger differences in life expectancy are observed between smaller groups (such as comparing the top and bottom 10% of the social spectrum), the differences observed above are remarkable in that they apply to huge numbers of people – 1.36 million Scottish voters in the most deprived group of constituencies and 1.30 million Scottish voters in the most affluent.

Census data show that the percentage of the Scottish population “lacking very good or good general health” is 42% higher in the most deprived group compared with the most affluent group, while the percentage “limited a lot by a long term health condition or disability” is 57% higher.

These data are part of an overall picture in which Scotland has the widest health inequalities in Western Europe. (2)

THE INVERSE CARE LAW

Most reports and policies on health inequalities in Scotland focus on social determinants of health which operate outside the NHS, especially in the early years. Decades will pass before the effect of such policies on adult health is known.

Very few Scottish reports on health inequalities recognise the role of the Inverse Care Law, within the NHS, as a factor maintaining and/or widening differences in health outcomes across the social spectrum (Annex B).

The Inverse Care Law was first described in 1971 (3):

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

Although principally concerned with the effect of market forces on health care, the original paper also described the maldistribution of general practitioners and other resources within the NHS, as a result of which good medical care was more difficult to provide in poor areas.

Since 1971, it is increasingly the case that “good medical care” has the ability to improve the health not only of individual patients but also, by mass delivery, the health of the public. Such health improvements are achieved partly via the application of evidence-based medicine (i.e. treatments which have been proven to work) and partly via the delivery of unconditional, personalised, continuity of care for all patients (consider the alternative). The net effect is to reduce the severity of patients’ conditions and to prevent, postpone or lessen their complications.

If such health care is not resourced and delivered equitably on the basis of need, the net effect of health care is to widen health inequalities.

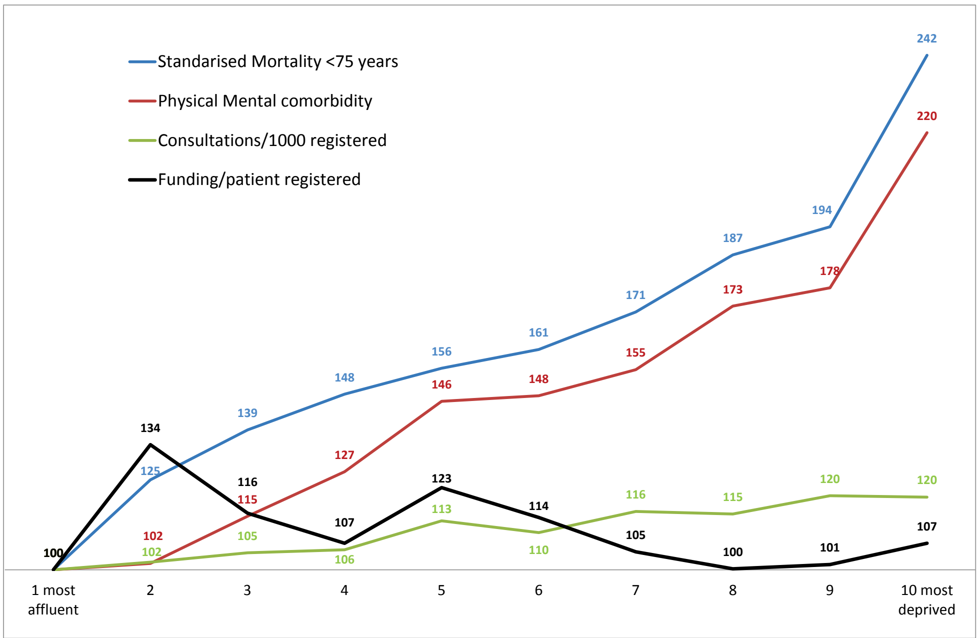
It is often assumed that because NHS Scotland deals equitably with emergencies, providing whatever care a patient needs at the time, it is also equitable in the provision of primary care, but this is not the case. Universal health care, whereby everyone can access health care, provides no guarantee that needs can be met.

For general practitioners working in deprived areas, the Inverse Care Law is experienced as the difference between what they can do, for and with patients, and what they could do with more time and better support.

THE INVERSE CARE LAW IN SCOTLAND

The clearest recent description of the inverse care law in NHS Scotland is a research paper by Dr Gary McLean and Professors Stewart Mercer and Graham Watt at Glasgow University and Professor Bruce Guthrie at the University of Dundee, which was published in the *British Journal of General Practice* (BJGP) in November 2015. (4)

Figure 1 *% Differences from least deprived decile for mortality, comorbidity, consultations and funding. Least deprived decile = 100.*



Explanation of the figure

- The Scottish population is divided into tenths, from most affluent on the left to most deprived on the right, with about 535,000 people in each tenth.
- Individual deprivation status is based on the data zone to which the postcode of the household address belongs. There are about 6500 datazones in Scotland, each containing 500-1000 people.
- All figures in the coloured slopes are expressed as a proportion of a score of 100 given to the most affluent tenth, on the left.
- Standardised mortality under 75 (in blue) and the prevalence of complicated multimorbidity (5+ conditions, or physical and mental health problems combined) (in red) more than double across the social spectrum.
- GP consultation rates (in green) increase by 20% across the social spectrum.
- Average GP funding per patient per annum (in black) has peaks in the 2nd and 5th tenth, but is broadly flat across the social spectrum, especially in the four most deprived tenths.

The paper concluded:

> ***No evidence was found 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 and are poorly related to the prevalence of multimorbidity. In these circumstances, general practice is unlikely to mitigate health inequalities and may increase them.***

The inequity demonstrated by the BJGP paper is not confined to a small, very deprived, group on the edge of society. In 2012, over 2 million Scots comprising the 40% most deprived section of the population received £10 less GP funding per patient than over 3 million Scots, comprising the 60% most affluent section. (£117 v £127, Reference 4, Table 2) Yet premature mortality, complex multimorbidity and shortened health life expectancy are substantially higher in the former group than in the latter. ***The challenge is to fund general practice more equitably across the social spectrum, pro rata based on need*****.**

The greatest discrepancy between GP funding and health needs is experienced in general practices serving the poorest areas. If health care is not seen at its best in such areas, health inequalities will widen. It follows that very deprived areas are the main testing and proving ground for the equitable intentions and policies of NHS Scotland.

CONSEQUENCES OF THE INVERSE CARE LAW FOR PATIENTS IN SCOTTISH GENERAL PRACTICE

The Inverse Care Law is experienced daily by patients and practitioners in deprived areas as (5, 6):

- The higher prevalence of premature multimorbidity and social problems
- Shortage of time within GP consultations

- Less patient enablement, especially for mental health problems (which are the commonest co-morbidity in deprived areas)
- Poorer health outcomes
- Greater practitioner stress

In a study of 3000 consultations with general practitioners in the West of Scotland, the average duration was 8.3 minutes in the most deprived areas, compared with 9.0 minutes in more affluent areas, despite higher levels of psychological problems, more long term illness, more multimorbidity and more chronic health problems. (5)

In these circumstances, unmet needs accrue in deprived areas, care is less coordinated and complications occur sooner. As general practice is less able to contain problems in the community, patients are more likely to access other, more expensive, types of care, including (7):

- out of hours services,
- accident and emergency departments
- admission to an acute hospital bed

The Inverse Care Law is one of the reasons why such services are under increasing pressure. 10% of patients in Scotland with 4 or more conditions account for 34% of patients with unplanned admissions to hospital and 47% of patients with potentially preventable unplanned admissions. (8)

POLITICAL AND PROFESSIONAL RESPONSES AND CHALLENGES

The BJGP paper was front page news in The Herald Newspaper and first item on BBC Reporting Scotland on 30th November 2015, the day of publication. The paper was mentioned in First Minister's Questions on 3rd December and a Government debate on Redesigning Primary Care on 15th December (Annex C). Both the First Minister and the Cabinet Secretary indicated their expectation that the issue highlighted by the paper would be addressed via a revision of the Scottish Allocation Formula, which is used to allocate resources to general practice via the GP contract.

