



COMMENTS ON THE DRAFT GLASGOW CITY INTEGRATION JOINT BOARD STRATEGY PLAN 2016-19

We welcome the opportunity to comment on the draft Strategy Plan, and do so in a constructive spirit, looking to build examples of genuine partnership and joint working.

The draft Strategy Plan currently underplays the crucial role of the unconditional generalist clinical function, allied to population coverage and continuity of contact, as the lynchpin of effective, efficient, personalised care, especially for the increasing numbers of people with multiple health problems.

This role is complemented, but not substituted, by the many services (over 20 listed on page 7 of the Draft Strategy Plan) that operate on a conditional basis (e.g. including/excluding by age, diagnosis, professional skill or time frame). Our experience is that decisions affecting such services can be made without consideration of the consequences for general practice which is left, and relied upon, to provide the continuity and coverage that conditional services lack. These are bad examples of joint working.

The true test of joint working and accountability is how well services work together to improve the experience and outcome of all patients. The Strategy Plan needs early, successful examples of such joint working and accountability.

Our remaining comments are made under five headings.

1. General comments
2. The Inverse Care Law
3. Weakening of the Generalist Function
4. GP leadership
5. How will the shortfall in GP funding, relative to need, be addressed?

General comments

Insofar as general practice and primary care are central to the Strategy Plan, a major objective must be to reverse the recent relative disinvestment in general practice, from 10 to 8% of NHS funding. Funding has not kept pace with increasing workload in general practice, due to increasing longevity and multimorbidity in the population, the transfer of work from secondary care and helping patients negotiate an increasingly fragmented and dysfunctional health care system.

When the system struggles to cope on a daily basis, horizons are foreshortened, energy is drained, senior GPs look to retire and GP careers become less attractive to young doctors.

While additional nursing, pharmacy and administrative support should help to make better use of general practitioners' time and skills, they are not an alternative to the expert generalist skills required by many patients, nor the GP involvement in leadership that is essential for the development of strong local health systems.

The Strategy Plan currently lacks a section which covers how the Glasgow City Integration Joint Board will develop and support the necessary GP workforce.

The Inverse Care Law

The Strategy Plan makes no reference to the inverse care law as a defining aspect of health care in Glasgow.

74 of the 100 most deprived general practice populations in Scotland are in Glasgow City, where they comprise 49% of all general practices, including 86% of practices in the NE Sector. Many of the other 76 general practices in the city serve only marginally less deprived populations.

The Strategy Plan refers to differences in **life expectancy** between social groups, but this captures neither the full extent of inequalities in health, nor the resulting implications for health care.

Men and women in the most deprived 20% of the Scottish population, including most of the population of the City of Glasgow, have a **healthy life expectancy** which ends over 20 years earlier (at age 48 in men and 51 in women) than it does in men and women in the most affluent 20%. Compared with the most affluent 20%, they spend twice as long in poor health before they die, 10 years earlier in men and 7 years earlier in women (Scottish Public Health Observatory, 2015)

This longer period of poor health is characterised by multimorbidity, which begins 10-15 years earlier in deprived areas (1). Comparing the most deprived and most affluent 20% of the Scottish population, complicated multimorbidity is 97% higher in deprived areas, when measured as the combination of a mental and physical health condition and 75% higher when measured as 5 or more conditions (2).

Yet general practice funding is virtually flat across the Scottish population (2). It follows that general practice is under-resourced relative to need, underachieves in reducing the severity and slowing the progression of established conditions and is forced to work under conditions of endemic unmet need.

Consultations in deprived areas are characterised by a higher prevalence of multimorbidity, shorter duration, less patient enablement (especially for patients with a mental health problem, the commonest co-morbidity in deprived areas) and greater practitioner stress (3). Unmet need accrues. When practices are unable to contain patients' problems in the community, they spill over into out of hours, accident and emergency and acute hospital care.

Rhoda Grant MSP captured the consequences concisely in a debate on Redesigning Primary Care in the Scottish Parliament on 15th December 2015, *"We know that those who shout the loudest get the service, but we sometimes forget what low expectations people in deprived communities have, because they have been taught over a lifetime not to expect much. Because of those low expectations, people do not call for services. We need to change our approach to the services that we give people throughout their lives, so that we raise people's expectations and ensure that they get fair access to services, especially when they become unwell."*

It is surely worthy of comment when an MSP for the Highlands and Islands expresses Glasgow's predicament more clearly than the Glasgow City Integration Joint Board Strategy Plan.

Weakening of the generalist function

This situation has been compounded by a decade of differential investment in primary care in Glasgow.

General practice is not unique in its intrinsic features of first contact, population coverage, continuity, flexibility and public trust, but it is by far the largest part of the public service with these attributes and the only part that works unconditionally, dealing serially with whatever condition or combination of conditions a patient may have.

For this reason, practices are the natural hubs of local health systems. Most of the other services listed in the Strategy Plan are conditional, based on a particular target group, diagnosis, professional skill or time frame. Many of them have referral criteria, waiting times, fixed protocols and discharge policies. Often what they do they do well, while leaving a lot for general practice to do, for patients who do not meet the entry criteria, who are not good at accessing services and who still need help after they have been discharged.

