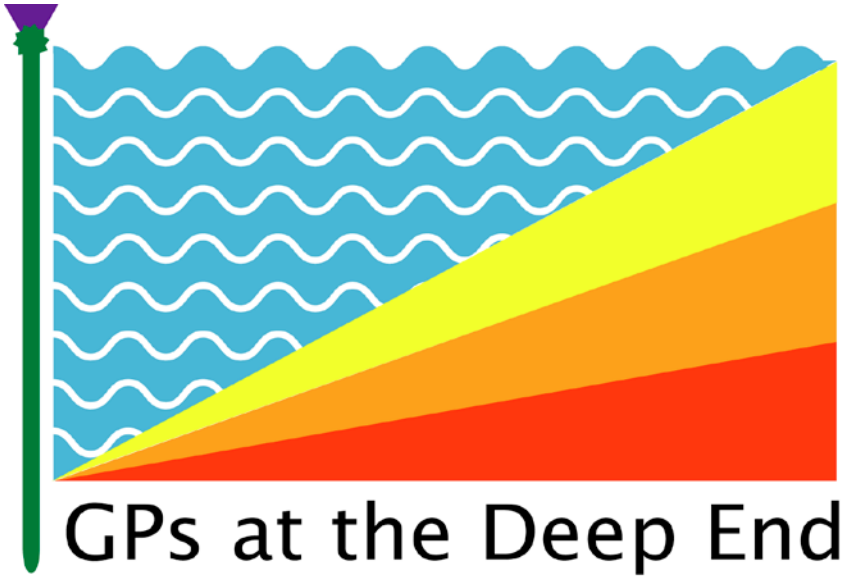


What can NHS Scotland do to prevent and reduce health inequalities?

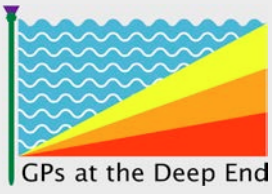
Proposals from General Practitioners at the Deep End

March 2013

Preventing and reducing inequalities in health are complementary activities in general practice

David is 14 months old. His 18 year old mum Sarah has had anxiety problems since her older brother hanged himself four years ago. She started college but left when she fell pregnant shortly afterwards. Sarah does not get on well with her mother, whom she accuses of drinking and “always shouting” since her brother died. Her mum says she is “mental” and a “teenage brat”. Sarah relies heavily on her own gran Margaret. Aged 50 she has moderately severe COPD (emphysema) and continues to smoke. Margaret has had several chest infections recently and is struggling to cope with Sarah's often strange behaviour and with a lively toddler for whom she is the main caregiver.

For David the next two years, as he learns to walk, talk and interact, will have a huge effect on the rest of his life. Early years interventions such as parenting classes may be important, but on their own will fail to change his life opportunities. He will need supportive neighbours, a good nursery and adequate family income, but also optimal COPD nurse reviews, responsive alcohol and mental health services, good communication with social work, persistent contraceptive advice and smoking cessation support, to name a few. At the hub of these lies the primary care team, offering unconditional care and the possibility of trusted relationships over the span of David’s life.



“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.*

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CONTENTS

General Practitioners at the Deep End serve the 100 most deprived general practice populations in Scotland. The views expressed in this paper are based on a series of 18 meetings and reports, and have been collated by the steering group, meeting 27 times between 2009 and 2013. With the exception of one daytime meeting, the steering group has always met in the evenings, after long days in practice.

STEERING GROUP

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Georgina Brown	GP, Springburn Health Centre (to Dec 2012)
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Susan Langridge	GP, Possilpark Health Centre
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SUMMARY

- 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.

OVERVIEW

The principal causes of inequalities in health lie outside the health service, which is why policies to prevent health inequalities must address the wider social determinants of health. It is not sufficient, however, to ***prevent future inequalities*** in health. It is also necessary to ***reduce existing inequalities*** in health, and to ***prevent them getting wider***.

Inequalities in health are an ever present fact, with healthy life expectancies of 57 and 61 years for men and women in the most deprived tenth of the Scottish population, compared with 76 and 78 for men and women in the most affluent tenth [1]. The NHS can do a great deal to improve health in the former group by helping people to live well, preventing or postponing complications, reducing the use of emergency care and, in general, reducing the severity and progression of conditions [2].

The flat distribution of general practitioners in Scotland, in contrast to the steep social gradient of health needs [3], combined with often dysfunctional links between general practice and other parts of the NHS, are principal causes of the inverse care law in Scotland, providing not only a partial explanation of 20 years of failure in addressing inequalities in health, but also a major obstacle as NHS Scotland searches for effective, affordable ways of delivering integrated care for the increasing numbers of people with multiple health and health-related problems.

This set of papers from General Practitioners at the Deep End imagines how NHS Scotland could and should address the inverse care law, reducing the consequences of inequalities in health for individual patients and narrowing social differences in life expectancy. The central and most urgent measure is additional time for patient encounters. Other measures are also necessary, however, as described in a series of position papers.

Change cannot be achieved by Deep End practices on their own, nor can the situation be addressed by top down measures, with incomplete knowledge of local circumstances, or a lot of single projects each addressing only part of the problem. General practice improves health principally via the unconditional continuity of care that is provided for all patients, especially patients with multimorbidity, whatever combination of problems they may have. There is an urgent need to increase the volume, quality and range of services provided for such patients.

Resources are a central issue, and a fundamental test of political will to address the inverse care law in Scotland, but there is also a challenge in how the NHS deploys its considerable resources to best effect. The principles of co-production, including mutuality and trust, apply not only to long term relationships between patients and practitioners, but also to relationships between general practices and other services, and to the relationship of leaders working at the top and bottom of NHS Scotland.

This set of proposals is based on three premises:

1. Well coordinated continuity of health care makes a substantial difference to the lives and life expectancy of people with multiple health problems.
2. The arrangements and resources for integrated care in NHS Scotland should reflect the epidemiology of multimorbidity, including its earlier onset in deprived areas.
3. To avoid widening inequalities in health, the NHS must be at its best where it is needed most.

We propose an integrated package of measures addressing the following issues:

1. The higher prevalence of multimorbidity in deprived communities compared with less deprived communities in Scotland.
2. The special features of health need in deprived areas, especially the higher prevalences of vulnerable families and people with mental health and addiction problems.
3. The lack of clinical capacity in general practices serving deprived areas to address patients' problems.
4. The fragmentation of care arising from dysfunctional links between general practices, area-based services and secondary care.
5. The general disconnection between primary care teams' knowledge and experience of patients and their use of community resources for health.
6. The lack of opportunity for primary care teams working in local areas, or serving similar types of population, to share experience, views, best practice and service developments.
7. The failure of many centrally-led NHS initiatives (including top-down policies, HEAT targets and screening programmes) to engage effectively with general practices.
8. The paucity of research evidence that applies to most of the work of general practice teams working in very deprived areas (only 12% of encounters involve a condition covered by the Quality and Outcomes Framework) and the need to produce relevant new evidence.
9. The low profile in very deprived areas of most central NHS support organisations.
10. The training and continuing professional development needs of health practitioners working in very deprived areas.
11. The need for leadership development within practices, practice clusters and localities.
12. The need for a new relationship between NHS leadership at area and practice level, based on mutual understanding, accountability and respect.

The intrinsic strengths of the system of general practice within NHS Scotland are patient contact, population coverage, continuity, flexibility, cumulative knowledge, long term relationships and trust. The system of complete and non-overlapping patient registration provides the only basis for NHS Scotland to assess progress in providing care for 100% of the population.

