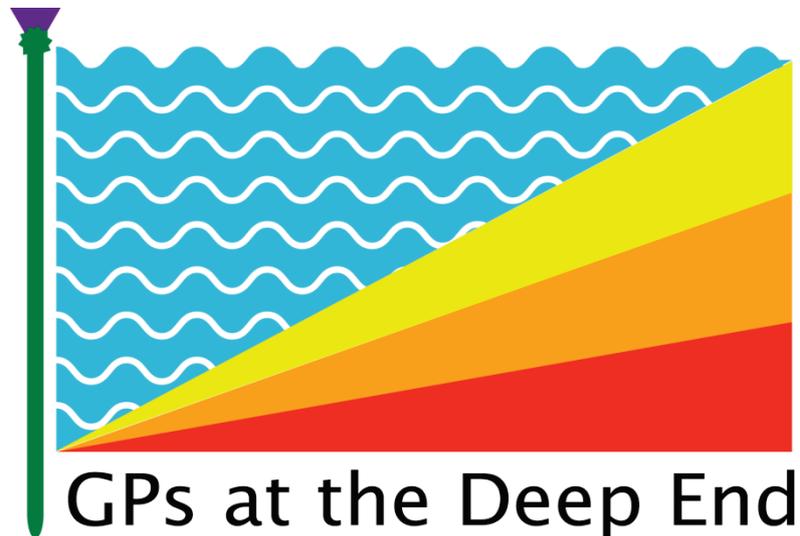


REPORT OF THE
3rd NATIONAL CONFERENCE OF GENERAL PRACTITIONERS AT THE DEEP END
24th NOVEMBER 2015



Key points

- General Practitioners at the Deep End are a vibrant group of GPs committed to improving the health and lives of patients living in very deprived areas.
- Professor Graham Watt described how this task is constrained by the continued existence of the Inverse Care Law in Scotland.
- Drs Peter Cawston and John Montgomery described the progress that is being made via the Scottish Government-funded Link Worker Programme and the Govan SHIP Project.
- Dr John Nugent described the challenges and opportunities provided by the new Scottish GP contract.
- Dr Helene Irvine described how over-investment in hospital and community health services, combined with under-investment in general practice, reduced numbers of district nurses and reduced funding in social care, has led to NHS Scotland's current financial and performance problems.
- Dr David Blane explained that while GP recruitment in very deprived areas is not currently an acute problem, the age structure of GPs at the Deep End means that it soon will be.
- The conference also involved 16 roundtable and 2 plenary discussions concerning the current state and future aspirations of General Practitioners at the Deep End

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Introduction

The third national conference of General Practitioners at the Deep End took place on Tuesday 24th November at the Erskine Bridge Hotel.

This report summarises the presentations and discussions at the conference. Powerpoint presentations and pre-conference papers are available on the Deep End website (www.gla.ac.uk/deepend).

In chairing the conference, Andrew Lyon described the considerable challenge of imagining the future, with reference to the Scottish philosopher David Hume’s dictum that “progress flows from disagreements between friends”.

Background

Deep End practices serve the 100 most deprived practice populations in Scotland, based on the proportion of patients living in the 15% most deprived Scottish data zones, ranking from 89% in the most deprived practice, to 44% in the 100th.

Most practices in Scotland have some patients living in deprived areas, but Deep End practices deal with deprivation and its consequences in high volume – “blanket” as opposed to “pocket” deprivation. 20% of practices in Scotland have no deprivation, by this definition.

Deep End practices are mostly in Glasgow City, with smaller numbers in Inverclyde, Ayrshire, Edinburgh and Dundee. The lists changes slightly from year to year. Overall, 85 practices have always been in the Deep End since 2009 while 35 have dipped in and out. Participation in Deep End meetings has involved 74% of the former and 37% of the latter, partly because of geography but also because there have been fewer meetings recently.

The “Deep End Project” comprises the activities of General Practitioners at the Deep End since September 2009, as coordinated by a volunteer steering group of Deep End GPs, with funding and administrative support from the Scottish Government, RCGP Scotland and the Department of General Practice at the University of Glasgow.

Previous national conferences took place in September 2009 and May 2012. The 3rd national conference was made possible by funding from Scottish Government and administrative support from RCGP Scotland.

55 Deep End GPs took part in the conference, from 47 practices from all areas except Renfrewshire, plus 3 colleagues from the Edinburgh and Glasgow homeless practices, 5 GP health inequality and academic fellows, 2 GP registrars, 2 medical students and primary care researchers, plus guests from Scottish Government, NHS Health Scotland, RCGP Scotland and NHS Greater Glasgow and Clyde.

Progress since 2009 – Professor Graham Watt

The initial objective of the Deep End Project, after engaging with Deep End GPs at the first conference, was to capture the experience and views of Deep End GPs, as an important type of evidence, often in the absence of any other evidence, which has been achieved via 27 reports, all with short and long versions on the Deep End website (www.gla.ac.uk/deepend). That stage is more or less done.

A simple manifesto emerged and was pulled together in Report 20 in March 2013. While Deep End practices can't prevent health inequalities, they can mitigate and slow the progression of the problems that patients have. By doing that for everybody, in every practice, population health would improve and inequalities would narrow. The report highlighted 6 ways to achieve this.