> *I welcome (the) findings, which we will take fully into account in delivering a new GP contract for 2017 and the accompanying revised allocation formula. ……. The resource allocation formula has been in place since 2004 and has undergone some revisions and changes since then. The new GP contract, on which we are in the early stages of negotiation and which will take effect in 2017, gives us a good opportunity to revise the allocation formula to ensure that it reflects the varying needs of GP practices in different local communities. I look forward to having the support of the Parliament as we seek to do that.*

Nicola Sturgeon MSP, First Minister, 3rd December 2015

> *Drew Smith talked about Professor Watt's report, Deep End practices, the Scottish allocation formula and the need for us to ensure that there is more reflection of the needs of deprived communities in the resources that go to them through the formula. All those things are subject to negotiation in relation to the GP contract. However, we need to ensure that all the challenges that are faced by those practices operating in*

more deprived communities are recognised in the resources that are provided to primary care. I correct Drew Smith's reading of the motion. The motion clearly says that the new contract provides "the opportunity to go even further to tackle health inequalities in communities". I deliberately put that in the motion in order to recognise that point.

Shona Robison, Cabinet Secretary for Health, 15th December 2015

These were the first occasions in the history of NHS Scotland that senior members of a Scottish Government not only recognised the existence of inequitable funding in general practice but also indicated how they intended to address the issue i.e. via the the Scottish Allocation Formula (SAF), which allocates funding to general practices as part of the national GP contract.

The statements are a significant advance on previous Scottish reports and statements, characterised by denial, slow recognition, vague commitment and weak resolve. (Annex B)

Almost a year later, however, it is not clear that the problem has been solved. There are five issues

First*, *it is unclear whether a suitably revised Scottish Allocation Formula can be achieved. The current formula uses data on GP consultation rates (how busy general practices are) as a measure of the needs of patients. This approach takes no account of unmet need i.e. the work that general practices are unable to do because of lack of time.

The BJGP paper shows that consultation rates increase by 20% across the social spectrum, which is substantially less than the increases in premature mortality and multimorbidity. With no extra resource, consultation rates can only increase by making consultations shorter (5) or by working a longer day. Current arrangements place a cap, therefore, on the ability of practices to increase consultations in response to need.

Consultation data are also unable to distinguish between needs and demands. Whereas a major feature of practice in more affluent areas is the "worried well" patient, a major feature of practice in deprived area is the "unworried unwell" patient. Both types of encounter are time-consuming, for different reasons, and make different contributions to the improvement of population health.

Until now, the Scottish Allocation Formula, using such restricted data, has been a mechanism for maintaining rather than addressing the Inverse Care Law.

Second, there is inconsistency. Neither the Scottish Government's 2015 Consultation Paper on *Creating a Fairer Scotland*, nor its recently announced 50 action points *To Build a Fairer Scotland* make any reference to unfairness within NHS Scotland in meeting the clinical needs of patients in general practice. The proposal to deploy lay link workers in deprived areas is welcome but is not an adequate response to the Inverse Care Law.

Third, Scottish politicians have been quiet on the issue. Following the 2016 Scottish General Election, 24 MSPs spoke in the first health debate in the re-convened Scottish parliament on 10th June 2016, including the Cabinet Secretary for Health and the Minister for Mental Health, 13 MSPs made no reference to health inequalities. The Cabinet Secretary referred to health inequalities but only to causes operating outside the health service. Of 22 MSPs who spoke in the debate from the three main political parties (10 SNP, 6 Scottish Conservative, 6 Scottish Labour), including 9 members of the newly constituted Health and Sport Committee, none made any reference to health inequalities arising as a result of inequitable NHS funding.

Fourth, there is a lack of professional support within general practice. Neither BMA Scotland nor RCGP Scotland have campaigned for measures to address the Inverse Care Law. Both have been more concerned, correctly, with the survival of general practice as a whole, given the recent decade of reduced general practice funding as a proportion of the NHS budget. Redistribution within general practice of its reduced funding allocation is not a realistic prospect, when all general practices are under pressure, and many practices cannot fill GP vacancies.

There is also concern that addressing the needs of general practices in deprived areas within current levels of national general practice funding would de-stabilise general practices in remote and rural areas. BMA Scotland has argued that while the needs of remote and rural general practices are met via the GP contract, the needs of deprived general practices should be met from elsewhere, such as local NHS budgets, via the new Integrated Joint Boards. Meanwhile, the Chief Officer of the new City of Glasgow Health and Social Care Partnership (HSCP), which includes three quarters of Scotland's most deprived general practices, has argued that increased funding for general practice should be provided from the centre. Both organisations are passing the buck.

It is possible that professional and organisational intransigence will reduce, following the Scottish Government's recent commitment, announced at the SNP conference in Glasgow in October 2016, to increase primary care funding within the NHS Scotland budget. This announcement could replace the challenge of resource redistribution with one of differential growth within an increasing budget i.e. so that no practice loses funding.

Fifth, there is a view that "primary care transformation" can be achieved without addressing the Inverse Care Law i.e. without adding to clinical capacity in general practices serving very deprived areas. Adding nurses, pharmacists and link workers to general practices is proposed as a way of releasing the time of GPs to be "expert medical generalists". While such proposals are welcome, their contributions as an efficient way of addressing the needs of large numbers of patients with complex combinations of physical, psychological and social problems are unproven.

A recent report from the SGHD-funded Govan SHIP Project (10) showed what GPs in very deprived practices could achieve with more time, highlighting a large number of patients with complicated combinations of health and social problems requiring re-assessment and re-planning of care (Annex D). Such re-assessments address unmet need (i.e. uncoordinated care), are an important driver of integrated care "from the ground up" and can only be carried out by medical generalists, capable of dealing with a wide variety of patients' problems.

The recently published Care Plus Study has shown that additional consultation time for patients with complex problems in deprived areas not only improves health but is also cost-effective, in terms of the criteria by which the NHS approves and funds new drugs and technologies. (11)

While additional clinical capacity is not the only solution to the inverse care law, it is an essential component of the solution and the most direct method of addressing the unmet clinical needs of patients in very deprived areas. Experience from the Govan SHIP Project suggests that a 10% increase in clinical capacity may be sufficient. Only 11 of the 100 most deprived general practices in Scotland have been provided with extra clinical capacity, via the Govan SHIP Project and Pioneer Scheme. Other practices also need support.

Other measures which are needed to address the Inverse Care Law include (12, 13):

- Protected time for general practitioners to engage with service development

- Closer links to specialist services, in both secondary and primary care, especially mental health services, which need to be more accessible, flexible and prompt in helping patients with complex problems
- Better connections with community resources for health, facilitated by link workers
- Better support from central NHS agencies in helping clusters of practices in deprived areas.

The need for such measures is common to all general practices in Scotland, but they are especially needed where patients' needs are greatest and where if the NHS is not at its best, inequalities will widen.

The proportion of GPs in Scotland aged 50 years and over is highest in deprived areas. (9) The effects of GP retirement and the associated challenge of recruiting the next generation of GPs will occur soonest in these areas.