General practice is not the only part of the NHS which has these characteristics, but is the main way in which the essential features of population coverage and continuity are achieved for most patients. Practices are natural hubs, therefore, around which local services should develop.

Most of the above issues, especially multimorbidity and the fragmentation of care, apply to most general practices in Scotland, differing only in degree. It is axiomatic that many of the following proposals should be applied not only in very deprived areas, but also pro rata across the country.

The significance of the "Deep End", comprising the 100 most deprived general practice populations in Scotland, is that if health care is not at its best where needs are greatest, the net effect of NHS Scotland is, and will continue to be, to widen health inequality.

While there are specific issues to address, such as the high prevalence of vulnerable families, the principal challenge of the NHS in very deprived areas is to increase the volume, quality and range of services provided for patients.

By providing unconditional continuity of care for all patients, whatever problems or combinations of problems they present, general practice can improve health, prolong independent living, prevent or postpone the use of emergency services and narrow health inequalities.

The challenge for health practitioners is to work in partnership with patients, "initially face to face, eventually side by side", increasing patients' knowledge and confidence, both in living with their conditions and accessing available resources and services.

To these ends, we propose the following measures:

1. Additional time for consultations with patients, including targeted appointments for the neediest patients (Annex A).
2. Support for serial encounters and the productive use of long term relationships.
3. Attachment of staff from area-based services (social work, mental health, addictions, child health) to general practices or groups of practices, on a named basis (Annexes B and C).
4. A national enhanced service for practices to address the needs of vulnerable families (Annex D).
5. Development of a lay link worker role connecting practices and patients with community resources for health (Annex E).
6. Support for training (Annex F) and leadership development within and between practices and linked to locality planning (Annex G).
7. Protected time for practices to share experience, information, learning and activity on a cluster basis, following the examples of the Primary Care Collaborative and Links Project (Annex G).
8. A new partnership between leadership at the top and bottom of the NHS, based on mutual understanding, accountability and respect.
9. Evaluation and research based on and informing the person-centred work of general practice, especially in very deprived areas (Annex H).
10. A greater focus by all central NHS agencies on the support of general practices serving very deprived areas, beginning with an audit of what these agencies currently do in very deprived areas.

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THE INVERSE CARE LAW IN SCOTLAND AND ITS CONSEQUENCES

1. **The distribution of NHS resources should better reflect the epidemiology of multimorbidity in Scotland, including its earlier onset in deprived areas.**

   A recent *Lancet* paper [1] showed that:

   - Multimorbidity (2 or more conditions) is the norm in Scottish patients over 50.
   - Although multimorbidity is most common in older people, most people with multimorbidity in Scotland are under 65.
   - Multimorbidity occurs most frequently in deprived areas, 10-15 years earlier than in affluent areas.
   - There are only small differences between affluent and deprived patient groups in the prevalence of multimorbidity over 80 years of age.
   - The most common co-morbidity in deprived areas is a mental health problem.

   Further analyses of the primary care data on which the *Lancet* paper was based shows that the prevalence of multimorbidity in general practices serving the most deprived fifth of the Scottish population is about ***one third higher*** than in practices serving the most affluent fifth of the population. Although there are more elderly patients with multimorbidity in practices serving affluent areas, the numbers are fewer than the numbers of middle-aged patients with multimorbidity in practices serving deprived areas.

   It is important to note that these epidemiological studies, describing multimorbidity in terms of two or more medical conditions, are likely to ***underestimate*** the frailty associated with multimorbidity in old age and the social problems associated with multimorbidity in deprived areas [2].

2. **Better integrated care for patients with multimorbidity and complex social problems can prevent or postpone emergencies, improve health and prolong independent living.**

   Modern health care improves population health, not only via the mass delivery of evidence-based medicine, as incentivised by the Quality and Outcomes Framework (QOF) of the general practitioner contract, but also via the ***unconditional*** continuity of coordinated care provided for all patients, but especially for patients with multiple problems, whatever combination of problems they may present.

   While there is high quality evidence of the effectiveness of many clinical interventions for single conditions (as in the QOF), there is much less evidence concerning the effectiveness of integrated care for multimorbidity. A major reason for this is that until recently there has been very little research on multimorbidity. Patients with multimorbidity have been largely excluded from most of the studies on which the QOF is based.

   Practice Team Information (PTI) data from the Information Services Division (ISD) show that only 12% of patient encounters in general practice concern QOF conditions [3]. Other Scottish data, published in the *Lancet*, shows that for all QOF conditions, patients with only that condition and no other comprise a minority of patients [1]. Clearly, the QOF provides too narrow a focus to address the multiple problems of patients with multimorbidity.

It is axiomatic that ***fragmented care*** for patients with multimorbidity (e.g. involving selective approaches to patients' problems by professionals with little prior knowledge of the patient, with insufficient time to address patients' problems, with poor links to other professions and services and with no commitment to what happens next) is a potent recipe for premature use of emergency medical services.

In a recent study of PTI data, 10% of patients with four or more co-morbid physical conditions accounted for 34% of patients with unplanned admissions to hospital and 47% of patients with potentially preventable unplanned admissions to hospital [4]. This study vividly shows the combined effect of deprivation, physical multimorbidity and mental illness on unplanned hospital admissions in Scotland, including admissions that could potentially be prevented if general practice in deprived areas were adequately resourced.

High quality personalised care for patients with multimorbidity improves life expectancy by preventing, delaying and reducing the complications of established disease conditions and risks. By definition, this approach can do little to improve healthy life expectancy i.e. prolong the period when individuals are free of illness. In practice, however, contacts with patients and their families provide many opportunities for primary prevention, in addition to dealing with established problems.

The strength of the general practice model is that it is the ***only part of the NHS with regular and continuing contact with almost the whole of the general population***. These contacts are almost always based on patients presenting with current health problems. Opportunities for preventive activity arise when current problems have been dealt with, when additional time is available and when both patients and practitioners have raised expectations.

The high prevalence of multimorbidity in deprived areas provides an important opportunity for the NHS to prevent, postpone or reduce the complications of these conditions, to improve health, to reduce the need for emergency services, to prolong independent living and to reduce health inequalities. NHS Scotland fails to do this, as well as it could, as a result of the inverse care law.

3. Policies to address inequalities in health in Scotland must address the inverse care law, whereby general practitioners serving deprived areas have insufficient time to address patients' problems.

It is recognised that many health improvement initiatives may have widened inequalities in health as a result of differential uptake by different social groups [5]. The same perverse process applies to routine NHS care and is exacerbated by the inverse care law.

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

The principal cause of the inverse care law in Scotland is the flat distribution of GP manpower which is independent of the steep social gradient in need [6].

The inverse care law is explained not by good medical care in affluent areas and bad medical care in deprived areas, but by the difference between what primary care teams are able to do in deprived areas and what they could achieve if they were better supported.

Deprivation increases in a stepwise fashion across deciles of the Scottish population with the largest step increase between the ninth and tenth deciles.

Independent health measures show a steep associated social gradient in prevalence with a greater than 2.5 fold increase across deciles of the Scottish population, from the most affluent to the most deprived.

On average, deciles of the Scottish population comprise 535,015 people, served by 105 general practices including 353 whole time equivalent (WTE) general practitioners.

Despite the steep gradient of need, the total WTE of general practitioners, including non-principals and doctors in training, is 11% higher (437.1 v 392.0 per decile) in the more affluent half of the population (deciles 1–5) than in the more deprived half (deciles 6-10).