- More time to spend with patients (redressing the inverse care law);
- better use of serial encounters, to create strong patient narratives, increasing their knowledge and confidence, as they live with their conditions and access services;
- developing local health systems around practice hubs, developing and nurturing all of the relationships that involves, including embedded workers ready to work with the practice;
- better connections across the front line, between practices, sharing experience, views, learning and activity;

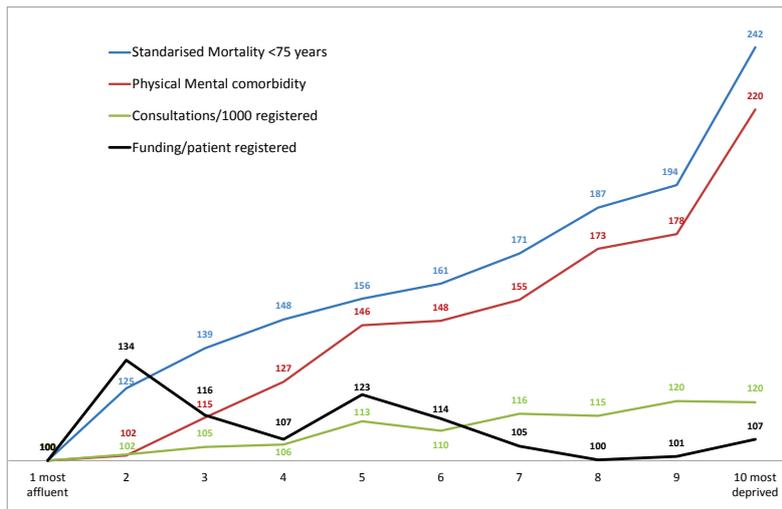
- better support for the front line from central organisations;
- improved leadership at every level, sharing power, resource and responsibility.

Several projects are giving expression to these ideas, such as the Link Worker Project and the Govan SHIP Project, which featured in conference presentations; also, the attached alcohol nurses scheme in Possilpark; and as Billy Watson described at the conference, a new opportunity to work more closely with the local resources of the Scottish Association for Mental Health. The conference was also used to advertise a joint meeting with colleagues from housing associations.

A continuing strand of activity, following some high profile Deep End reports (Nos 16, 21, 25 and 27), has been engagement with Financial Inclusion Services, looking for ways of helping patients having problems with changes to their welfare benefits (described in Deep End Report 27, issued in December 2015). In a perfect example of the inverse care law, such work falls most heavily on general practices which are already hard pressed and least able to take this on.

We have lobbied consistently via contacts with the Scottish Government, parliament and politicians, to improve their understanding of the problems and challenges that Deep End practices face. Recently, there was a member's debate in the Scottish parliament about General Practitioners at the Deep End. That has raised our profile, but as everyone is all too aware, it hasn't yet made any difference to the inverse care law, and its practical implications for patients, practices and population health. As the Scottish general election approaches, neither the BMA nor the RCGP are campaigning on this issue.

On 1st December 2015 the figure below appeared in a paper in the British Journal of General Practice. Across the bottom, it divides the Scottish population into tenths, most affluent on the left, most deprived on the right. Premature mortality under 75, in blue, increases over two and half fold across the social spectrum, as does, in red, the prevalence of complex multimorbidity, whether defined as 5 diagnoses, or the combination of a physical and mental health diagnosis. Total general practice funding declines as deprivation increases. Consultation rates increase by 20%, much less steeply than the slopes of need. With no extra resource, consultation rates can only rise by having shorter consultation times or working a longer day.



Previous studies reported a flat distribution of GPs, but such data, especially data on whole time equivalents, are increasingly hard to get. Total funding per patient per annum provides a better indication of the total resource that is made available via the GP contract.

The paper shows an average spend of £120 per annum in the Deep End compared with £123 for Scotland as a whole. The pattern is mostly accounted of by the global sum. QOF earnings rise slightly with deprivation, while earnings from enhanced services go down slightly, but neither trend makes much difference to the overall pattern.

The most affluent six population deciles, comprising over 3 million Scots, have allocated funds of £127 per head per annum, while the most deprived four deciles, comprising over 2 million more deprived Scots, receive £117 per annum. The difference is partly due to rurality and remoteness, but mostly due to the Minimum Practice Income Guarantee.

Removing these two elements only makes the pattern flat; it doesn't produce a slope of funding that rises with need. We hope that MSPs will be impressed by these figures, and finally come round to addressing the inverse care law. It isn't simply a matter of re-designing services.

The third national Deep End conference was an important opportunity to take stock and look forward, not only to describe general practice in the Deep End, but to change it. In many respects, the Deep End is no different from general practice in the rest of Scotland, facing a manpower crisis, the challenge of recruiting the next generation of GPs, health and social care integration, a new GP contract, re-designing general practice and primary care.

But there are also special challenges in the Deep End : the higher prevalence of some types of problem, as identified by Deep End GPs discussing their CPD needs, the higher prevalence of complicated multimorbidity in younger people (not yet recognised in the contract), engaging with patients who may be hard to engage, but need help in engaging with an increasingly fragmented and dysfunctional system, the lack of relevant evidence and how to stay cheerful,

despite the heavy daily burden of need and demand. And doing all this, while the inverse care laws still applies.

Sisyphus pushing his boulder up the hill provides a metaphor for general practice. Simply staying in the same place requires effort. Pushing it higher up the hill needs help. If help doesn't arrive, the boulder will roll down the hill, perhaps never to return.

The fundamental issue is not general practice or general practitioners. It is the 10% of the population whose life expectancy lags ten years behind, and whose healthy life expectancy ends just less than twenty years earlier than in the most affluent 10%. The NHS provides equitable access to emergency care but could do much more to provide equitable needs-based primary care in deprived areas.

The inverse care law states that the availability of good medical care tends to vary inversely with the need for it in the population served. It is not a natural law, but a policy which restricts care based on need. It isn't the difference between good care in affluent areas and bad care in deprived areas; it's the difference between what practices can do and what they could do if adequately resourced.

That is why Deep End GPs argued at the last Scottish general election that NHS Scotland should be seen at its best where it is needed most; otherwise, inequalities in health, already the widest in any western European country, will widen further. As the 2016 Scottish general election looms, that is still an important message.