WHAT NEXT?

Neglect of the Inverse Care Law in Scotland can no longer be explained by lack of evidence and information. A major explanation is underestimation of the role of general practice in stemming the tide of poor health and its complications in socio-economically deprived areas (Annex D). Other NHS interests are also served by louder voices.

Until 2009, general practitioners serving Scotland's most deprived communities, which are most affected by the Inverse Care Law, had not been convened or consulted by anyone. They now have identity, a national profile and a coherent voice concerning the unmet needs of patients living in very deprived areas. (12, 13)

They need to be joined by MSPs representing such areas, but not only by MSPs from the most deprived areas. The Inverse Care Law affects at least a third of the population of Scotland and should be addressed via a funding formula which addresses needs pro rata across the country.

The first step is to secure political determination to address the Inverse Care Law in Scotland.

Second, proposed changes to the Scottish Allocation Formula will need scrutiny to determine whether and by how much the needs of patients in deprived areas are being addressed. If changes to the SAF do not or cannot deliver the necessary changes, alternative measures must be found.

Third, MSPs should insist that the new policy of "primary care transformation" includes adequate time for the clinical assessment and care of patients with complex physical, psychological and social problems. The prevalence of such patients is highest in deprived areas.

The Scottish Government's recent commitment to increase primary care funding provides a historic opportunity to correct the Inverse Care Law. It is up to Scotland's politicians to ensure the opportunity is not lost.

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ANNEX A Scottish Parliamentary constituencies ranked by deprivation and life expectancy

Data obtained from Scottish Parliamentary Constituency Profiles (http://www.scotlandscensus.gov.uk/news/scottish-parliamentary-constituency-profiles-and-regions)

RANK	CONSTITUENCY	MSP	PARTY	DEPRIVED DATAZONES	MALE LIFE EXPECTANCY	FEMALE LIFE EXPECTANCY
1.	East Kilbride	Linda Fabiani	SNP	0% (0/100)	77.7	81.6
2.	Moray	Richard Lochhead	SNP	0% (0/96)	78.7	81.6
3.	Aberdeen South & Kincardine North	Maureen Watt	SNP	0% (0/95)	78.7	81.7
4.	Edinburgh Southern	Daniel Johnson	LAB	0% (0/94)	79.3	83.3
5.	Edinburgh Central	Ruth Davidson	CON	0% (0/93)	79.2	83.2
6.	Eastwood	Jackson Carlaw	CON	0% (0/87)	81.5	84.1
7.	Angus North & Mearns	Mairi Evans	SNP	0% (0/85)	78.3	81.9
8.	Aberdeenshire West	Alexander Burnett	CON	0% (0/84)	80.5	83.1
9.	Western Isles	Alasdair Allan	SNP	0% (0/36)	77.0	82.1
10.	Orkney Islands	Liam McArthur	LIBDEM	0% (0/27)	78.7	82.8
11.	Shetland Islands	Tavish Scott	LIBDEM	0% (0/30)	77.9	82.4
12.	Fife North East	Willie Rennie	LIBDEM	1% (1/93)	79.6	83.0
13.	Skye, Lochaber & Badenoch	Kate Forbes	SNP	1% (1/93)	79.4	83.8
14.	Midlothian South, Tweeddale & Lauderdale	Christine Graham	SNP	2% (2/89)	79.0	82.6
15.	Perthshire North	John Swinney	SNP	2% (2/84)	79.4	82.8
16.	Midlothian North & Musselburgh	Colin Beattie	SNP	3% (3/104)	77.4	81.4
17.	Strathkelvin & Bearsden	Rona Mackay	SNP	3% (3/93)	79.7	83.3
18.	Angus South	Graeme Dey	SNP	3% (3/89)	79.2	81.8
19.	East Lothian	Iain Gray	LAB	3% (3/88)	78.7	82.3
20.	Dumfriesshire	Oliver Mundell	CON	4% (4/99)	78.8	81.8
21.	Clydesdale	Aileen Campbell	SNP	4% (4/95)	77.9	81.6
22.	Aberdeenshire East	Gillian Martin	SNP	4% (4/92)	80.1	83.1
23.	Perthshire South & Kinross-shire	Roseanna Cunningham	SNP	4% (4/91)	79.6	83.1
24.	Edinburgh Western	Alex Cole-Hamilton	LIBDEM	4% (4/91)	79.4	83.6

RANK	CONSTITUENCY	MSP	PARTY	DEPRIVED DATAZONES	MALE LIFE EXPECTANCY	FEMALE LIFE EXPECTANCY
25.	Ettrick, Roxburgh & Berwickshire	John Lamont	CON	4% (3/81)	79.0	82.3
26.	Banffshire & Buchan Coast	Stewart Stevenson	SNP	5% (5/94)	77.3	81.1
27.	Linlithgow	Fiona Hyslop	SNP	6% (6/105)	77.9	80.8
28.	Cumbernauld & Kilsyth	Jamie Hepburn	SNP	6% (5/84)	76.6	81.3
29.	Almond Valley	Angela Constance	SNP	7% (7/106)	77.8	80.1
30.	Inverness & Nairn	Fergus Ewing	SNP	8% (8/101)	77.4	82.1
31.	Falkirk East	Angus MacDonald	SNP	8% (8/101)	77.6	81.2
32.	Caithness, Sutherland & Ross	Gail Ross	SNP	8% (8/98)	78.4	82.6
33.	Stirling	Bruce Crawford	SNP	8% (7/92)	77.6	81.6
34.	Aberdeen Central	Kevin Stewart	SNP	9% (8/90)	74.4	81.1
35.	Argyll & Bute	Michael Russell	SNP	9% (8/86)	78.0	81.6
36.	Aberdeen Donside	Mark McDonald	SNP	10% (10/101)	77.7	81.2
37.	Falkirk West	Michael Matheson	SNP	10% (10/96)	77.0	80.7
38.	Galloway & Dumfries West	Finlay Carson	CON	10% (9/94)	77.2	81.2
39.	Fife Mid & Glenrothes	Jenny Gilruth	SNP	11% (10/89)	77.8	81.0
40.	Dunfermline	Shirley-Anne Somerville	SNP	11% (9/81)	77.9	82.9
41.	Renfrewshire North & West	Derek Mackay	SNP	12% (10/81)	77.1	82.9
42.	Glasgow Kelvin	Sandra White	SNP	13% (11/83)	73.7	78.4
43.	Ayr	John Scott	CON	14% (14/102)	77.8	80.1
44.	Cowdenbeath	Annabelle Ewing	SNP	14% (13/91)	77.4	80.3
45.	Edinburgh Northern & Leith	Ben McPherson	SNP	14% (12/86)	76.4	79.6
46.	Dumbarton	Jackie Baillie	LAB	15% (15/98)	76.2	80.3
47.	Carrick, Cumnock & Doon Valley	Jeanne Freeman	SNP	17% (17/99)	77.1	79.0
48.	Clackmannanshire & Dunblane	Keith Brown	SNP	17% (14/82)	78.3	81.0
49.	Kilmarnock & Irvine Valley	Willie Coffey	SNP	18% (18/100)	76.1	80.6