These published GP WTE data come from 2003, the last occasion when it was possible to obtain such data based on a complete national sample. Since then the NHS has contracted with practices rather than individual GPs, with the effect that data on GP whole time equivalents are no longer available.

Subsequently, and as reported in Audit Scotland's report *Health Inequalities in Scotland* [7], data on GP WTE have been collected by a voluntary survey, which is by definition incomplete, was last carried out in 2009 and provides data on numbers of GPs not WTEs. The 2009 data confirm the generally flat distribution of GPs in the most deprived four quintiles, but also shows an unexpected and unexplained reduction in the number of GPs in the most affluent quintile. It is likely that the 2003 data provided a more comprehensive and accurate picture than more recent surveys. There has been no substantial attempt to address this issue in the interim. (see footnote)

Consultation rates

Recent PTI data [3] show a pattern of increasing rates of face to face consultations with either a GP or nurse, with age and deprivation, which mirrors the pattern of multimorbidity reported in the *Lancet* [1].

When these PTI consultation rates, divided by age and deprivation quintile, are applied to the 957 general practice populations in Scotland in 2012, it is estimated that practices serving the most deprived fifth of the population provide ***15% more consultations*** per 1000 patients per annum than practices serving the most affluent fifth.

This figure masks the extent to which, within practices serving the most deprived fifth of the population, there are higher consultation rates in the most deprived decile (i.e. the Deep End), compared with the next most deprived decile.

Limitations of PTI data

PTI data come from only 60 Scottish general practices, but these practices are considered to be broadly representative of the Scottish population, and include six practices serving the most deprived tenth of the population (the Deep End).

It is important to note that these data provide little information on the content of consultations, especially the high prevalence of psycho-social co-morbidity which lengthens the time it takes to engage with patients and to address their problems.

PTI data provide no information on unmet need (i.e. the extent to which the number, duration and content of consultations would increase if current resource constraints were lifted).

PTI data take no account of telephone consultations, nor are data available on the WTE numbers of GPs and nurses available within PTI practices to provide consultations.

As practices serving deprived areas have no extra resource, in terms of GP manpower, the observed increase in consultation rate is presumably achieved by a combination of working longer hours and providing shorter consultation times.

Effect on consultations

A study of 3000 GP consultations in the west of Scotland (comprising a narrower social range than Scotland as a whole) illustrated the consequences of the inverse care law for the content and outcome of consultations in deprived areas, which were characterised by [8]:

- Multimorbidity and social complexity.
- Shortage of time.
- Less patient enablement, especially of patients with mental health problems.
- Practitioner stress.

Average consultation times were 8.2 minutes in deprived areas and 8.6 minutes in affluent areas, with more consultations lasting 6–9 minutes and fewer lasting more than 15 minutes in deprived areas.

4. As populations age and multimorbidity becomes more common, the long term challenge for all health care systems is to support patients to become more knowledgeable and confident in living with their conditions and in making use of available resources, for routine and emergency care.

Policies to encourage self-help and self-management by patients often imply that this is a minimal intervention, which quickly transforms patient behaviour. The reality is that reversing years of low expectations can be a long haul, "initially face to face, eventually side by side" [9]. In the large study of consultations described above, an essential ingredient was patient perception of practitioner empathy. While practitioner empathy was often reported by patients without enablement, patient enablement was never reported without practitioner empathy [10]. "Co-production" implies long term relationships between patients and practitioners who know each other well [11].

In the same way that Antonovsky's theory of social coherence, based on comprehensibility, manageability and meaningfulness [12], provides a basis for coping with stress throughout life, these attributes are particularly important for people struggling to cope with multimorbidity and its many practical and emotional implications.

5. The need to develop better systems of integrated care is common to all parts of the NHS, but is especially urgent in very deprived areas if widening of health inequalities is to be avoided.

It is axiomatic that if the NHS is not at its best where it is needed most, the net effect of NHS activity will be to widen inequalities in health.

6. **The intrinsic features of general practice in the NHS, which make practices the natural hubs of local health systems, include patient contact, population coverage, continuity of care, flexibility, long term relationships, cumulative shared knowledge and trust.**

   Additional time for GP consultations is essential but insufficient. Our package of proposals concerns how general practices can work more effectively with other professions, services and organisations, using the intrinsic contact, coverage and continuity of general practice as the hub of local health systems. In general, the NHS has too many hubs and not enough integrated working with patients at the centre. The intrinsic features of general practice make it the natural hub of care for most patients.

7. **The key delivery mechanism for integrated care is the serial encounter, mostly with a small team whom patients know and trust, but also involving other professions, services and resources as needs dictate.**

   General Practitioners at the Deep End would welcome an end to short term health improvement initiatives, employing a screening approach, emphasising the start of processes rather than their continuation, and invariably achieving incomplete coverage (describing patients as "hard to reach") and follow up. General practice has coverage and continuity but lacks the time and links to make effective use of the contact it already has.

A package of measures

To address these issues, we have proposed a package of measures to address the challenge of meeting the needs of patients in very deprived areas [13]:

1. ***Additional time*** is needed to address patients' problems. There is a variety of ways by which such additional time could be provided.
2. There is a need to establish best practice as to how ***serial encounters*** are used to improve patient's health.
3. Local systems of care should be based around the natural and sustainable **hub function** of general practices (combining contact, coverage and continuity), involving attached workers from area-based services (e.g. mental health, addictions, health visiting, social work) and link workers for joint working with community organisations.
4. There is a need for ***better connections across the front line***, connecting local general practice-based systems addressing the same challenges in different settings, sharing experience, views, activity and learning.
5. NHS support systems should be better aligned and coordinated to support the activities of practices in the front line, as an integrated ***learning organisation***.
6. The development of local health systems based on general practice hubs requires ***leadership*** both at practice level and at area level. Both types of leadership need to be supported and to work productively together.

Resources are a central issue, and a fundamental test of political will to address the inverse care law in Scotland, but there is also a challenge in how the NHS deploys its considerable resources to best effect. The principles of co-production, including mutuality and trust, apply not only to long term relationships between patients and practitioners, but also to relationships between general practices and other services, and to the relationship of leaders working at the top and bottom of NHS Scotland.

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Footnote

Following the Audit Scotland report, the chief executive of NHS Scotland is on public record, giving evidence to the Public Accounts Committee [minute of meeting on 19 December 2012, col 1083] that "there are around 25 to 30 per cent more GPs in the most deprived areas than in the least deprived areas". This remark appears to depend on the unexpectedly low and unexplained figure for affluent areas. It is not known whether this statistic, based on reported numbers of GPs and not whole time equivalents, is correct, reflecting fewer part-time GPs in affluent areas, or an artefact, based on incomplete reporting, but it provides a very weak basis for contesting the existence and consequences of the inverse care law in Scotland.

ANNEX A
Additional time for patient encounters

What type and scale of intervention is needed?

Available data are insufficient to propose a specific formula to redress the inverse care law. This paper is illustrative and not definitive.

NHS Scotland spends about £710 million annually on general practice services. On a simple pro rata basis, General Practitioners at the Deep End working in 100 practices serving 8% of the Scottish population, receive at least £57 million per annum. The issues addressed in this paper cannot be addressed effectively by small projects, involving tiny shifts in funding.

In keeping with the principle of proportionate universalism, resources should be provided pro rata according to need. Simply targeting the most deprived areas will not reduce the overall problem of inequalities in health. All of the recent epidemiological studies cited in this paper show that social gradients are continuous across the social spectrum. Although the greatest increase in the prevalence of ill health is observed between the 9th and 10th decile [1], there is no clear cut-off point. Formulae for resource distribution should reflect this.