Communities in the Deep End – Dr Peter Cawston

Helping patients with complicated multimorbidity is the stock in trade of general practitioners at the Deep End. There is much more to the task than simply prescribing medicines.

For many patients the health care system can seem like a fortress that is difficult to access.

The Community Links Approach is being developed via the Link Worker Programme, which is a partnership between General Practitioners at the Deep End and the Alliance for Health and Social Care, funded by the Scottish Government.

7 Deep End practices have a full-time Community Links Practitioner fully integrated into the practice team. Some of their work involves helping patients access community resources for health. They can also help patients navigate their way through health and social care services.

Each practice has a development grant to use at its discretion. There is also peer review and shared learning within the cluster of Link Worker practices.

Both patients and practices are on a journey with the aim of living well in the community. In order to do this, a first task for practices has been to look after themselves e.g. via yoga classes and health walks.

Some commentators have criticised the project for being too expensive and unsustainable, but the costs are small in relation to many “acceptable” health care costs, such as Duloxi-Pregaba-Varisatis therapy costing £2225 per year and an admission to the Queen Elizabeth University Hospital costing £1000 per night.

A realistic aim of the Link Worker Programme is to reduce such costs.

Integrated Care in the Deep End– Dr John Montgomery

The Govan Social and Health Integration Partnership (SHIP) is funded by the Scottish Government to strengthen integrated care via multidisciplinary team working at Govan Health Centre.

Key features of the project are additional clinical capacity (two WTE salaried GPs shared between 4 practices), two full-time attached social workers, two community links practitioners (attached to two of the 4 practices), support for monthly multidisciplinary team (MDT) meetings (focusing on frail elderly patients and vulnerable families), plus protected time for GP leadership and shared learning.

Improved multidisciplinary team and multi-agency working is taking place via four work streams : Frail/Elderly, Vulnerable Children and Families, Unscheduled Care and Information.

Early uses of the additional clinical capacity include extended consultations, additional home visits, attendance at case conferences, case finding/reviews and project development.

Behind the quantitative data (e.g. 742 cases raised at MDTs in the first 6 months) are cultural improvements including patient engagement and stories and improved links and morale.

The estimated cost of rolling the model out to 100 Deep End practices is £4.5 million per annum.

Opportunities provided by the new GP contract and integrated care - Dr John Nugent

The 2004 GP contract introduced a “layered” contract involving Essential, Additional and Enhanced Services, including the Quality and Outcomes Framework (QOF).

Ten years on there is increasing workload (as a result of the ageing population, multimorbidity and transfer of work from secondary care), bureaucracy and professional dissatisfaction.

Care has become more systematised, especially for specific conditions, as a result of performance-related pay and related standards and processes for verification.

Current challenges include access, multimorbidity, workload, demand, bureaucracy, recruitment, retention, health and social care integration, and the special problems of rural, remote and deprived areas.

The common direction of travel is that there should be “more care at home”.

In discussions with the BMA the Scottish Government is looking to develop the role of GPs as “expert generalists” in dealing with complex care, undifferentiated illness, quality and leadership. GPs should work “at the top of their licence” while having a voice in the development of the wider system.

Every GP should be involved in quality, with a focus on outcomes, while some GPs will also be involved in leadership, especially within clusters of GPs.

Litmus tests of whether new arrangements are working include whether care is delivered by the person with the most appropriate skills, whether people are admitted to hospital only when they need to be and whether the journey out of hospital is planned and straightforward.

£60 million of new investment is allowing new models of care in ten areas, new roles in pharmacy, developments in mental health and IT, leadership for integration. GP recruitment retention and education, and renewed funding for the Scottish School of Primary Care.

Discussion

Following the above presentations, eight roundtable discussion groups generated the following conclusions.

WHERE WE ARE

- Health improvement is hampered in very deprived communities by the lack of aspiration and feeling that change is possible, which can be apparent from an early age.
- The resignation of patients and professionals, in coping with today’s problems only is realistic and pragmatic, but by definition short term.
- Colleagues who do not work in deprived areas often do not understand what deprivation does to people, especially in terms of low expectations and the ability to engage
- Patient enablement takes longer in very deprived areas. Contact is only the start. “Hard to reach” has a different meaning in this context.
- Disempowerment causes multiple pressures and effects throughout the system
- Patients with low literacy and agency are apt to be confused by lots of services (“not knowing where to turn”)
- Change can only be slow in a fixed system
- Smaller practices can innovate more quickly
- Much change is cultural, involving values, attitudes and relationships
- GPs are angry and frustrated at what they see as an unjust system, rewarding those who live longest.
- The system generally ignores unmet need. There is a desperate need for data, including information on reasonable appointment times and numbers of appointments.
- The Deep End projects have provided a glimmer of hope, but only involve a few practices