RANK	CONSTITUENCY	MSP	PARTY	DEPRIVED DATAZONES	MALE LIFE EXPECTANCY	FEMALE LIFE EXPECTANCY
50.	Edinburgh Pentlands	Gordon MacDonald	SNP	18% (16/88)	78.9	83.8
51.	Cunninghame North	Kenneth Gibson	SNP	19% (17/90)	77.3	81.7
52.	Clydebank & Milngavie	Gill Paterson	SNP	20% (18/90)	78.1	80.9
53.	Uddingston & Bellshill	Richard Lyle	SNP	21% (19/92)	75.7	79.4
54.	Renfrewshire South	Thomas Arthur	SNP	21% (18/85)	76.7	80.4
55.	Edinburgh Eastern	Ash Denham	SNP	23% (22/97)	74.9	80.3
56.	Hamilton, Larkhall & Stonehouse	Christina McKelvie	SNP	24% (21/88)	76.1	80.0
57.	Kirkcaldy	David Torrance	SNP	25% (25/99)	75.7	80.0
58.	Glasgow Cathcart	James Dornan	SNP	25% (23/93)	74.8	80.8
59.	Airdrie & Shotts	Alex Neil	SNP	26% (23/87)	74.9	78.9
60.	Rutherglen	Clare Haughey	SNP	27% (26/95)	74.8	80.1
61.	Dundee City East	Shona Robison	SNP	30% (27/89)	75.3	80.7
62.	Coatbridge & Chryston	Fulton MacGregor	SNP	30% (25/83)	75.5	80.7
63.	Dundee City West	Joe Fitzpatrick	SNP	31% (28/91)	75.3	79.7
64.	Paisley	George Adam	SNP	31% (27/87)	74.7	79.1
65.	Glasgow Southside	Nicola Sturgeon	SNP	32% (25/78)	74.0	79.4
66.	Motherwell & Wishaw	Clare Adamson	SNP	33% (30/92)	75.1	78.8
67.	Cunninghame South	Ruth Maguire	SNP	33% (29/89)	75.5	80.0
68.	Glasgow Anniesland	Bill Kidd	SNP	39% (34/87)	74.0	79.8
69.	Greenock & Inverclyde	Stuart McMillan	SNP	42% (44/104)	75.1	80.3
70.	Glasgow Pollok	Humza Yusef	SNP	47% (41/87)	73.1	77.6
71.	Glasgow Shettleston	John Mason	SNP	53% (47/88)	72.5	78.6
72.	Glasgow Maryhill & Springburn	Bob Doris	SNP	60% (52/87)	72.4	77.7
73.	Glasgow Provan	Ivan McKee	SNP	62% (56/91)	72.4	78.0

Deprivation by Scottish Regional Constituencies

Percentages based on the proportion of data zones in the region in the 15% most deprived data zones in Scotland. By definition, the percentage for Scotland as a whole is 15%. Although the Inverse Care Law applies more widely than the 15% most deprived data zones, the figures are nevertheless indicative of which Regional List MSPs represent the most deprived areas.

HIGHLANDS & ISLANDS	**4%**	**MID & FIFE**	**11%**
Douglas Ross	CON	Murdo Fraser	CON
Edward Mountain	CON	Liz Smith	CON
Donald Cameron	CON	Dean Lockhart	CON
Rhoda Grant	LAB	Alexander Stewart	CON
David Stewart	LAB	Alex Rowley	LAB
Mare Todd	SNP	Claire Baker	LAB
John Finnie	LIBDEM	Mark Russell	GREEN

LOTHIAN	**8%**	**CENTRAL**	**17%**
Miles Briggs	CON	Margaret Mitchell	CON
Gordon Lindhurst	CON	Graham Simpson	CON
Jeremy Balfour	CON	Alison Harris	CON
Kezia Dugdale	LAB	Richard Leonard	LAB
Neil Findlay	LAB	Monica Lennon	LAB
Alison Johnstone	GREEN	Mark Griffin	LAB
Andy Wightman	GREEN	Elaine Smith	LAB

NORTH EAST	**9%**	**WEST**	**20%**
Alex Johnstone	CON	Jamie Greene	CON
Ross Thomson	CON	Maurice Golden	CON
Peter Chapman	CON	Maurice Corry	CON
Liam Kerr	CON	Neil Bibby	LAB
Jenny Marra	LAB	Mary Fee	LAB
Lewis Macdonald	LAB	Ken McIntosh	LAB
Mike Rumbles	LIBDEM	Ross Greer	GREEN

SOUTH	**9%**	**GLASGOW**	**40%**
Rachael Hamilton	CON	Adam Tomkins	CON
Brian Whittle	CON	Annie Wells	CON
Claudia Beamish	LAB	Anas Sarwar	LAB
Colin Smyth	LAB	Johann Lamont	LAB
Joan McAlpine	SNP	James Kelly	LAB
Emma Harper	SNP	Pauline McNeill	LAB
Paul Wheelhouse	SNP	Patrick Harvie	GREEN

ANNEX B A brief review of the Inverse Care Law in Scotland as described in health reports

The recent history of the Inverse Care Law in Scotland, as mentioned in official reports, is characterised by denial, slow recognition, vague commitment and weak resolve.

Reports which make no mention of the Inverse Care Law

The Inverse Care Law in Scotland, as manifested by the generally flat distribution of general practice funding despite steep slopes of need, is not mentioned in the following documents.

- Equally Well. Report of Ministerial Task Force on Health Inequalities, 2008
- Equally Well Review, 2010
- Realistic Medicine. Chief Medical, Officer's Annual Report 2014-15
- Creating a Fairer Scotland. Consultation by the Scottish Government, 2015
- Review of Public Health in Scotland. Strengthening the Function and Re-Focussing Action for a Healthier Scotland. Scottish Government 2016
- History, politics and vulnerability: explaining excess mortality in Scotland and Glasgow. A report by the Glasgow Centre for Population Health, NHS Scotland, the University of the West of Scotland and University College, London, 2016 (despite 353 pages, 683 references and 35 expert signatories)
- Glasgow City Health and Social Care Partnership. Glasgow City Integration Joint Board Strategic Plan 2016-19.
- Royal College of General Practitioners Scotland. Promoting General Practice. A manifesto for the 2016 Scottish Parliamentary Election
- Auditor General. NHS in Scotland 2016.

Reports of the Inverse Care Law in Scotland, and what happened to them

Between 2005 and 2015, five publications highlighted the flat distribution of general practitioners across the social spectrum.

- Mackay D, Sutton M, Watt G. Deprivation and volunteering by general practices: cross sectional analysis of a national primary care system. BMJ 2005; 331:1449-51
- Tomlinson J, Mackay D Watt G, Whyte B, Hanlon P, Tannahill C. The shape of primary care in NHS Greater Glasgow and Clyde. Glasgow Centre for Population Health 2008. http://www.gcph.co.uk/assets/0000/0423/The_Shape_of_Primary_Care_FinalFull.pdf
- Mackay DF, Watt GCM. General practice size determines participation in optional activities: cross-sectional analysis of a national primary care system. Primary Health Care Research and Development 2010;11:271-9

- RCGP Scotland Health Inequalities Short Life Working Group Report. TIME TO CARE : Health Inequalities, Deprivation and General Practice in Scotland. RCGP Scotland, Edinburgh, 2010
- Audit Scotland. Health Inequalities in Scotland. December 2012

Such reports are no longer possible, as the Scottish Government stopped collecting compete data on GP whole time equivalents (WTE) in 2004.

The following account describes what happened in the case of the Audit Scotland Report on *Health Inequalities in Scotland*, (2) beginning with consideration of the Report by the Public Audit Committee of the Scottish Parliament.