Providing integrated care for patients with multimorbidity should be supported as a core practice activity, and not as a bolted-on additional activity. The focus should be on sustainable development, with an emphasis on continuity and the productive power of long term relationships. New initiatives should be funded for at least three years, with ongoing evaluation and protected time to allow shared learning.

In *Treating Access*, RCGP Scotland reports that the average patient consultation rate in Scotland in 2008/09 was 62 consultations per 1000 patients per week, while suggesting that 70 is a more realistic figure [2]. The general practice serving the most deprived population in Scotland offers 80 face to face GP consultations per 1000 patients per week, This very hard pressed practice also deals with an average of 56 telephone consultations per 1000 patients per week, saving on face to face consultation times, but adding a substantial workload to the practice.

With the expanding fragmentation of primary and secondary care, and patients presenting with increasingly complex medical and social issues, a significant amount of time is now spent on case management outwith surgery times. Clinicians liaise with secondary care, midwives, health visitors, district nurses, school nurses, addiction workers, social workers, rehabilitation teams, community projects, counselling services and benefits advisors. Peer support via practice based learning (or local groups of practices), networking with projects and case discussions, are vital to ensure a consistent and effective practitioner approach towards patients.

From this experience, we recommend a model that acknowledges the higher demand for appointments and the time required for case management. It can be demonstrated that working in this way in an area of highly concentrated deprivation (88% of patients living in the 15% most deprived datazones) equates to an additional four-hour session of GP time per week per 1000 patients living in very deprived areas.

Pro rata support is needed for practices serving areas with lower levels of deprivation, not only within the Deep End, where the proportion of patients living in

the 15% most deprived Scottish datazones ranges from 88–44%, but also in practices serving lesser degrees of deprivation, from 0–44%.

For illustrative purposes, a practice with 88% (i.e. 2715) of its 3085 patients in the most deprived 15% of datazones would receive 2.7 additional GP sessions per week, while the 100th most deprived practice with 44% of its 6687 patients in this category would receive 2.9 additional GP sessions.

On average, about 60% of patients in the 100 Deep End practices live in the 15% most deprived Scottish datazones. With an average list size of 4,300, it may be estimated that the average number of patients living in very deprived areas is about 2580, resulting in an average of 2.6 additional sessions of GP time per week.

At an approximate rate of £210 per session, the average cost per annum would be £28,392 per practice i.e. £2.8 million for the 100 most deprived practices. On the same basis, the next 100 most deprived practices, with an average list size of 5128, of whom an average of 1949 (38%) live in the most deprived 15% of datazones, would receive additional support costing £2.1 million.

The figure of £2.8 million per annum for the most deprived 100 practices equates to less than a 5% increase in expenditure on general practice in these areas.

This is a modest proposal, well below the level needed to equate GP manpower with need, in recognition that additional GP capacity is not the sole solution and needs to be complemented by the other measures proposed in this report.

There are two models for how such additional time should be used. The first uses the additional time to leave every fourth surgery appointment free, so that the time can be used on an ad hoc basis, as patients present, addressing patients' needs and reducing stress on practitioners.

The second model is being evaluated in the Care Plus study, in which practices use additional time to focus on selected patients, with high levels of need and service use.

Practices should opt for whichever approach, or combination of approaches, they prefer, but practices following similar approaches should be linked (on a similar basis to the Primary Care Collaborative and Links Projects), for joint working and shared learning. The results of the Care Plus study should help to establish realistic outcome measures, by which the new approach may be evaluated.

There are several possible mechanisms by which additional GP time could be provided, including the GP assistant scheme, as used for remote and rural areas, and a GP fellowship scheme (See Annex H). These are preferred to simple locum costs, as they provide a more integrated and sustainable approach, building capacity for the future.

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ANNEX B
Stepped approach to engagement for attached workers in general practice

Introduction

The model of engagement that follows is derived from what is already normal practice for many health and social care professionals who work with vulnerable patients. For example assertive outreach contacts are used in community addiction teams, community mental health teams, social work teams and specialist homelessness health teams with patients who struggle to engage with services. This model sets out both an ethos and a structure of working for attached workers in general practice. The evidence base comes from a number of health research fields. It is intended as a generic model that is recommended for any attached worker working with patients with complex medical or social needs in general practice. It is assumed that the general practitioner has a role in gatekeeping which patients are referred to attached workers and also that they will have an ongoing role in monitoring direction and progress alongside the patient and attached worker.

Ethos

1. A clear commitment from the attached worker to work with the patient for an agreed period of time in a collaborative manner that works from the patient's agenda [1–2].
2. Relationship building, assessment of priorities and planning for positive change takes time and engagement with the patient may require stepping up and down over time depending on the patient's needs [1–3].
3. Continuity of relationship and boundaries of care are important both for the patient, worker and GP for attached worker input to be successful [2–3].
4. Careful attention to joint working with other services is required [1–2]. The advocacy role of attached workers and fostering links with other services will strengthen communication and the hub role of general practice.
5. The expectation is that having attached worker input will decrease GP contacts for many patients and increase contacts for some (appropriately). The worker would be clear about the remit of the GP and they would work collaboratively with the patient to utilise this appropriately.

Structure

1. Identify the most appropriate attached worker that best meets the patient's needs, discuss this with the patient and reach agreement they will accept a trial of this support.
2. The key to initial engagement with a worker is becoming known to the patient and building trust. A stepped approach is as follows:
   - Offer an appointment at the surgery by letter.
   - If patient does not attend, use assertive outreach; phone the patient and offer a further appointment or a home visit.

- Make a number of attempts to phone and visit the patient (number of attempts dependent on patient's perceived vulnerability).
- If repeated attempts at home visits fail, patient is flagged on the practice computer system and with receptionist. When next they make an appointment to see GP, attached worker then also attends GP appointment. Patient, worker and GP discuss future working collaboratively. The GP re-endorses their support for attached worker input at this time.
- The tone of the engagement approach is important; friendly concern, collaborative interest.
- If all of the above results in non engagement and the patient does not wish support at the present time, leave 'open door' for this option in the future and the GP to broach with the patient at future appropriate opportunities.

Evaluation and development of best practice

1. A formal evaluation of the model of engagement with attached workers in general practice is recommended and should be built into the overall evaluation of attached worker programmes in the Scottish NHS.
2. Protected learning time should be funded for GP practices and attached workers to bring complex cases for discussion and learning within small groups. This would encourage problem solving, sharing of good practice and would feed into professional development for all professionals involved.

Implications for Scottish general practices

All practices include patients with complex health or social care needs. Prevalence varies according to practice setting. The focus of the Deep End Project has been on settings of concentrated socio-economic deprivation but this approach is likely to be of proportional benefit in settings of pocket deprivation too. Hence many practices may benefit from an attached worker resource weighted by need and using this model of engagement to meet their patient population requirements.

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ANNEX C
Proposal for attached alcohol workers

There has been a persistent and consistent call for named practice-attached addiction workers throughout the life of the Deep End to date [1]. Concern has been particularly expressed with respect to support for those with predominantly alcohol problems due to the massive unmet need in the areas of greatest deprivation in Scotland. Alcohol related hospital discharges were 7.5 times greater in the most deprived areas compared to the least deprived areas in 2009/2010 [2]. Drug services have been better resourced than alcohol services even though referral rates are 1:3 respectively. [3] Those with alcohol problems have been relatively neglected. The current political determination to introduce a range of public health measures including minimum pricing for alcohol is welcomed but needs an associated improvement in service provision for those with alcohol problems. The caseload of community addiction teams (CATs) in Glasgow is thought to cover about 40% of people with alcohol problems, which leaves about 60% using other services including general practice [3].