- Finding a collective voice has led to opportunities via pilot projects, especially involving the Scottish Government.
- GPs need to be well informed about what is available for patients locally and further afield.
- 17c contracts can loosen the shackles of the QOF, but practices with 17c contracts in deprived areas are still struggling.
- Getting rid of the QOF won't solve the inverse care law
- How to increase uptake by those who need it, without increasing demands by those who don't – public information campaigns don't always reach the right people.
- Longer consultations (e.g. in the Links project) have been “revolutionary” e.g. allowing GPs to spend more time with complex patients, and to attend social work case conferences.
- GP extra time does wonders for morale.
- Extra clinical capacity at the Govan SHIP Project has released time for experienced GPs to do new things.
- In five years, the practice team will be bigger with many new types of colleague working more closely within an integrated team, referring patients within the team, rather than outside to external services.
- Interventions don't have to be costly (e.g. cooking classes at Tower Hamlets)
- GPs can influence behaviour by being role models e.g. cycling to house visits.
- Asylum seekers are no longer a small population
- Interpreters are self-employed and can be difficult to access
- Funding per patient is a good comparator between areas.
- GPs need to work more collectively, but it can be difficult for small practices to attend meetings
- Clusters can work well, sharing experience and information, and reducing duplication, but are better when developed around goodwill, rather than conscription.
- Practices need good models of GP leadership (e.g. taking an overview of population demographics and needs, managing service delivery, liaising with managers) with responsibility and authority.
- When GPs are “too busy for leadership”, the service drifts.
- The South Glasgow GP Committee is a good model of practice engagement, with 14 funded places for elected GPs.
- The Health Board can't help individual practices for fear of setting an unaffordable precedent.
- Greater Glasgow and Clyde HB should be competing with the rest of Scotland, not within itself
- Is there political will to re-distribute resource e.g. from secondary care (given the huge increase in the number of hospital consultants)
- Work that can be delegated includes prescribing review, medical reports, eyes, dentistry, unnecessary letters.
- DNAs are always explained as “problem patients”, never as symptoms of a problematic system.
- GPs need to reduce their time commitment to simple bureaucracy e.g. re-referrals

- GPs should be more aware of the costs of what they decide, sharing such information with patients.
- So called “alternatives to GPs” – are there sufficient numbers? How will they be trained, supervised, trained, indemnified? Even GP locums leave work for practice GPs to do.
- Locums are harder to recruit and may need support
- There is room to use others (pharmacists, mental health workers, physiotherapists, link workers), but they have to be competent (high calibre), trustworthy and able to deal with the higher level of multimorbidity in deprived areas.
- If the alternates cannot “hold risk”, they can generate rather than reduce work for others. Managing risk and uncertainty is a key part of the generalist function.
- Alternate models can’t be assumed to work, and need evaluation, including the views and experience of patients.
- Alternates can’t obviate the need for a modest increase in the number of GPs
- Specialist nurses (e.g. heart failure nurses) can provide intensive home support, but may be out of their depth in dealing with multimorbidity
- Breast feeding specialists “would be better employed giving mothers the knowledge and confidence to manage minor illness”.
- “Elderly” should be defined as “years from death” rather than by age alone.
- The “salaried v independent contractor” debate is complicated.
- Strong agreement on need to avoid “10 layers of managers”
- Working conditions and job satisfaction are paramount, if experienced GPs are to be retained.
- Protected time has been squeezed out of the system
- General practice needs to be made more attractive to potential entrants.
- Part-time practice is the increasing option in deprived areas, with GPs pursuing portfolio careers
- Will the next GP generation be up for the leadership role?
- Young GPs need to be supported early in their careers
- Unconditional general practice is much more accessible to patients than most conditional services
- Large practices score less well for patient continuity and relationships between GPs.
- It is not clear that large practices are more efficient. The English Super Practice model is commercially driven rather than evidence-based
- There is widespread inequity in the caseloads of health visitors, with some having very many more child protection cases.
- Appalled at distribution of District Nurses based on age alone.
- The demand for Citizen’s Advice has increased substantially
- Beleaguered practices need support.

WHERE DO WE WANT TO GO

- Structural change is needed now, not tinkering with projects
- The situation in Deep End practices is not sustainable
- The system needs to be more flexible and quick in response to local population needs
- Continuity is key and needs to be valued

- GPs and patients are on the same journey, with shared knowledge of what has been said and unsaid.
- “The job is easier when you know your patients”
- Consistency is an important part of the journey, while transience (seeing someone you don’t know) weakens it
- The “practice” is best considered as the place where patients go to get care. Many colleagues contribute to this. A good practice can “hold” patients for longer in the community
- The ten minute consultation should become a historical memory
- Patient education is needed to reduce the demand for medication.
- Professions should be jointly accountable for improving patient’s experience.
- Better communication is needed with most services e.g. social work
- GPs need to be engaged in developing an increased neighbourhood focus, via contacts with community organisations, the third sector, social work etc.
- Link workers have shown the value of helping patients engage with services; also community orientation, links to 3rd sector, social prescribing, support of wellbeing, advocacy, promoting self-help etc
- Co-location of services makes them more likely to be accessed, but the managerial trend towards centralisation works against this.
- Patients from very deprived areas are less likely to take up referrals to distant and unfamiliar locations which are expensive to reach.
- Co-ordination is facilitated and speeded up by joint multidisciplinary meetings
- Different professions need to work to the same catchment areas
- Attached workers (e.g. alcohol nurses) are more helpful when embedded within practices
- The “real issue is access to mental health services”
- It would help if mental health and addiction services were integrated. Both services need to communicate more quickly.
- CPNs are perceived to be accessible in Inverclyde but not elsewhere.
- Mental health access was said to be “two weeks in London”
- How will pilot projects be sustained? There is a need to “size up” their achievements to all practices.
- Collective agreement between GPs is necessary for local systems to develop.
- A step change is needed to “jump across the gap”, and not try “shuffling across”.
- GPs can’t just “work to the top of their medical licence” – patients’ social issues can’t be ignored. The medical model is “dead”
- GPs are often the patient’s advocate, taking their side against issues and systems that impede their health, but this takes time and needs support.
- Engagement with patients takes longer in the Deep End
- Literacy, language, financial and cultural issues may all complicate access
- Managing “super-users” of services can be a win-win-win i.e. benefits for everyone
- The “Deep End” is not a separate case, but an extreme example of the general case that resources should be provided pro rata based on need.
- Reducing demand and addressing need can help to reduce hospital admissions.