In taking evidence concerning the report, the Committee was mis-informed by Derek Feeley, the then Chief Executive of NHS Scotland,

"It looks to me that there are around 25 to 30% more GPs in the most deprived areas than in the least deprived areas".

Mr Feeley was accompanied by the Chief Medical Officer, Professor Sir Harry Burns, who did not contradict him.

The Committee was given more accurate information by General Practitioners at the Deep End, when Dr Jim O'Neil, Dr Susan Langridge and Professor Graham Watt gave evidence to a subgroup of the Public Audit Committee, reviewing cardiology services in Scotland, at Glasgow City Chambers on 22nd June 2012 and when Dr Peter Cawston, Dr Susan Langridge and Professor Graham Watt presented to the full committee on 30th January 2013.

The Public Audit Committee's main recommendations in its report in April 2013 (3) were:

- *overcoming the practical barriers to collating WTE headcount figures for GPs, and providing this information broken down according to the level of deprivation.*
- *increasing the importance of the primary care team as a whole in tackling health inequalities in deprived areas*
- *increasing the proportion of GPs based in deprived areas*
- *increasing the number of fellowships in deprived areas*
- *shifting towards treating patients based on multimorbidity, and how the effectiveness of any such shift will be measured*
- *considering the potential merits of a centrally funded research function to asses specific initiatives*

The Public Audit Committee then concluded its interest in Health Inequalities. When pressed on how the Committee would follow up the recommendations in the Audit Scotland Report, the PAC chair referred the question to the Health and Sport Committee.

Professor Graham Watt gave evidence on Health Inequalities to the Health and Sport Committee of the Scottish Parliament on 5th February 2013 and 1st April 2014

Following the second session, the following questions (based on the Audit Scotland report) were asked by Duncan McNeil MSP, convenor of the Health and Sport Committee, and answered by Alex Neil MSP, Cabinet Secretary for Health and Wellbeing in April 2014

Question S4W-20525: Duncan McNeil, Greenock and Inverclyde, Scottish Labour, Date Lodged: 02/04/2014
To ask the Scottish Government whether it has introduced "national indicators to specifically monitor progress in reducing health inequalities" as recommended by Audit Scotland in its December 2012 report, Health Inequalities in Scotland.

Answered by Alex Neil (24/04/2014): *Health inequalities are complex, long-term and influenced by a wide range of societal and individual factors. The Scottish Government already uses a breadth of indicators to monitor progress in reducing health inequalities. Rather than introducing new indicators, we are further developing the existing range so they can be used more effectively and give the fullest perspective possible on the levels of health inequality experienced in Scotland.*

Question S4W-20526: Duncan McNeil, Greenock and Inverclyde, Scottish Labour, Date Lodged: 02/04/2014
To ask the Scottish Government whether it has, along with NHS boards, "reviewed the distribution of primary care services to ensure that needs associated with higher deprivation are adequately resourced" as recommended by Audit Scotland in its December 2012 report, Health Inequalities in Scotland.

Answered by Alex Neil (30/04/2014): *The agreement the Scottish Government has reached with the Scottish General Practitioner's Committee for 2014-15, embeds into the contract support from each GP practice for health and social care integration, enabling every practice to make a contribution to local integration processes, locality planning and decision-making.*

In addition for the first time this year, health boards were also required to complete a 'strategic assessment of primary care' as part of the annual local delivery plan process. This is an important step forward and gives real opportunity to place much needed focus and emphasis on primary care. Within health boards these assessments will inform the measurable resource shift necessary to innovate and strengthen primary care.

The assessments will also assist the development of approaches to enable the Scottish Government to provide support to health boards in expanding the role of primary care, recognising that across Scotland health boards have different priorities, reflecting their geographic situation, current infrastructure and health needs and enable the development of collaborative ways of working to achieve an expanded role for primary care.

Question S4W-20527: Duncan McNeil, Greenock and Inverclyde, Scottish Labour, Date Lodged: 02/04/2014
To ask the Scottish Government whether the GP contract now includes measurable outcomes to monitor progress toward tackling health inequalities, as recommended by Audit Scotland in its December 2012 report, Health Inequalities in Scotland, and, if so, what outcomes.

Answered by Alex Neil (30/04/2014): *The arrangements we agreed with the Scottish General Practitioner's Committee for 2013-14 introduced a number of measures important for deprived areas, including anticipatory care and poly-pharmacy for those most at risk of hospital admission; importantly, this also paved the way towards minimising the bureaucracy associated with the GP contract in Scotland whilst placing more freedom in the hands of GPs to exercise their clinical judgment in the provision of care for patients, rather than the constraints of a tick-box approach.*

The Scottish Government through recognising the challenges in the national contract in relation to practices whose patients face the greatest inequalities have significantly *altered the 2014-15 contract to free those practitioners up to devote more time to the complex problems that their patients face.*

Subsequently, in its report on *Health Inequalities* in January 2015, the Health and Sport Committee concluded:

99. This is not to suggest that we think that health services do not have an important role to play in reducing health inequalities. As we have indicated in the report, the least well-off and most vulnerable individuals and communities often have the poorest access to primary health services and this remains an issue that the NHS will need to make efforts to improve, by whatever means. The health service also has a clear role in preventing ill-health through education and awareness-raising, notwithstanding what we have said in the report about the tendency for public health campaigns to widen health inequalities rather than narrow them. The health agencies are also where data are collected and analysed and progress is measured. Health service initiatives like the Early Years Collaborative and the Family Nurse Partnership (and the activities stemming from them) are also reported to be making a difference. More widely, we have seen developments like self-directed support, the integration agenda and moves towards preventative spending, all of which can play some role in helping to reduce health inequalities.

In summary, by January 2015, after 5 years of lobbying, the impetus which had been established by the RCGP Report Time to Care and the Audit Scotland Report on Health Inequalities, and which had been endorsed by the Report of the Public Audit Committee, was diffused, first by a series of Ministerial replies to parliamentary questions and second, by the bland conclusion of the Health and Sport Committee that ***"this remains an issue that the NHS will need to make efforts to improve, by whatever means."***

Other Reports

Route Map to the 2020 Vision of Health and Social Care,

The Scottish Government Health Department, in its *Route Map to the 2020 Vision of Health and Social Care*, endorsed the "Deep End approach", without specifying what this was. (4)

Reducing health inequalities

We will refocus our efforts on health inequalities particularly in the context of benefits cuts which will impact those most at risk of ill-health. We will do this by targeting improvement resources into primary care in the most deprived areas of Scotland including staff and equipment such as tele-health facilities, learning from and rolling out successful initiatives such as the 'Deep-End' GP practices in Glasgow.

Key deliverables for 2013/14

There will be a new focus on targeting resources to the most deprived areas. The successful approach developed in the 'Deep-end' GP practices will be rolled out more widely across relevant areas of Scotland reducing the risk of admission to hospital and improving outcomes for people in Scotland's most deprived communities.

To date, only 11 of the 100 most deprived general practices in Scotland have been provided with additional clinical capacity to address the needs of their patients.

The future of primary care. Creating teams for tomorrow

The influential report of the Primary Care Workforce Commission, *The future of primary care. Creating teams for tomorrow,* commissioned by Health Education England and published in July 2015 makes explicit reference to General Practitioners at the Deep End, their proposals and examples of activity. (5)

2.5 Population groups with particular needs
2.5.1 Care in areas of severe socio-economic deprivation

People in areas of major socio-economic deprivation often suffer the dual disadvantage of poor health and poor health services. 'GPs at the Deep End' is a group of GPs working with general practices serving Scotland's 100 most socio-economically deprived populations, and comparable support groups are also being set up in English areas of socio-economic deprivation.