Within addiction services the focus for an individual worker is either alcohol or drug misuse. Through GP methadone clinics, links are often already established with a drug worker and they are attached to a specific practice for a specific clinic. There is no such linkage for those with alcohol problems. The services available are not in the same building, stigma may be attached to attending the local community addiction team and significant motivation is required to enable patients to contact other community alcohol services. It is vital that help and support is made as accessible as possible when a patient presents with an alcohol problem.

GP workload may be eased if an appropriate worker is able to engage with the individual and enable progress. (Contact rates with the GP can also rise as sobriety brings other health problems to the fore but at least progress is being made.)

A practical proposal for a practice attached alcohol/ mental health worker would be as follows:

1. **Expertise/skill set** – worker with expertise in working with those with alcohol problems. Their role would be similar to that of the current drug workers attached to GP methadone clinics but dealing with alcohol problems and any other issues that arise as a result – they could become key worker for that individual. (GP is still the care manager). This role is currently being provided through the Community Alcohol Support Services (known as CASS within Glasgow Addiction Services e.g. Glasgow Council on Alcohol (GCA) and Addaction). There is not an equivalent role within the Community Addiction Teams (CATs). There the alcohol workers are generally CPNs who focus on detoxes and after care.
2. **Employed by the local addiction services** – either Community Addiction Team (CAT) or by Community Alcohol Support Services (CASS) but managed in conjunction with the local GPs.

   Current model for this in primary care is the health visitor and the district nurse. Both are attached to specific GP practices and are responsible for the care of the patients of those practices as needed. They are employed by the Health Board (and line management is within the Health Board.)

   Similarly the practice attached alcohol worker would be attached to specific practice(s) (depending on numbers) and employed and managed by the

local addiction team (with GP involvement). This ensures that the worker is part of the established team in the area and has access to the knowledge of local services and is thus able to link patients in to other services.

3. **Place of work** – see patients on practice premises or at home visits. Active follow up and engagement encouraged as detailed in the Deep End proposal on engagement for attached workers. (Only if space does not allow should it be accepted that patients would be seen elsewhere but the specific worker and practice need to work to develop and maintain strong links). "Collocation" of services is vital when we are asking for practice attachment.
4. **Mode of working** – as per QATS [4] – "Tier 2 interventions" which specify open access and outreach - providing alcohol specific advice, information and support, extended brief interventions and assessment and referral of more severe and complex problem users to CAT/ CPN for detox. Other issues that will arise such as comorbid mental health problems and child protection – the worker would need the level of expertise to recognise, refer on appropriately and ensure engagement.
5. **Numbers required?** How to decide on worker/practice ratio? Would need to consider list size and prevalence figures. (Current service providers could help here.)
6. **Funding** would need to be targeted and clearly allocated for this role. Specific funding for mental health services. – *This works already within the CATs in drug misuse. The CATs provide drug workers for GP methadone clinics. These workers have often established good links with practices and their patients. Frustration arises when drug workers are moved elsewhere and established relationships, knowledge and experience are lost*.
7. **Accountability** – resource is managed by the local addiction service with local GP input. This needs to be funded in the form of locum cover for all recruitment/ management and ongoing engagement with the attached worker. This aims to ensure that the service is being provided and used as effectively as possible. Outcome measures – what level of engagement has been achieved with the most deprived population?
8. **Minimum three year pilot** – in Deep End practices initially, with a view to developing a model that would be transferable to other practices particularly those with "pocket" deprivation. Importance of continuity means that any pilot has to be a minimum of three years with presumed longer term commitment thereafter (also recommended by QATS [4]).
9. **The next step**, at a local level, would be to discuss this proposal with Glasgow Addiction Services and the relevant Alcohol and Drug Partnership. At a national level, funding for this service development must be sought.

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ANNEX D
Vulnerable children and families

Current thinking

It is uncontested that vulnerability in early years and beyond impacts adversely on child and adult physical and psychological dimensions of well-being. [1–2] A conservative estimate of the economic cost of the vulnerable child to society in the UK is £735 million annually [3].

Where is general practice?

The Deep End manifesto and reports on vulnerable families [4–5] clearly outlined the contribution that general practice can make to safeguarding children and families. GPs contribute to the process of ongoing family assessment and support [6–7] and are well placed to understand the specific challenges that result in the vulnerable family and the vulnerable child [8].

A skilled and long term professional relationship, built on trust, that provides a low-level of inquiry into the circumstances of the vulnerable family [9] is key because vulnerable parents are often avoidant and suspicious of supportive services [10]. Furthermore, the majority of vulnerable children will not meet sufficient thresholds of harm or endangerment that will trigger formal child protection proceedings [11].

The Deep End has consistently highlighted the 'multiple jeopardy' that economically poor and disadvantaged families face [12] with poverty an enduring characteristic of families who would be considered vulnerable. The Deep End recognises the clear association between disadvantage with social class and adverse effects on child health in the first 10 years of life [13] with increased mortality rates [14]. The impact of poverty and the accumulative effect of negative factors on health outcomes of vulnerable children are highlighted in the Deep End Austerity Report [15]. This publication contextualises current research concerns to real-life narratives of vulnerable families who are living within the constraints of swingeing cuts across health and social care budgets.

That said, knowing and stating our contribution to supporting children and families is of limited value if general practice does not have the strategic support within policy directives and contractual obligations to undertake this challenging area of health care.

Current policy – is it collective and inclusive?

Whilst we welcome the acknowledgement of the role of the GP in Scotland's national child protection framework [16] and the RCGP child health strategy [17] this is not replicated in other important policy directives. For example GIRFEC, whose ethos is at the heart of government policy in ensuring that all children in Scotland are 'safe, healthy, achieving, nurtured, active, respected, responsible and included' [18–19] and the National Parenting Strategy [20], do not mention GPs. This is disappointing given that the newly instated 30-month child development check will address issues of 'child development and physical health, parenting capacity and family matters including domestic abuse and parent-child relationships, along with

wider parental health such as smoking, alcohol or drug abuse, and mental and physical health' [20]. It is obvious to the Deep End group where the obligation to general practice provision lies in addressing this agenda.

Given that there has been a noticeable decline in preventative child health care in general practice since the implementation of 'Hall 4' [21], the Deep End have advocated for a National Enhanced Service for Vulnerable Families (NES). This approach will not diminish the reach of a universal child health care system but recognises the need to reduce disadvantage in vulnerable families by developing services according to the needs of the community.

How would the proposal work, both internally within practices, and externally in practices' relationships with others?

The NES is a collaborative model that promotes organisational learning where all involved professionals meet regularly to discuss their vulnerable children caseloads.

It is hypothesised there would be immediate gains in terms of improved health outcomes and consistent support for vulnerable children.

The NES would build on the work that is already done in some GP practices where GPs have regular and minuted meetings with their health visitors but it remains 'unofficial' as there is no contractual requirement to do so. Across practices the NES could be the basis of a protected learning event to disseminate results (similar to the COPD pilot in the South Glasgow CHP) and would include other relevant professionals in the learning agenda.

The attached social worker is not a new idea for general practice and many practices have positive experiences of working with a named social worker across health and social care domains. It would seem axiomatic that the unmet needs of vulnerable children and families require that both professions collaborate but there is a paucity of evidence of effective practices in complex families where health and social care professionals have intervened [22].