- Over-diagnosis and treatment are recognised problems but need time to discuss and sort out.
- “How many of us would take what we prescribe?” i.e. polypharmacy
- There is a need for better information and record sharing across services e.g. with social work and community care.
- Practices need to make better use of appointment time, including phone triage by GPs, open v. appointment surgeries etc.
- There should be fewer NHS staff who don’t take part in front line patient care.
- And less tolerance of activities that do not contribute to patient care
- Email access to consultants, either directly or via a departmental service, can lead to better decisions
- Relationships with hospital consultants need to be based on the understanding that “Your problem is our problem”.

Using routinely collected data to figure out where the NHS is going wrong - Dr Helene Irvine

This presentation was based on analyses carried out by Dr H Irvine, CPHM and Mr J Gomez, Senior Information Analyst at NHS GG&C. These analyses investigated the Board’s persistent financial over-parity, trends in hospital activity, and poor and declining compliance with the 4 hour A&E HEAT target. The results showed:

- NHS GG&C financial overparity (i.e. spending above target share of the national territorial budget) is explained not by under-funding of the needs of patients in socio-economically deprived areas but by increasing hospital activity involving patients from more affluent areas.
- Relative to the rest of Scotland, over-subscription of hospital activity applied to all SIMD quintiles in GG&C but was greatest and rising most rapidly in the most privileged quintile, and was particularly marked in elective care.
- Poor compliance with the 4 hour A&E target over a recent four year study period in both GG&C and the Rest of Scotland correlated with clusters of very old patients, the rate of ageing of A&E attendees increasing two to three times faster than the ageing of the resident population, suggesting a failure of services supporting patients living at home and other community settings.
- Analysis of manpower and funding trends suggests that disinvestment in general practice in GG&C since 2006, combined with a reduction in the number of fully qualified district nurses since 2007 and reduced funding for social care of the elderly since 2009 are likely major determinants of increased unscheduled hospital use as the last line of care.
- The above findings are part of a national picture of relative disinvestment in general practice, with resultant weakening of the gatekeeper function, in association with a shift in resources to community health services budgets under the control of CH(C)Ps (now, HSCPs).
- In October 2015, the Auditor General reported financial and performance failures in NHS Scotland which we believe are attributable to the above strategic trends, implicating central government health service planning and decision-making.

See: [http://www.audit-](http://www.audit-scotland.gov.uk/uploads/docs/report/2015/nr_151022_nhs_overview.pdf)

[scotland.gov.uk/uploads/docs/report/2015/nr_151022_nhs_overview.pdf](http://www.audit-scotland.gov.uk/uploads/docs/report/2015/nr_151022_nhs_overview.pdf)

Balancing needs and demands, quality and equity

- Current financial and performance difficulties in NHS Scotland are largely the result of rising demand for hospital services, which is outstripping supply, despite increasing investment in hospital services, rising throughput and rising numbers of hospital medical staff.
- Productivity and efficiency on the hospital side of the service in Scotland is not rising fast enough to enable it to deliver the quality of service required, in terms of meeting targets, despite the increasing resources currently allocated.
- Short of substantially increasing investment in the NHS to European levels, the Scottish Government needs to examine whether it has the right balance of financial and manpower trends to deliver a high quality service whilst ensuring equity, the latter achieved by maximising the match between the levels of need and service at a geographic level.
- These difficulties in the acute sector, especially within A&E departments, have distracted attention and diverted resources from upstream factors which play a major role, namely the reduced ability of general practice to act as gatekeeper to the entire service, moderating the demands by the “worried well” for specialist investigation and treatment and preventing or delaying the need for, and use of, emergency services by patients in deprived areas.

Underfunding of care in the community

- Although these problems are multi-factorial in origin, many stem from the historical underfunding of general practice, which has been singled out in recent years for real-terms reductions.
- Although this is a national, indeed UK-wide problem, it is felt most acutely in deprived and rural/remote areas where unmet need accrues and GPs struggle to provide a service.
- The effects of the underfunding of social care (SC) of the elderly resulting from the council tax freeze and the reduction in numbers of fully qualified district nurses (DN) have been exacerbated by the maturation of the 1920 baby boom cohort.
- This underfunded triad (GP, DN, SC) is important in the aetiology of the steep rise in emergency admission after 2006 in GG&C and the 4 hour A&E compliance failure after 2010 in GG&C and elsewhere in Scotland.
- The weakening of general practice as a gatekeeper to unnecessary investigation and treatment must be considered a factor in the steep rise in demand for elective health care in GG&C since 2000

Imbalance in medical manpower

- The ratio of the hospital consultants to GPs has climbed steadily in both England and Scotland from 0.75 to 1.25, and has been very similar in the two countries for a decade.
- Many of Scotland’s policies, directives, targets, funding and manpower trends, and resultant problems appear to be the same as those observed in England, raising doubts about the Scottish Government’s willingness to exploit devolution of health policy, achieved in 1999, to Scotland’s advantage.
- GG&C has a particularly high consultant:GP ratio, even when adjusted for incoming cross boundary flow.
- The combination in GG&C of relatively high bed provision, high consultant provision, super-specialisation, multiple hospital sites, and relative underprovision of the GP/DN/SC triad

favours relative overuse of secondary care overall, but particularly of elective care in the affluent, and emergency care in the socially deprived.

- The 'mismatch' of service provision and need, is the most likely explanation for the falling morbidity and life circumstances index (MLC) and rising financial over-parity in GG&C in relation to the National Resource Allocation Formula, particularly in recent years.