A consistent finding from the Deep End Project is that patients in deprived areas need referral services which are quick, local, flexible and familiar. Too many referral services lack these qualities and are accessed less successfully as a result. The treatment burden which falls on patients is particularly hard for those with multimorbidity.

The last decade has seen a substantial increase in community health services in Glasgow, but no increase in general practice. Services which used to be closely allied with general practice, such as district nursing, health visiting and sometimes social work, have been withdrawn to area-based work. The consequent weakness of the generalist function, which is able to deal with patients' problems close at hand, and which is so necessary for the "gatekeeper" function to work (when patients are confident in primary care, they are less likely to present at hospital) has been a major strategic error, increasing the fragmented and dysfunctional nature of care, which the Strategy Plan should address. A significant part of community health services needs to be relocated nearer to patients as they visit their general practice.

GP leadership

At a meeting of the Health and Sport Committee of the Scottish Parliament on 15th December 2015, including Mr David Williams, the Chief Officer Designate of the Glasgow City Joint Integration Board, it was generally agreed that the engagement of GPs in local leadership roles is critical to the success of health and social care integration. ***This pivotal role is not explicit in the Glasgow Strategic Plan.***

The Strategy Plan refers to the Govan Integrated Care Project (funded by the Scottish Government) as "testing new forms of integrated care delivery" but makes no reference to other key features of the project, as advocated by General Practitioners at the Deep End (4), including additional clinical capacity to help address the inverse care law and to provide protected time for GP leadership.

Nor is there mention of the Scottish Government-funded Link Worker Programme, via which community links practitioners are embedded in practices not only to signpost

patients to community resources for health but also to help patients navigate their way through an increasingly fragmented and dysfunctional care system. Practice development funds have enabled GPs in practices with links practitioners to take an active role in service development.

The future described in the draft Strategy Plan needs strong GP leadership, not only at representative level but also in the development of local health systems, including cluster working between practices and better links between all services and resources. The Strategy needs a plan for how it will encourage, inform and support GP leadership.

How will the shortfall in GP funding relative to need be addressed?

Asked by the Convenor of the Health and Sport Committee, “*How much of your budget will we need to give to GPs*”, Glasgow’s Chief Officer Designate replied “*We have not worked that out – negotiation on the GP contract is national and IJBs are not substantially involved in that. We have been variously consulted and presentations have been made to chief officers by representatives working on behalf of GPs nationally*”.

The steering group of General Practitioners at the Deep End has been advised by these same representatives that additional resources for general practice in deprived areas will not be delivered by the new GP contract, but should be made available via the local Integration Joint Boards.

At the Health and Sport Committee on 15th December, the following exchange took place:

The Convenor *We see workforce costs in our evidence on the workforce – there is a 1 per cent increase or whatever. What has been factored in for additional costs of the new GP contract and their impact?*

David Williams : *We have not factored in anything for the new contract.*

The Convenor : *I presume that the Scottish Government will pay for that and that it will not come out of your budget.*

David Williams : *I have to be honest and say that in Glasgow we have not given that issue that level of consideration. My assumption is that additional costs for the contract would be provided nationally*

It appears that in considering how the inverse care law (i.e. the shortfall in general practice funding relative to need) may be addressed, both national GP representatives and the Glasgow City Integration Joint Board are passing the buck.

David Williams commented to the Health and Sport Committee, *“From a budget management perspective, for a significant chunk of the health budget that will be part of the health and social care budget infrastructure, there appears to be very little scope for manoeuvrability in the way it is used.”*

If this is so, a large part of the success of the Strategy Plan depends crucially on three questions :

- 1. How will the recent relative disinvestment in general practice, from 10% to 8% of NHS expenditure, be reversed?**
- 2. How will the underfunding of general practice in deprived areas be made good?**
- 3. How will the local leadership function of general practitioners be supported?**

Summary

The Strategy Plan is insufficiently expressed on several very important issues affecting health and social care in Glasgow, including :-

- The inverse care law
- Premature multimorbidity
- Unmet need
- Low patient expectations
- The importance of the generalist function
- The need to relocate services nearer to patients in general practice
- Community links practitioners
- GP leadership
- Joint accountability based on the needs of patients

Glasgow members of the steering group of General Practitioners at the Deep End

Dr Peter Cawston, Dr Margaret Craig, Dr Lynsay Crawford, Dr Maria Duffy, Dr Susan Langridge, Dr Anne Mullin, Dr Petra Sambale, Professor Graham Watt

31st December 2015

References

1. Barnett K, Mercer, S.W., Norbury, M. et al. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *Lancet* 2012; 380: 37–43.

2. McLean G Guthrie G Mercer SW Watt GCM. GP funding underpins the persistence of the inverse care law : cross sectional study in Scotland. BJGP 2015; DOI: 10.3399/bjgp15X687829
3. Mercer S, Watt G. The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland. Ann Fam Med 2007; 5:503-10.
4. General Practitioners at the Deep End. What can NHS Scotland do to prevent and reduce health inequalities? 2013 (see www.gla.ac.uk/deepend)