The NES provides the mechanism to improve a positive working environment where professional roles are clarified and shared understanding of the language of vulnerability is achievable. It also begins to address a pressing need to meaningfully research the complexity of child welfare outcomes in 'real world' situations [23].

How would progress be consolidated, with practices learning from each other?

A rolling programme of protected learning events funded through the CHP structure. There is a learning coordinator within each CHP (these appear to be new posts but are welcome if they have this remit). Of equal importance is recording the long term outcomes of vulnerable children that would require substantial investment in preventative health care and would provide a robust research database.

How would individual practices and groups of practices be accountable for the additional resource?

At present there is no mechanism for GPs within CHPs to be directly responsible for monies spent. Financial sector spending would have to be carefully evaluated with appropriate management support and would require robust accountability and governance structures.

Is the proposal for all practices, with each being resourced pro rata according to need, which could be taken forward within local areas; or something for Deep End practices only, requiring a network approach?

This would not be exclusive to Deep End practices as the NES is embedded within the principles of universal health care for children. Realistically, it would be anticipated that the strong influence of poverty on child health outcomes and vulnerability would ensure a greater proportion of vulnerable children would be identified within Deep End practices. Nonetheless, the NES would be relevant to all practices in Scotland.

Who are the significant partners/funders and how can they be influenced?

SG, HBs, health and social care professions. There is an expectation that SGPC and the BMA will acknowledge the call for greater emphasis on child health matters within the forthcoming contract negotiations. This would reflect the profession's aspiration for an improvement to the structure of child health care provision in general practice and primary care. This is envisaged under a broader approach of child safeguarding that at present remains patchy and inconsistent.

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ANNEX E
Practice-attached community link workers

Background

Many health disorders develop in the context of personal, domestic, economic and social problems. These may be presented by the patient as their primary problem, or the health care team may be aware of these in the background or they may lie unrecognised behind a range of health issues.

For GP practices working in areas of high socio-economic deprivation these problems are not just more common but are amplified. For example a person coping with very low income and unemployment is also more likely to be a witness to violence, have experience of early bereavement or suicide among relatives or acquaintances or be exposed to disruption in the home setting. These have a dark synergy in creating a pervading sense of hopelessness.

Most GPs develop strong long term relationships with patients in difficulties, and for many patients this supportive relationship is their main, or indeed only, source of help. Other current responses to these wider problems consist of pharmacological therapies (widely used and often expected by patients), stress reduction strategies, often with referral to stress centres, addictions support, often with referral to Community Addiction Teams and cognitive therapy, sometimes with referral to Primary Care Mental Health Teams (although access to this may be limited). These responses are important and necessary but insufficient to adequately address the problems of existential alienation, anomie and lack of self determination which are rooted in the post-industrial marginalisation of poor communities.

Description of the policy concept

This proposal for practice attached community link workers draws on two overlapping but distinct frameworks – social prescribing and assets-based community development. Both have a long history, and are linked to a wider theory of community oriented primary health care long advocated by the WHO [1]. The social prescribing model has been explored recently through Deep End publications [2] and through the Scottish Government funded Links Project. The assets model is currently being piloted in a number of sites with involvement by RCGP Scotland and support by the Chief Medical Officer. By enabling increased local activity, these approaches enhance community connection, trust and cohesion while reducing fear, suspicion and intimidation. Their strength is that they cut across professional and service boundaries, for example being as applicable to policing as it is to public health.

In broad terms, *the purpose of the link worker is to act as a catalyst to hope and self determination, using the strong relationships with patients that exists in General Practice as a natural community hub*.

In more concrete terms, the goals of the model are:

1. **To provide GP practices with a social prescribing adviser who will:**
    a. maintain up to date accessible information on social resources available in the community and provide practices with a knowledgeable source who they can refer to for advice;

b. work with practices to improve their ability to respond effectively to problems such as domestic violence, threatened childhood, lack of employment, food and fuel poverty or vulnerable housing;
c. work with patients to find opportunities such as volunteering, education or community group membership to help develop self confidence and self determination.

2. **To provide the localities in which GP practices are based with a community catalyst who will:**
   a. develop creative relationships with local residents and across a wide range of sectors in the locality, including social services, the police, education (school and further education), housing, work and employability, welfare rights and advocacy, health improvement, culture and leisure, the third sector, the business and social enterprise sectors, community groups and individual residents;
   b. foster practical ideas for ways in which local residents, social enterprises and service sectors, including GP practices, can collaborate in a less ineffective and inefficient manner than they do currently. It is highly unlikely that the creation of the new role will deliver successful outcomes unless it helps to integrate local residents into service delivery;
   c. identify untapped potential and positive strengths among individuals, groups, businesses, statutory services and third sector resources to find imaginative solutions to problems. This is likely to include strengthening solidarity to campaign on issues affecting the community.

There are numerous examples of these objectives being delivered in a general practice context in Scotland. In a GP practice in Dumbiedyke in Edinburgh, a rapid appraisal method was used to effect changes such as a new bus route [3]. In Drumchapel in Glasgow a participatory action research project helped to establish a volunteer led community health action team which worked closely with GP practices in the manner being described here, until funding was withdrawn [4]. Examples from assets-based pilot projects include a resident setting up a successful archery club and students at a further education college providing free hair and beauty therapies to pregnant mothers attending midwife clinics [5]. In the Links Project GP practices in Glasgow and Fyfe developed a local database and used protected learning events to foster relationships with local voluntary services. This study showed that 60% of patients who were signposted to local resources had made contact with these, with 70% still having contact at one month follow up [6]. One key recommendation from this pilot was that a sustainable model for maintaining connections to community, such as a link worker, should be developed.

Practical considerations

It is envisaged that link workers would be attached to a small locality group of GP practices, with a total practice population of approximately 10,000.This is likely to represent 2–4 GP practices. Localities should be selected on the basis of socio-economic need. Where a GP locality infrastructure is being developed as part of integrated health and social care reforms, the workers could be directly employed and managed by the GP practice locality group. In the absence of this structure they could be employed either by a lead GP practice or by the Community Health Partnership.

The long term nature of this approach needs to be recognised. Link worker posts should be funded for a minimum of three years.

Regardless of the line management structure, the link workers would be directly accountable to the GP practices to whom they are attached, and should work closely with them. They also need to be supported by and work closely with the Community Health Partnership who would also assist for example in freeing practice time for protected learning events.

This proposal represents an opportunity to integrate signposting into other related services. For example police officers will attend many locations where GP patients live but they will probably be unaware of informal referral routes of the sort proposed in this paper. Where there is scope for inter-sectoral funding and partnership working, for example with the police or other sectors, the potential strengths of this should be balanced carefully against the implications of potential conflicts, although the balance is likely to be in favour of such a joined up approach.

The proposed link worker role would interact synergistically with the emerging ALISS resource (Access to Local Information to Support Self management for people with long term conditions). As well as using the resource link workers would be active contributors to its development and would play a key role in integrating its use into local practice through their close links with GP practices.

While this policy proposal is being put forward as a concept for consideration, further work is needed to develop the details in consultation with relevant partners.

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ANNEX F
GP training

For the NHS to be at its best where it is needed most, NHS staff working in areas of greatest need require the best support available, including support for training and leadership activities.