Integration is unlikely to solve the problems

- Against the national backdrop of a top heavy NHS that preferentially funds secondary care (59% of NHS funding) over general practice (7.6%), the funding of the community health (CH) service budget increased by more than 35% after 2006 to achieve in excess of 17%. The remaining 16% of NHS funding went to the other primary care services (dental, ophthalmic, pharmaceutical) that have also given up a small amount to fund the rise in CH services.
- We believe that shifting resources from general practice to the community health services (slide 19), and allowing the disengagement by HSCP management of HVs, DNs and other CH professionals from previous close working relationships with general practice, has been a serious strategic error, failing to control or moderate the excessive use of emergency secondary care which rose over the same time period, and therefore a significant factor in the cause of the failing performance of the NHS as a whole.
- Despite being mandated by legislation, and underpinned by an unprecedented £8b budget, integration has yet to show signs of viability and cost effectiveness. Scotland is currently embarking on an even more ambitious integration programme.
- Social care budgets require adequate funding in their own right. When underfunded social care services are integrated with top heavy health care services, health care managers will be unwilling to relinquish their commitment to current treatment standards (and funding), to fill the hole in their partner's budgets.

The need for transparency

- The lack of openness surrounding the review of how resources are allocated between general practices by the Scottish Allocation Formula reinforces the sense that the distribution of this funding is beyond open scrutiny and debate, even amongst the GPs themselves, because of the unique degree of secrecy afforded to deliberations, on the grounds of commercial sensitivity.
- The use by senior politicians of GP manpower data based on a headcount rather than WTEs, and a headcount that includes trainees, allows perpetuation of the myth that 'Scotland has never had so many GPs'.

The future

- A range of recommendations is made that emphasises the need to reverse most of the strategic funding changes that occurred between 2004 and 2007.
- A key recommendation is to increase the percentage spent on general practice, because of its crucial role, to 12% of NHS funding with a view to expanding the WTE number of principal and salaried GPs by halting premature retirement, retrieving recent retirees and attracting junior doctors to take up unfilled training posts.

- Reducing expenditure on hospital services from 59% to 57%, and on community health services expenditure from 17% to 15%, of the national territorial budget, would free up the funding required for general practice.
- The proponents of integration may 'talk up' general practice, but have yet to address or begin to reverse the negative consequences of ten years of relative under-funding of general practice. Scarce resources should not be wasted on trying to enhance the image of general practice while denying the resources it needs.
- It is uncertain whether and to what extent GPs can be substituted in sufficient numbers by nurses, AHPs and pharmacists in the delivery of the high level functions required of GPs (managing risk, uncertainty and complexity), as argued by the BMA, to reduce unnecessary admissions.
- The way to attract doctors to enter and stay in general practice is to invest in the speciality and give the clear message that the main gatekeeper to the NHS is respected, here to stay, and needed more than ever.

LUNCH

The Third Sector and the Deep End– Billy Watson

The Scottish Association for Mental Health (SAMH) is Scotland's largest mental health charity, directly supporting 2,200 people every week via 64 community services (for mental health, addictions, homelessness and employment) and 4 national programmes (Anti-Stigma, Anti-Bullying, Suicide Prevention and Get Active).

In response to a survey showing that 84% of SAMH supporters said that "early intervention services at GP surgeries is the number one priority", and based on several discussions with General Practitioners at the Deep End, SAMH is aiming at a joint programme with the following elements :

- targeting practices within 2 miles of an existing SAMH service
- embedding a SMH worker in the practice
- improved service delivery
- service development

Four key elements will be :-

- Distress
- Peer support
- Personal resilience
- Community resilience

Additional elements will include :-

- Welfare benefits
- Employment support

- Therapeutic horticulture
- Suicide prevention
- Sport and Physical activity
- Community development (including ALISS)
- Evaluation

SAMH is on track to have 15-20 Deep End practices involved in the programme, but there is still time for practices to note interest (via : neil.armstrong@samh.org.uk)

Recruitment and Retention in the Deep End – Dr David Blane

Recruitment and retention are becoming crisis issues, as a result of pressures on and within practices, the perceived unattractiveness of GP careers, the age and gender profile of general practitioners and increasing numbers taking early retirement.

Governments in Scotland and England have begun to address the problems with measures to improve recruitment, retention and returning to general practice.

The Report of the Primary Care Workforce Commission in England recommends :

- General practice hubs
- A stronger population focus
- Expanded workforce in primary care
- New roles (e.g. physician associate)
- More administrative support
- More time with patients
- New models of care
- Better use of IT
- Improved premises

In Scotland, the age distribution of GPs is bimodal. Most GPs in their 50s are men while most GPs in their 30s are women.

Although data on GP numbers and WTE have become less reliable, due to voluntary reporting, the available data show that GPs serving the most deprived population decile have 25% more patients than GPs serving the most affluent population decile.

54% of GPs serve the more affluent 50% of the population, which is 16% (n=358) more than the 46% of GPs serving the more deprived 50%

The most deprived decile has the oldest GPs, with 37% aged 50 and over, including 6% over 60.

“The most challenging question of how to recruit and retain GPs in under-doctored areas will remain an intractable one as long as the underlying problem of under-investment in primary care in these areas persists”.

Based on three focus group sessions (with GP registrars and young doctors) held prior to the conference, most GP trainees are planning to do locums after their training to gain a range of experience in different practices

A full-time (9 session) commitment is considered unsustainable. Many are looking for portfolio careers

Few GP registrars had given much thought to the potential leadership role of GPs. Most are concentrating on issues of clinical competence and assessment.

General practice in very deprived areas is not in itself off-putting for younger GPs. More important issues in determining whether a practice is attractive or not, are whether it is well organised, with strong nurse support and a good working atmosphere.

Deep End general practice is also attractive because “you just genuinely feel you’re going to make a difference”.

Measures to increase recruitment to Deep End practices include :-

- More training practices in deprived areas (currently involving about a quarter of Deep End practices, compared with 40% in more affluent areas)
- Additional support for Deep End training practices
- Practice rotations for all GP trainees
- Expanding the NES Health Inequality Fellowship Scheme

The next generation of GPs is “up for the challenge” of general practice in the Deep End, but need more support, especially in relation to the development of leadership roles.