Deep End projects have identified a range of measures to improve the care of, and outreach to, the most vulnerable and marginalised groups within local communities. These include targeted appointments for people with the most complex needs, combined with additional consultation time, practice-attached community link workers to help people navigate the health and social care systems, connecting practices and individuals to community resources for health, and attached alcohol and mental health workers.

Recommendation: Measures are needed to address inequalities in the distribution of healthcare professionals in order to improve the major deficits seen in areas of socioeconomic deprivation and poor health. New workforce initiatives should be prioritised in these areas.

National Clinical Strategy for Scotland

In 2016, the National Clinical Strategy for Scotland recognised the "inequitable distribution" of general practitioners in Scotland. (6)

The distribution of general practices across Scotland is determined largely by historical patterns of care and populations, and there is evidence that the allocation of resources does not always match need, particularly deprivation. In general there is evidence of fewer doctors working in smaller practices in the most deprived areas of Scotland. A recent survey by the Deep End GPs (a group who work in the 100 most deprived practices in Scotland) has shown that deprived areas generally have fewer doctors, and that the doctors there are more likely to be older and in single-handed or smaller practices. There was an ambition to address this inequitable distribution in the 2004 GMS contract and there is potential through the new 2017 GMS contract, and resource allocation by Integration Joint Boards to further address this issue whether by redistributing existing resources or ensuring that any additional resources improve the match with need.

References

1. Audit Scotland. Health Inequalities in Scotland. December 2012
2. Public Audit Committee, 1st Report, 2013 (Session 4). Report on Health Inequalities, 10/4/13 http://www.scottish.parliament.uk/S4_PublicAuditCommittee/Reports/paur-13-01w.pdf

3. Report of the Health and Sport Committee on Health Inequalities, January 2015
4. A Route Map to the 2020 Vision for Health and Social Care, NHS Scotland 2012
5. The future of primary care. Creating teams for tomorrow. Report by the Primary Care Workforce Commission, commissioned by Health Education England, July 2015
6. The Scottish Government. A National Clinical Strategy for Scotland, February 2016

ANNEX C Ministerial responses

First Minister's Questions, Scottish Parliament, 03 December 2015

Murdo Fraser: Conservative list MSP for Fife, submitted a question to the First Minister, Nicola Sturgeon, asking, *"What the Scottish Government is doing to reduce healthcare inequalities".*

First Minister: *"One of the ways in which the Scottish Government is tackling health inequalities is by reforming the general practitioner contract, to reduce bureaucracy and give GPs more time to devote to the complex problems that patients can face, particularly in areas where patients face the greatest inequalities and health issues. Further changes will be made to the 2017 contract, which will include a review of the Scottish resource allocation formula, to ensure that GP surgeries in the areas of most need receive funding that is proportionate to the needs in their areas".*

Murdo Fraser: *"The First Minister mentioned GP funding. She will be aware that earlier this week a report from the University of Glasgow, highlighted that GPs in the most deprived areas of the country receive £10 less per patient than GPs in wealthier areas receive. The report said that "We have got health inequalities which are the worst of any country in Western Europe", and went on to say that GP funding is one of the reasons behind that. In my region, every GP practice in Kirkcaldy is operating with a full list and cannot take on any new patients. What more can the Scottish Government do to combat inequalities?"*

The First Minister: *"I welcome Professor Watt's findings, which we will take fully into account in delivering a new GP contract for 2017 and the accompanying revised allocation formula…… The resource allocation formula has been in place since 2004 and has undergone some revisions and changes since then. The new GP contract, on which we are in the early stages of negotiation and which will take effect in 2017, gives us a good opportunity to revise the allocation formula to ensure that it reflects the varying needs of GP practices in different local communities. I look forward to having the support of the Parliament as we seek to do that."*

(See more at: http://www.scottish.parliament.uk/parliamentarybusiness/report.aspx?r=10248&i=94327#ScotParlOR)

Government debate on *Redesigning Primary Care*, Scottish Parliament, 15 December 2015

Cabinet Secretary for Health, Shona Robison: *Drew Smith talked about Professor Watt's report, deep-end practices, the Scottish allocation formula and the need for us to ensure that there is more reflection of the needs of deprived communities in the resources that go to them through the formula. All those things are subject to negotiation in relation to the GP contract. However, we need to ensure that all the challenges that are faced by those practices operating in more deprived communities are recognised in the resources that are provided to primary care. I correct Drew Smith's reading of the motion. The motion clearly says that the new contract provides* *"the opportunity to go even further to tackle health inequalities in communities". I deliberately put that in the motion in order to recognise that point.*

Ministerial Correspondence, 06 January 2016

On 6th January, the Cabinet Secretary Shona Robison wrote to Nicola Sturgeon, the First Minister

"*Thank you for your email of 14 December asking about the distribution of primary care funding relative to need on behalf of your constituent Dr XXXX.*

As you know, tackling health inequalities are a key priority. We are in regular contact with senior representatives from the Deep End Group of practices and officials last met during September. A number of issues were discussed and a senior SG official subsequently attended a meeting of the Deep End Steering Group on Friday 23rd October at Glasgow University.

Professor Watt raises the important question of how funding is distributed and, in negotiating a new Scottish GP contract from 2017, we are reviewing the Scottish Allocation Formula (SAF) to ensure it distributes funding fairly. We have always been clear that the approximate 60% of funding allocated through the SAF must change to reflect changing circumstances. We will take full account of Professor Watt's funding as we deliver a new GP contract for 2017 and the accompanying revised allocation formula.

We have already started to take significant steps towards long term, sustainable, transformational change that will evolve our health service. By reforming the general practitioner contract, we are reducing bureaucracy and giving GPs more time to devote to the complex problems that patients face, particularly in areas where patients face the greatest inequalities and health issues.

As part of this transformational change, as you will be aware, on 15 December 3015, I announced we have agreed with the BMA in Scotland that QOF will be dismantled from the contract from April 2016. This means greater stability of funding and services for GP Practices, removing bureaucracy and freeing up more GP time to spend on face to face patient care. This will also mean GPs will use their clinical judgment to provide the right care for each individual patient without having to tick boxes for certain checks being carried out or questions being asked.

The future of general practice is one where care is provided by multidisciplinary professional teams, planned and delivered within the localities that need them and where professionals collaborate across the boundaries of primary, secondary and social care.

The important role of the GP in the evolving localities within the new Health and Social Care Partnerships is integral to this agreement and will help ensure that decisions about all aspects of care and services to patients in localities will be informed by the expert input of the GP. To support this, we are investing over a million pounds in a programme for local GP leadership and networking.

All this is focused on high quality care and improved health outcomes that will provide a more connected, streamlined working across health and social care and voluntary support services. This will ensure that professionals are able to support patients facing wider social issues which are having an impact on their health and wellbeing.

Thank you again for your email. I hope the information provided is helpful in responding to your constituent."