This proposal sets out ***four priority areas*** for improving the training and leadership support available to primary care staff in the Deep End:

1. **More training practices in deprived areas**
2. **Additional support for Deep End training practices**
3. **Implement practice rotations for all GP trainees**
4. **Expand NES Health Inequality Fellowship Scheme**

Scotland has some of the worst health inequalities in Western Europe. General practice should be part of the solution, not part of the problem. This will require collaborative effort – and resource – to improve the training of future GPs in order to address the health needs of individuals, families, and communities in the most deprived areas.

1. **More training practices in deprived areas**

   At the national level, GP training continues to take place in disproportionately affluent areas.[1–2] In a 2010 Scottish study, practices with training status constituted 39% of the least deprived 25% of practices, compared with 23% of the most deprived 25% [3] – a manifestation of the ***inverse care law***.[4]

   This present situation cannot continue. It contributes to the problem of health inequalities in two senses. First, in a ***structural/material sense***, this imbalance in training numbers equates to an imbalance in resource – GP trainees, particularly as they become more experienced, are an invaluable resource for practices. Indeed, a reluctance to release this resource has been cited as a reason for non-participation in practice rotations, including a recent NHS Education for Scotland (NES) project involving rotation of GP trainees through the Homeless Health Service in Glasgow (see number 3).

   Secondly, in a ***cultural/behavioural sense***, as proportionately less GPs are trained in relatively deprived areas there are less GPs who have a practical understanding of the issues involved and may, therefore, be less supportive of measures taken by the profession as a whole to support general practice in deprived areas. Furthermore, recruitment and retention of GPs in deprived areas is known to be more challenging. Qualitative research with trainees has shown that there are considerable misconceptions about working in deprived areas, which are difficult to challenge if a trainee never has any experience of working in such communities.

   There are many factors which influence whether or not a practice will take on training responsibilities (including perceived benefits, capacity, and accommodation) but there is a strong case for ***positive discrimination*** of practices from deprived areas that are applying for training status, whether through fast-tracking applications or other support.

2. Additional support for Deep End training practices

Consultations with patients in very deprived areas are characterised by multimorbidity, lack of time, low expectations, and higher GP stress. [5] It is unclear, however, what effect this increased complexity has on GP trainees. Do they too have higher stress? There is anecdotal evidence that this is the case. It is likely that both trainers and trainees in Deep End practices would benefit from ***enhanced support***. Areas such as addictions, child protection, and mental health – all significantly more common in deprived areas – have been found to generate particular apprehension among GP trainees. [6] The exact form of this enhanced support is open to debate, but might include additional time for trainers or more structured peer support for trainees.

3. Implement practice rotations for all GP trainees

The ***curriculum*** and ***assessment*** for GP training in Scotland should ensure that all GP trainees have exposure to the challenges of primary care in very deprived areas. This is difficult to implement if a trainee is only ever placed in a relatively affluent practice. Focus groups with GP trainers representing a range of different practices found consistent support for the idea of ***practice rotations***, if adequately resourced, to allow trainees the opportunity to experience primary care in deprived and affluent areas. [7]

The introduction of ***extended*** and ***enhanced training*** offers an ideal opportunity to pilot different *formats* of practice rotation. The NES pilot of rotating through the Homeless Health Service is just one example, but has limited capacity and has, thus far, only been of two weeks duration. Two weeks is not long enough to prepare trainees for practice in deprived areas and to challenge potential misconceptions.

Key considerations for any practice rotation include:

- **Duration** – Deep End training practices have found that there is most to be gained (for both trainer and trainee) from having trainees in the practice for at least 12 months, and ideally 18 months. This would be possible with extended four-year training programmes.
- **Timing** – Given the additional complexity/stress inherent in general practice in the most severely deprived areas, there is a strong argument for having more experienced trainees rotating through more deprived practices. For example, in a four-year training programme a trainee may do his/her first six months in practice A (relatively affluent), then 18 months of hospital rotations, then a further six months in practice A, before finishing with 18 months in practice B (relatively deprived).
- **Consistency** – It is important to maintain a consistent throughput of trainees in deprived practices, to aid planning and to avoid the disruption that can be caused by "fallow" periods with no trainees.

Alternative models might consider the use of "non-training" practices that are willing to provide facilities and support (albeit to a lesser degree) for trainees. An example of this approach is the "Hub and Spoke" system that is in place in NHS Humber and Yorkshire.

4. Expand NES Health Inequality Fellowship Scheme

There is a need to develop and support ***leadership roles***, developing local systems of care, based on the hub role of general practices and making best

use of available contacts, skills, staff, space, time and links to improve services for patients. (See Annex H)

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ANNEX G
Leadership

Context

Deep End Report No 18 on Integrated Care (Annex I) highlights the importance of integrated care as the antidote to service fragmentation, discontinuity and premature use of emergency services, especially in very deprived areas, where multimorbidity occurs 10–15 years earlier than in affluent areas, where premature mortality is preceded by twice as long in poor health as in affluent areas, where the number of whole time equivalent GPs is the same as in affluent areas and where health care can achieve its largest impact in improving health and narrowing health inequalities.

It is axiomatic that if health care is not at its best where needs are greatest, the effect of health care will be to widen inequalities in health. It follows that leadership in the development of general practice and primary care is needed most in very deprived areas.

The Deep End manifesto

The manifesto, based on 15 meetings of Deep End practitioners, argues for:

- Extra time for consultations.
- Best use of serial encounters, in which patients work with a small team of professionals whom they know and trust.
- Development of practices as the hubs of local health systems, based on their intrinsic strengths of contact, coverage, continuity, flexibility, long term relationships and trust.
- Attached workers from area-based services (mental health, addiction, social work, health visiting etc), on a named basis, to improve joint working.
- Lay link workers to develop and maintain improved joint working between practices and local community resources for health.
- Improved links and working between generalists and specialists, based on mutual understanding and respect, and joint ownership of problems in service delivery.
- Protected time for practices to share experience, knowledge and activity.

A large number of relationships are crucial, therefore, for the development of integrated care and may be considered as social capital requiring to be established and maintained.

Leadership at area level and above

The current Scottish Government consultation on integrated care focuses largely on issues of organisational integration and accountability at the level of senior managers. General practitioners are mentioned as an important constituency within the proposed new arrangements for locality planning. The consultation document says little about what GPs at the locality planning table will be representing, nor about how power, resource and accountability will be transferred.

General practitioners may become leaders in a variety of ways:

1. Leaving general practice, fully or partly, to become health service managers.
2. Representing general practice within locality planning.

This paper is not concerned with either of these roles. Rather, it is concerned with the development of general practice and primary care ***at ground level***. Leadership in this context is the responsibility and opportunity of many GPs, not a career option for a few. Leadership needs to be supported, therefore, at practice level.

Leadership at practice level

General practice in general, but Deep End practices in particular, have very little capacity for additional activity. Leadership initiatives on their own, without additional resources or opportunities, can only be about improved efficiency or sharing best practice. The development of integrated care will need much more than this.

It is not possible to make proposals for leadership activity in particular areas of service development without knowing what other elements are available. This paper makes three proposals, therefore, which are concerned primarily with the "how" rather than the "what" of leadership development, and are based on three positive features of the Deep End Project:

1. Addressing the lack of opportunity for practices to share experience and views.
2. Giving voice to, and sharing, collective experience and views.
3. Collaborative working on new activities.

Proposal 1 *Practice clusters*

Following the example of the Primary Care Collaborative, where practices found it acceptable and effective to work in small groups of practices, with modest resources for internal activity and external support, Deep End practices have become involved in the Links and Bridge Projects, exploring and building links with community organisations.