Discussion

1 What needs to change in the doctor patient interaction?

NOW

- Different ways of working
- Flexible appointment times
- Combination of reactive and proactive approaches
- Patient education of GP role
- Realistic expectations
- Support from Government/Defence Unions/employers/schools

- Positive publicity for GP
- More time for palliative care and care planning
- More team working
- Address fragmentation in the PHC team, support current relationships, invite new contacts
- Health visitors are overloaded, especially with child protection issues
- Co-location to establish personal relationships with visiting specialists
- Improve relationships with secondary care via better communication, visiting specialists, training rotations, email advice lines, joint forums
- Address the issue of rejection, looking after “our patients,” with compassion

FUTURE

- Targeting the “unworried unwell”
- Increasing confidence in self-management
- Development of expert generalist role
- No more “just go and see your GP” adverts
- Seeing the RIGHT person at the RIGHT time
- Attached workers, to reduce silo working
- Additional roles
- Stigma associated with some referrals less likely if kept in general practice
- Liaison with public health initiatives, such as line dancing, “fun” in general practice
- Time for links to community resources
- More research in the Deep End
- Campaigning – Doctors for Social Justice – example of younger doctors
- Know your local members of parliament
- Get to know community activists

2 What can the GP delegate?

NOW

- M/S, podiatry, addiction, immunisations, social, prescribing, ophthalmology, dentistry, financial advice
- Community respiratory teams (CRTs). Physios are trained to listen to chests.
- Heart failure and COPD teams can lead to more house calls.

- Chronic disease management by practice nurses, but will there be enough PNs?
- How well will other services cope with undifferentiated problems?
- Can they provide access which is as quick?
- Should there be open access or triage? (physio open access is over-used)
- Patient education needed
- New arrangements need evaluation
- Might physios prescribe? Would that lead to polypharmacy?
- Palliative care is increasing. Will need bigger teams and links to charities.
- How much can pharmacists take on? Not happy about examining and diagnosing patients. “Don’t know what they don’t know”. GP registrars need support – who will provide this for pharmacists?
- If new colleagues are not “upskilled”, patients are more likely to be referred to the GP or hospital
- DNs have agreed delegated functions
- “All nurse managers should do some clinical work”
- Communication is central to delegation and helped when hubs are in the same place.
- Nursing home liaison

FUTURE

- Is there political will to increase capacity?
- Need clear boundaries
- A clear policy is needed concerning house calls.
- GP training needs to include how to work with a delegated workforce
- Important to be able to say No
- Be wary of knock-on effects of new ways of working – volume of work, dependence on patients being able to explain things.
- Needs to be better analysis of current and future workloads
- General practice needs better PR in medical school
- The media should stop slagging off GPs
- Other services should be able to re-refer/refer onwards without referring back to the GP
- GPs are poorly placed to assess fitness for work
- In-house translators – the “language line” is not satisfactory

- Patients need better English lessons
- Links project for all practices
- Signposting to voluntary sector
- Worry that delegation could break the continuity of care
- Housebound patients should get the same care as ambulatory patients, but this needs a “hospital at home” team with good links to primary care. PNs and DNs need upskilled for this.
- Elderly care should begin 10 years earlier in deprived practices
- Mental health and addiction services should be embedded

3 What does the next contract need to look like for me to do the job I want to do?

- Light touch concept
- Increase personnel in primary care via the attached multidisciplinary team (MDT)
- Flexibility fosters innovation
- Keep control of practice staff
- Middle managers to facilitate attached staff (redressing the balance of power)
- Quality control measures that are not too time-consuming e.g. referral and prescribing patterns
- Fair remuneration, taking deprivation/disease prevalence into account

4 What do we need to do to recruit the GP work force?

NOW

- Promote general practice as front line practice
- Require students to stay and work in the NHS
- Recruit and retain from local areas
- Make work-shadowing a routine team-building activity
- More time, not only for patients, but also colleagues, practice staff, medical students.
- The practice as a training environment for the whole team
- GP involvement in management re-structuring
- More support *across* practice teams, sharing knowledge and expertise
- Support from Health Board for practice restructuring and cluster development within localities
- Supportive environment for practices which are struggling

FUTURE

- Develop personal relationships with practice staff and other agencies
- Capitalise on motivations such as “making a difference”
- Fostering practice team relationships by meeting regularly in and out of practice
- Commitment to sustainable workloads
- Have a proper recruitment drive
- Promote general practice in medical schools
- Make general practice tasters standard in medical school
- End “GP bashing” during FY years
- End the culture of primary care v. secondary care
- Build better relationships with secondary care
- Team-based complex patient management, being able to talk through the “grey areas”
- Support each other e.g. sharing difficult patients
- Mandatory GP training for all medical students
- Provide portfolio career opportunities
- How to recruit from local areas e.g. deprived communities?
- More training practices in deprived areas
- Maintain quality of general practice in deprived areas
- Open opportunities for youths from deprived areas to get work experience in general practice

5 What would the ideal Deep End practice look like?

- Practices communicating within clusters, and supported by salaried GPs (One very big practice was noted to be “mopping up” ex-trainees into salaried posts.
- 20% more GPs
- 15 minute appointments
- A contract shaped to their locality
- The cluster having easy links to a link worker, a mental health worker, local community health support services and assertive outreach
- Funding to take account of morbidity burden, not current activity data.
- Varied views on independent v salaried contract
- Practices as hubs of local health systems

- Quality should be the driver
- Discussion about triage and gatekeeping roles – can anybody else do them?