ANNEX D Content and outcome of extended consultations

Reproduced from Deep End Report 29, listing patients receiving extended consultations with 15 GPs at Govan Health Centre during two weeks in February 2016 (www.gla.ac.uk/deepend)

Length	
20min	Patient with major depressive symptoms/suicide risk and substance misuse; **Outcome**: planning of future care and involvement of other organisations.
20 min	Patient with newly diagnosed depression and child protection issues; **Outcome**: during consultation likely COPD diagnosed referred for spirometry/smoking cessation.
20 min	Pregnant patient – major child protection concerns – background of domestic violence and drug misuse. **Outcome**: SW contacted and telephone discussion re planned case conference.
20 min	Poorly controlled diabetic who is reluctant to engage with services.
30 min	HV to newly diagnosed palliative care patient; **Outcome**: met with family and discussed management and DS1500.
20 min	Patient with h/o head injury personality change and depressive features very reluctant to accept input from support services.
25 mins	Planned palliative care discussion at home with patient and carer, non-cancer diagnosis. **Outcome**: clinical expectations discussed to allay fears over management. Linked with secondary care consultant by phone for agreement with treatment plan.
30 mins	Post hospital discharge visit in elderly lady with multiple co morbidities and polypharmacy; **Outcome**: medication review and link with social services and ACP planning.
30 min	Planned visit to elderly patient and carer with dementia and new diagnosis of advanced malignancy. **Outcome**: discussion over diagnosis, to some extent prognosis and palliative treatment. Linked into district nursing and palliative care team. ACP planning with carer.
20 min	Child < 5 years frequent attender to surgery with minor self-limiting symptoms. English poor and requires translator. Planned review to discuss support and education of such illness;

	Outcome: linked in with Health Visitor for further ongoing support which also involves local third sector agencies. Aim to support mother and reduce attendances at general practice.
20 min	Extended consult in surgery for a patient with complex medical and psychosocial needs. **Outcome:** management plan and education provided.

30 mins	Seen GHC. Middle aged patient 'A' who has moved to homeless accommodation. Anhedonia, thoughts of self-harm, lack of self-worth and despondent. Little self-care. Patient whom I have known for many years. Family quarrel and patient feeling excluded. **Outcome:** discussion, DWP benefits arranged, housing officer appointment. Trial anti-depressant and advice in terms of family contact. Review planned for 1 week.
40 mins (including travel time)	Housebound elderly patient, lives alone with carer support. Highly anxious and had prolonged admission for 2+/12 late 2015. Chest infection and anaemia of uncertain origin. **Outcome:** reviewed and blood checked. Medication reviewed and amended after discussion. With social support, aim is to pre-empt admission if possible. So far managing in community.
30 mins	Patient well known to me for many years. Attends our substance clinic. Complex family circumstances -father has alcohol problems and mum died from a long term condition. Patient had been carer for both parents and has a dependent child. CAT worker had been concerned about suicidal thoughts from patient. Came to see me for prolonged consultation. History as above and father's insanitary habits a great stress. Ambivalence about her care burden. Her extended family had decided to have nothing further to do with the father, leaving patient alone to care. **Outcome**: contact with housing and letter given of support. Review 1/52.
30 min	73 year old patient with CVA and incapacity. HV to assess and liaison with her husband who has guardianship. **Outcome**: DNA CPR discussed, agreed and Adult with Incapacity Form completed and provided to NH.
30 min	80 year old highly anxious patient who lives alone. Recurring anaemia and rectal blood loss. Has had recent colonoscopy and UGD showing gastritis and diverticular change only. **Outcome:** copies of reports taken to patient and discussed. Further FBC taken and result given to patient with reassurance. Further supportive monitoring at home. Patient also contacts by phone as required.

30 min	Review visit from 1 week ago. Patient A has moved to homeless accommodation. **Outcome**: very much brighter, self-caring and has established contact with his mum. Seen housing officer and has offer of permanent housing. Very keen to get back on his feet and out of the hostel. Anti-depressant unlikely to have had any material impact but continued meantime. Will attend for review 1 week.

30 min	Planned review. **Outcome:** patient more settled and has contacted three housing associations and applied formally for rehousing. Physical concerns also addressed during consultation and investigations arranged. Reinforcement of support and of her accommodation
45 min	Frail elderly patient with poor mobility and fall in bedroom several days before being seen at home following telephone contact with daughter. High falls risk. Virtually housebound and daughter has moved to stay with her mum who is not fit for independent living. Detailed background medical and social history taken. Daughter has no respite and daughter has personal health problems. Mum has long standing diarrhoea under investigation. Potentially nearing crisis and admission risk; **Outcome**: place on MDT list for discussion, referred to rehab team for input. Referred to Links Practitioner for carer support. Planned HV review 2 weeks. Aim to reduce risk of unplanned hospital admission or social crisis.
30 min	50+ year old asylum seeker. Registered July 2014 with us. Headaches. Social history taken. Her dependent children still live in her country of origin. Cost prohibits much contact with her children. Speaks by phone about once per month. Had a part time job. HIV under treatment and PMH of probable meningeal TB. Known PTSD. **Outcome**: referred to Links Practitioner and offered advice via Money Matters Govan. Medication review and will be offered ongoing support via extended consultation process.
45 min	Patient B mentioned in passing by her mum during routine appointment. Not been out of the house for several years. On no benefits and not been seen by practice for years before Project contact. This meeting is one of a series that have taken place at home. Complex needs and social and legal concerns surrounding lack of benefits, DWP not knowing that patient existed (and having an out of date address for the previous flat which was knocked down around 8 years previously), and mum having single occupant rates relief. Significant lack of resources, uncarpeted floorboards, financial stress. Local authority unaware that Patient I was in the house. **Outcome**: Links Practitioner input. Correspondence with DWP, establishment of ESA, fruitless contact with psychological services who visited once and have not returned. Ongoing support and major input from Links Practitioner is moving towards benefits being established, fine for rates relief being addressed and future support for psychological issues will be of long duration.

2 hours	One home visit to a patient who was recently discharged; **Outcome**: requiring bloods, review of complex care needs, discussion about resuscitation and eKIS / ACP.
	One extended consultation with a patient who has multiple comorbidities and who repeatedly attends the practice and A+E; **Outcome**: medications review, eKIS, call to chemist and also had time to do a full memory assessment.

60 min	Extended home visit to a complex patient; **Outcome**: discussion with carers, 2 further discussions with family, review of meds, bloods taken, epilepsy review, mental health review and review of old notes. eKIS entry done.
60 min	Extended home visit – complex patient; **Outcome**: medication review, anticipatory care, called her family, Discussed resuscitation, discussed future care needs with home.
30 min	Extra extended review was able to be slotted in for a patient with odd behaviour and a full memory assessment undertaken; **Outcome**: Called family, referred on to rehab and psychiatry as well as social work.

2 hours	Surgery of 6 x 20 minute extended consultations with 6 patients with significant diabetes related problems and complex co-morbidities; **Outcome**: aimed at improving engagement with medical management plans and improving sub-optimal diabetic control.
30 min	New first diagnosis of diabetes. Complex history of multimorbidity including hypertension previous perforated DU and COPD. Osmotic symptoms +++. HbA1c (235). Chol 2.8. BP 126/80 mmHg. eGFR >60. Microalbuminuria -ve (<5). Wt98.8kg. BMI 30.49. **Outcome**: ex-smoker Advised to arrange optician eye review (referred retinal screening retinal screening). Medication reviewed (polypharmacy). Already on statin. Satisfactory lipid control. Already on ARB - not for blood pressure control. Review 3/12 after repeat HbA1C. Advised +++ re lifestyle issues - diet and exercise.
40 min	Consultation with new patient C. Single parent. Mother of 2 dependent children. Presented urgently, accompanied with 2 children – younger of which had apparent behavioural problems, with constellation of problems. ‘Urgently’ needed prescription for diazepam, tramadol and zopiclone. Benzos apparently started by psychiatrist from CMHT. Reports moved to area for her own safety because of threats of violence. **Outcome**: this consultation raised numerous concerns re child safety and need to liaise with psychiatry and SWD for clarification of facts and ongoing monitoring and supervision. The children as yet were not registered with the practice.
20 min	Multiple co-morbidities. **Outcome**: (1) several infected skin lesions (impetiginous appearance). Rx Fluclox + Fucidin H. (2) irritated eyes - conjunctivitis Rx Chloromycetin eye oint. (3) Drinking again - stressed by concern re mum and investigations she is undergoing. Discussion ++. Adv re-establish contact with alcohol support services. Has contact details. (4) Reports amenorrhoea.(mum had an early menopause). Has mild vasomotor symptoms. Cervical smear out of date. Will make appointment for smear.
20 min	Patient D attends with next of kin, has been self-harming. Hearing voices that direct her to 'cut herself'. Also sees visual hallucinations of deceased relative. Had contemplated taking an overdose several months ago but was held back by effect that this would have on her family. Had been attended by CMHT but lost to follow up when she failed to attend because