Key features include:

1. Restricting clusters to a size conducive to joint working e.g. 5-6 practices, or 20,000 patients.
2. Protected time for joint meetings between practices to reflect review and plan activity.
3. The principle of co-design, whereby practices have a key role in determining what they will do and how.
4. Modest resources to support additional activity within practices.
5. External support and co-ordination, especially for evaluation.
6. Protected time for a GP lead to coordinate activity and represent the cluster.

This approach fosters leadership roles within and between practices. Although the cluster approach has been proposed (for larger numbers of practices) within geographical areas as part of locality planning, there is also a need for clusters of similar practices (e.g. Deep End practices) working in different areas, especially when the issues being addressed do not involve links to local services.

Essentially, this proposal is for the re-establishment of the Primary Care Collaborative approach, with additional features, to address the main elements of integrated care.

Proposal 2 *Leadership groups*

The NES GP ***Health Inequality Fellowship Scheme*** should be increased in size (at least, matching the scheme for remote and rural areas), and developed as an integrated package, providing enhanced training for young GPs, additional clinical capacity for Deep End practices and sessional release for experienced GPs to take on leadership roles.

Twelve fellows should be appointed, based in Deep End practices, for two years at least, with a 50/50 commitment to clinical and service development work. Their service development work should be coordinated, so that they work as a group, sharing experience, views and activity.

Their clinical work will provide additional capacity within the practices, a proportion of which should be used to release the time of experienced GPs (one or two, depending on the size of the practice) to take on leadership roles in the development of integrated care. This group should also be supported and coordinated.

Essentially, this proposal is to develop models of individual and collective leadership at different stages of the career pathway, but especially at the stage which experienced GPs have reached, in knowing their patients, practices and localities well and being best placed to initiate service developments.

In time, it is likely that this proposal will produce leaders in general practice, whose personal authority in representing general practice at higher levels, comes from their involvement in collective working within and between clusters of practices.

Proposal 3 *Support for learning organisations*

Both proposals embody the concept of a learning organisation, with collective commitment to learn from each other in the drive to improve and develop integrated care.

National NHS support organisations, such as Health Scotland, Quality Improvement Scotland, NHS Education in Scotland, the Information Services Division and the Chief Scientist Office, currently provide little support that is apparent to General Practices serving Scotland's poorest communities.

The challenge for these organisations, in addressing integrated care, is to re-deploy part of their budgets to provide an ***integrated package of support*** for the learning organisations described above (avoiding the fragmented and ineffective approach of multiple policies, all lacking focus on the most deprived areas).

For example, a quality improvement/educational programme could be developed specifically by and for areas of high socio-economic deprivation, allowing small clusters of practices (as described above) to meet for education and practice development, with built in arrangements for patient surveys, 360^{o} feedback, audits, prescribing data support, population data support etc. Such an initiative could be of direct value in improving quality and efficiency, while also preparing for revalidation. At present there is a large disconnect between day to day quality improvement, the demands of revalidation and appraisal, and available educational opportunities.

Synergy between CPD time (which GPs would provide, since PGEA was incorporated in GMS) and local development time (which should be funded) could release a lot of potential at relatively low cost.

Developments such as this, with recognised internal and external leadership functions, are needed especially in very deprived areas, where needs are greatest. The implications of the Equality Act fall heaviest on such practices, because of their higher numbers of asylum seekers, patients with learning disabilities, chronically unwell patients and vulnerable adults with difficulties in using services. Managing such needs under time pressure in the context of changing legal requirements is a complex task for very deprived practices, requiring leadership and support.

ANNEX H
Evaluation and research

Most research involving patient participation is conditional and exclusive, in the sense of focusing on specific conditions and excluding complicated cases, such as people with multimorbidity.

In contrast, most of the work of general practice is unconditional, providing continuity of care for whatever problem or combination of problems a patient may present. One consequence of this mismatch between research needs and research effort is that the Quality and Outcomes Framework (QOF) incentive scheme, based on the delivery of interventions for which there is clear evidence of effectiveness, applies to only 12% of face to face consultations in general practice.

Studies such as Care Plus have shown that high quality research is possible in very deprived general practice populations, but requires extra effort in engaging with practices, co-designing the project and recruiting and following up patients. There needs to be more research of this nature to inform policy and practice in the Deep End. Instead of withdrawing its support of such research programmes within the Scottish School of Primary Care, the Scottish Government should follow the funding examples of the English and Welsh governments in supporting their national schools of primary care research.

The unconditional nature of most work in general practice poses a challenge for conventional research, which seeks to measure clear outcome measures for specific conditions. Some progress has been made, using the Patient Enablement Instrument (PEI) and Consultation and Relational Empathy (CARE) measure. The Care Plus study has also employed quality of life measures to assess over a 12 month period the effects of extra time for consultations.

Given that the long term aim of serial encounters is that patients become more knowledgeable and confident in living with their conditions, that they acquire a trusted network of professional advisors and become confident and adept in making good use of the resources available to them, making less use of unscheduled care and living successfully in their own terms, there is a need to ***develop measures*** to capture and monitor such progress. Given the unconditional nature of general practice, the most appropriate basis for assessing the experience of patients and the effectiveness of practices is ***random sampling***. Work is needed to establish how best to support practices in collecting and using such information.

Similarly, as practices develop their role as hubs of local health systems, they will acquire networks of relationships with other services, all of which should be audited, in terms of ***social capital*** within the system. The health of local systems could then be assessed in terms of the quality of relationships between services and with NHS management.

ANNEX I
Deep End summary on integrated care

This report and recommendations draw on research evidence, previous Deep End reports and discussion groups at the second national Deep End conference at Erskine on 15 May 2012.

- To avoid widening inequalities in health, the NHS must be ***at its best where it is needed most***.
- The arrangements and resources for integrated care should reflect the ***epidemiology of multimorbidity*** in Scotland, including its earlier onset in deprived areas.
- Better integrated care for patients with multiple morbidity and complex social problems can ***prevent or postpone emergencies***, improve health and prolong independent living.
- Policies to provide more integrated care must address the ***inverse care law***, whereby general practitioners serving very deprived areas have insufficient time to address patients' problems.
- Patients should be supported to become more ***knowledgeable and confident*** in living with their conditions and in making use of available resources, for routine and emergency care.
- The key delivery mechanism for integrated care is the ***serial encounter***, mostly with a small team whom patients know and trust, but also involving other professions, services and resources as needs dictate.
- The intrinsic features of general practice in the NHS, which make practices the ***natural hubs of local health systems***, include patient contact, population coverage, continuity of care, long term relationships, cumulative shared knowledge, flexibility, sustainability and trust.
- Health and social care professionals working in area-based organisations (e.g. mental health, addiction and social work services) should be ***attached to practices***, or groups of practices, on a ***named basis***.
- Practices should be supported to make more use of community assets for health via a new lay ***link worker*** role.
- The quality and timeliness of hospital discharge information should be a consultant responsibility and audited as a ***key component of the quality of hospital care***.
- Practices needed ***protected time*** to share experience, views and activities, to connect more effectively with other professions, services and community organisations, to develop a collective approach and to be represented effectively.
- ***Collective working*** between general practices is best achieved with groups of 5/6 practices, as shown by the Primary Care Collaborative and Links Project. Larger groupings are less likely to achieve common purpose.
- ***Locality planning arrangements*** should be based on representation (not consultation), mutual respect and shared responsibility.

See full **Deep End Report 18** *at* www.gla.ac.uk/deepend