6 What needs to happen to make evidence work, pilots be sustainable and policy be on the side of deep end communities?

- The hectic nature of daily work makes it difficult to step back and reflect on how to do things differently (“can’t see the wood for the trees”)
- GPs should lead pilot projects, with patient and public engagement
- Deep End GPs are stronger together than working individually in practices
- Politicians should be pressed to support community projects and patient education (including loop videos in waiting rooms)
- MSPs should be accountable for making changes and should hold change leaders to account
- There is a need for more evidence (“do GPs keep patients out of hospital?”), expanded pilots and a campaign to influence politicians.
- Practices need better links with charities, the third sector and local community resources for health
- The Link Worker Programme has been slow to take off, but this is the nature of many long term strategies.
- Campaigning material needs to be packaged properly.
- Academic general practice needs to be bigger and stronger to help produce such evidence, especially evaluations based on outcomes.
- There is too much investment in single diseases
- Abandoning the QOF could free up time to be more holistic
- Patients should be encouraged to lobby their MSPs. This may be more difficult in deprived areas, but patients could be helped by signposting to MSPs
- The Cabinet Secretary had declared her intention to invest more in general practice, but more detail and transparency is needed.
- The general public has become more selfish and needs to develop a stronger interest in social justice.
- Media coverage of general practice tends to be negative.
- The “Put Patients First” campaign has not been well communicated
- The power of communities, including multiple small acts of kindness, should not be underestimated.

- Over diagnosis and treatment are challenges, especially when consultation time is short.

7 What should we do to share best practice?

- Lack of time and infrastructure are barriers, especially as demands on practices have increased
- The tendency is for practices to work in isolation
- Protected time is crucial, with GEMS cover as required
- But there is competition for protected time and not all shared learning initiatives have been successful
- The agenda has to be responsive to the needs of practices, if they are to give up time.
- It is a challenge to include practices which tend not to engage.
- Practices are generally curious and creative, responding quickly when convincing information is made available
- Progress, and funding, is easier when local developments and national policy are in tandem.
- Smaller groups are better for getting everyone to contribute.
- “We need fewer people who don’t do our job telling us how to do our job”
- Shared learning works in some areas better than in others
- Practices tend not to share their experience of appointment systems, including the number of appointments they provide.
- Some practices are “hard to reach” for this type of activity
- Modesty prevents declarations of “best practice” while no one likes to present poor practice.
- GPs can feel that their experience is insufficient as “evidence”. Academic evidence is not the only kind.
- External support can help by gathering evidence and collating information, but the information needs to be informative
- Prescribing advice provides a useful model of feeding back comparative information.
- Deep End meetings provide a non-threatening way of sharing experience and views between front line GPs.

WHAT TO DO NOW?

- Important not to de-stabilise with too many changes at once.
- The Deep End logo is now widely recognised and provides a basis for lobbying

- National GP representatives have to represent all GPs, which works against the interests of deprived practices and communities.
- However all practices have been affected by the national reduction in GP funding from 10 to 8% of the NHS budget.
- Helene Irvine's data were exciting, the first time such material had been seen, and showing where Heath Boards and CHPs have over-invested.
- The Government's £60 million for primary care isn't yet committed or obviously targeted but includes support for pharmacy initiatives, taking the load off general practices.
- Practices need easier access to locums – this could be organised better
- It's important to evaluate outcomes – that's where Keep Well went wrong.
- Developments need internal evaluation to drive change and external evaluation to persuade others
- Randomised controlled trials are seldom possible. Other types of evidence are needed.
- Would Deep End projects such as Govan SHIP and Link Workers work as well in other practices?
- If you keep on what you are doing, nothing changes.
- Improved funding would help morale, boosting both recruitment and retention.
- Many MSPs cover areas of blanket deprivation and are motivated to support Deep End practices.
- Once you lose services you never get them back
- Centralisation is thought to be more efficient, but for services, not patients.
- The social care budget is being cut even more than the health budget.
- Variations between practices make it difficult for budget holders to hand over funds.
- Are amalgamations the future?
- Salaried service would bankrupt the NHS if it tried to provide the same service as independent contractors. The NHS would also have to provide sickness cover.
- The current contract was said to be very good at defining the GP role.
- Safeguards are needed for the risks experienced by independent contractors.
- It is unlikely that the next generation of GPs will contract for 9 sessions per week.
- Protected time could help, as happens in the consultant contract
- Is there still a perception to correct that GPs only see sore throats?
- The Deep End can speak freely, unlike the BMA which also speaks for doctors in secondary care.

- General practice isn't a sink into which new, unresourced work from secondary care can continue to be poured.

8 What needs to change in our relationship with others (e.g. other primary health care, secondary care etc)?

- NHS management should stop breaking up existing relationships and the cumulative knowledge and experience they involve e.g. with CPNs, health visitors and district nurses.
- Attached workers need to be embedded, not working in silos, based on close working relationships
- Practices can make use of co-workers' skills and discuss cases with them (e.g. a co-located psychologist visiting once a fortnight)
- The SAMH initiative could be useful
- Horizontal, local referral keeps care within the team, with better uptake, improved coordination and continuity, and fewer DNAs
- Some services have less stigma attached to them if co-located within a practice
- Working as a team means working with colleagues, not services.
- Accountability should shift to colleagues and patients, rather than external managers.
- Speciality trainees should rotate to general practices
- Public health/health promotion colleagues could "sit in" to gauge new services e.g. indirect health promotion via line dancing for type 2 diabetic patients.
- Improved links to community services and resources – fostering an environment in which this can happen
- Improve links to secondary care specialists via email advice lines, visiting clinics, joint forums etc

Conclusions

This report is primarily a document of record, comprising what was presented and discussed at the 3rd National Deep End Conference on 24th November 2015. It is already informing Deep End activity in 2016.

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