	of phobic anxiety symptoms. Has been binge drinking between half and a bottle of vodka weekly with alcohol free intervals between; **Outcome**: Rx diazepam 4 mg tid + thiamine tid –next of kin will supervise. Discussion +++ Refer CMHT. Appointment to be arranged via NOK.
20 min	Under major stress. Feels agitated and unsettled. Reports that he is living as main carer with his terminally ill relative (who is registered with another GP).Siblings help but are restricted by having young children. Ongoing GI symptoms with haemorrhoids ++. Has dyslexia and has had problems negotiating and explaining his absence from work to line managers. **Outcome**: explanatory comment added to med cert and 4 week review.
20 min	Under pressure because of benefits concerns re PIP. **Outcome**: advised to contact Money matters. Given a copy of medical summary. (2) Distressed+++ following recently unexpected death of sibling. Second sibling currently in hospital. Difficulty coming to terms with the bereavement. Discussion ++. Advised self refer CRUSE - given relevant information. Repeat medication reviewed.

	We have one blocked 10 minute slot per surgery which I find invaluable as there will always be at least one consultation which runs much longer due to the complexity/ multi-mobidity of the patients we are seeing. This morning an example of this was a man who has been found to have cancer and was due to have surgery. Before he came in I checked on clinical portal and saw that his pre-op MRI had identified metastases and so when he came in I was already aware that his surgery would have been cancelled. He was very upset but with the longer time available I was able to discuss lots of future planning/family support/financial issues and complete a DS1500 for him. At the time he had made the appointment he was not expecting to have been given a poor prognosis and the flexibility of a blocked slot allowed a longer discussion without being concerned that the whole surgery was going to run very late.

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

	on family discussed at length. Management strategies discussed and agreed for both individuals with goal setting, etc.

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

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

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

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

	services.
	Carer for husband with neurological problems and complex social history. Review in place as unexpectedly pregnant and s/b perinatal. However, miscarrying. **Outcome**: 1. antidepressant ISQ given pregnancy not continuing 2. support services available and aware patient group carer support. Signposted money matters to ensure carers benefits in place.
	Released from prison and required med 3, antidepressants, review of chronic sinusitis and reported "first fit" witnessed by cell mate. **Outcome**: extra 10 min "unbooked" slot within surgery allowed time for 1. Medication review 2. First fit history, assessment, referral 3. Previous attendance at ENT – reinstatement of medication and technique demonstrated nasal spray. 4 Homeless. Offered and declined involvement with homeless.

45min	Review of patient with multiple medical/social issues who had opted herself out of healthcare for many months. **Outcome**: review of all these issues (addiction, physical health, financial, housing, mental health, medication). Contacted her housing officer to clarify some of the issues raised and ensure being addressed as pt unclear.
1 hour	Assessment of patient with decompensated alcoholic liver disease. Multiple issues raised by patient and patient's partner regarding ongoing health issues, medication. **Outcome**: referred to DN for advice on pressure sores and continence pads. Needing weekly review at present.
1 hour	Home visit to housebound patient with mental health problems. **Outcome**: review of physical health but also whilst visiting found door entry system not working properly and therefore door not actually locking. Raised with social work and over the next week after speaking to 5 people this was eventually addressed. Would probably not have followed this up if I didn't have extra time.

1 hour	Home visit to very elderly housebound pt. Recent A+E attendance after fall at home and cellulitis diagnosed. **Outcome**: declined admission. Arranged review after receiving A+E letter. Review of physical health, medication, pressure sores. Community rehab team involved and new walking aid provided. Update of pts next of kin/POA details. Referral to DNs for skin care and provision of pressure cushion. Review for a week later arranged.
45 min	Review of patient with dementia with carer after carer reported a deterioration in condition. **Outcome**: review of social issues including financial concerns and carer signposted to local carers centre. Review of medication, discussion about mental health and started on antidepressant and agreed to referral to CPN. Referred for continence pads. Carer advised to seek advice on guardianship as no current arrangements.

1 hour	Home visit to patient with diagnosis of bowel cancer and who is housebound. **Outcome**: discussed at MDT as part of Govan SHIP and realised no contact with pt for some time and had had correspondence from hospital re ?recurrence. Polypharmacy review and bloods taken.
1 hour	Home visit to patient discharged from hospital to carry out review of medication, check on status now home and check managing as lives alone. **Outcome**: patient clearly struggling but denies further assistance. Updated records with current level of help, keysafe code for entry, next of kin details. Bloods taken due to meds change and poor hydration status.
45 min	Home visit to patient with long history of chronic pain/mental health issues. Recent exacerbation of mental health problems and referred as emergency to psychiatry; **Outcome**: review of current status, review of change in meds and home circumstances. Also discussion regarding lifestyle issues and trying to get out more, discussed further exercise referral to encourage activity although declined at present. CPN follow up now in place.

20 min	Polypharmacy review.
20 min	Polypharmacy review.
20 min	Polypharmacy review.

40 min	Polypharmacy review (housebound patient).
30 min	Polypharmacy review (patient with dementia).

	All my consultations are now extended to 15 minutes. This affords the time to deal with the presenting problem and ancillary issues, either on the patient's agenda or my own. Examples below:
	■ Patient F. IVDA, methadone, depression, alcohol and psychological problems. Counselling on alcohol and relationship problems. Hoped for outcomes are empowerment, improved self-worth, reduced risk of risky behaviours/self-harm/relapse
	■ Patient G, IVDA, under increased stress, trying to find a job. Long history of grief associated with mother's death. Hoped for outcomes are empowerment, employment, return to "normal" life, self-worth.Offered to act as character referee.
	■ Patient H, IHD, also has worries, COPD, smoking, dietary issues. Hoped for outcomes: lifestyle changes, with time to do it properly in an inclusive and non-condescending fashion.

45 min	Extended visit. Triple consultation with niece and sister. Still concerned for mental health since death of mother two months ago. Not going out or to work. Abnormal grief reaction.
30 min	Consultation for alcohol dependency. Young Mother. Husband

	sectioned and drinking again. **Outcome**: appointment arranged for support back to sobriety.
45 min	Extended visit. Early HV at request of district nurse. New unliteral oedma in patient previously refusing any input at all. **Outcome**: now engaged with DN and GP. Vulnerable adult.

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

45 min	Home visit with district nurse to patient E with self-neglect, leg ulcer and mental health problems.
1 hour	Further visit to same patient E who refuses to go to hospital in an ambulance. Several phone calls to ambulance HQ and hospital concerning this man.

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

Note

All of the above entries have been anonymised to protect confidentiality.