All Aboard the Govan SHIP

The Inverse Care Law ‘the principle that the availability of good medical or social care tends to vary inversely with the need of the population served’ (Julian Tudor Hart)

What are Health Inequities?

- Equality = SAMENESS
  - Only works if everyone starts from the SAME place
- Equity = FAIRNESS
  - Making sure people get access to the same opportunities

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

Proposals from General Practitioners at the Deep End

March 2013

www.gla.ac.uk/deepend
Deep End GPs - Who Are We and What Do We Want?

• General Practitioners at the Deep End work in 100 general practices serving the most socio-economically deprived populations in Scotland based on the Scottish Index of Multiple Deprivation (SIMD).
• 88-44% of their patients in the most deprived 15% of datazones

OUR PRIORITIES:
• GP leadership with protected time for service development
• Build links between practices and local communities and services
• Collegiality based on joint working, peer review and shared learning with other practices (beyond the DE)
• Advocacy based on collective experience and common cause
• Accountability, individually and collectively, for the use of public funds
• Involvement of the next generation of GPs in all the above.
• Opportunity to provide unconditional, personalised continuity of care whatever problem or combination of problems a patient has
• The inverse care law being the difference between what it’s possible to do and what GPs know they could do if better resourced, connected and organised.
DEEP END MANIFESTO 2017

In March 2013 Deep End Report 20 (Annex A) took the form of a manifesto entitled:-
What can NHS Scotland do to prevent and reduce health inequalities?

The report and recommendations remain relevant but need updating to take account of changed circumstances concerning general practice in NHS Scotland.

Deep End Report 32 (www.gla.ac.uk/deepend), reviewing the past, present and future of the Deep End Project, 8 years after the initial meeting in 2009, provides a detailed background to the new manifesto.

To counter the dominance of specialism and managerialism in NHS Scotland, generalist clinical care based on general practice hubs needs to provide solutions to the health care challenges of multimorbidity, fragmented care, increased pressure on emergency services and static inequalities in health.

If general practitioners are to be recruited and retained in sufficient numbers to serve and lead this function, it is axiomatic that the role of general practitioners must be an attractive career option.

The Deep End Project, comprising the collective activities of General Practitioners at the Deep End, serving Scotland’s 100 most deprived communities, has developed a coherent vision, with worked examples, for the future of general practice in Scotland.

The project now seeks common cause with other general practices to protect and promote the future of generalist clinical care in NHS Scotland.

October 2017
<table>
<thead>
<tr>
<th>Measure</th>
<th>Govan/ Linthouse SIMD 1</th>
<th>WhiteCraigs SIMD10</th>
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<tbody>
<tr>
<td>Male Life Expectancy</td>
<td>67</td>
<td>85</td>
</tr>
<tr>
<td>Female Life Expectancy</td>
<td>73</td>
<td>94</td>
</tr>
<tr>
<td>Patients hospitalised with coronary heart disease</td>
<td>570</td>
<td>35</td>
</tr>
<tr>
<td>Early deaths from CHD (&lt;75)</td>
<td>95</td>
<td>35</td>
</tr>
<tr>
<td>Patients hospitalised with asthma</td>
<td>94</td>
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<td>Patients with emergency hospitalisations</td>
<td>11880</td>
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<td>Patients (65+) with multiple emergency hospitalisations</td>
<td>8913</td>
<td>3979</td>
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<tr>
<td>Patients with a psychiatric hospitalisation</td>
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<td>95</td>
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<td>Deaths from suicide</td>
<td>36</td>
<td>11</td>
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<tr>
<td>Teenage pregnancies</td>
<td>81</td>
<td>17</td>
</tr>
<tr>
<td>Mothers smoking during pregnancy</td>
<td>32%</td>
<td>3.4%</td>
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<tr>
<td>Immunisation uptake at 24 months - 5 in 1</td>
<td>97.6%</td>
<td>97.1%</td>
</tr>
<tr>
<td>Immunisation uptake at 24 months - MMR</td>
<td>97%</td>
<td>93%</td>
</tr>
<tr>
<td>Children Living in Poverty</td>
<td>38%</td>
<td>3%</td>
</tr>
</tbody>
</table>

http://www.scotpho.org.uk
It’s Not Just Glasgow!
Frequent Attenders at an Ayr Hospital

A&E Frequent Attenders

A Tale of 2 Communities


Emerg Med Conf November 2018
MULTIMORBIDITY IS SOCIALLY PATTERNED

• Multimorbidity (2 or more chronic morbidities) is socially patterned, more common and occurs at a younger age as deprivation increases, associated with reduced functional status, increased use inpatient and ambulatory care, high mortality (Barnett, K. et al (2012). Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet 380(9836), 37-43)

• Mental health problems are strongly associated with the number of physical conditions that people have, particularly in deprived areas.

• Male HLE at birth in the 10% most deprived areas in Scotland was 43.9 years, 26.0 years lower than in the least deprived areas (69.8 years).
• Female HLE at birth was 49.9 years in the most deprived areas, 22.2 years lower than in the least deprived areas (72.0 years)
  http://www.gov.scot/Publications/2017/12/4517/5

• Affluent patients with multimorbidity get 25% longer consultations. Similar patients in deprived areas get NO additional time (Mercer SW et al. Ann Fam Med 2018 16 (2): 127-131)
LOSING THE GP GATEKEEPER FUNCTION

2y CARE

4 HOUR TARGET

THE ‘UNWORRIED UNWELL’

THE ‘WORRIED WELL’

OVERCONSUMPTION SERVICES/OVERINVESTIGATION

FRAGMENTED HEALTHCARE & GP SERVICES – IN HOURS, OOH

LACK OF COMMUNITY BEDS

ACEs

HEALTH LITERACY

REDUCED SOCIAL CARE ELDERLY BUDGET

REDUCTION DNS – AGENDA FOR CHANGE 2007

1y CARE

EARLY END OF HEALTHY LIFE EXPECTANCY

RURAL vs URBAN POVERTY

THE INVERSE CARE LAW

MULTIMORBIDITY

REDUCTION GPS RELATIVE TO CONSULTANTS

COMPLEX PATIENTS ARE MORE COMPLEX IN THE COMMUNITY

Emerg Med Conf November 2018
# The Big Picture - The 4 Hour Target Across Scotland

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>03-Dec-17</th>
<th>10-Dec-17</th>
<th>17-Dec-17</th>
<th>24-Dec-17</th>
<th>31-Dec-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>96.4%</td>
<td>94.0%</td>
<td>92.4%</td>
<td>92.9%</td>
<td>86.7%</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>88.9%</td>
<td>93.9%</td>
<td>88.5%</td>
<td>86.7%</td>
<td>82.7%</td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>90.0%</td>
<td>89.5%</td>
<td>88.6%</td>
<td>83.4%</td>
<td>83.5%</td>
</tr>
<tr>
<td>NHS Fife</td>
<td>93.8%</td>
<td>94.9%</td>
<td>85.4%</td>
<td>89.0%</td>
<td>81.5%</td>
</tr>
<tr>
<td>NHS Forth Valley</td>
<td>80.1%</td>
<td>83.4%</td>
<td>64.1%</td>
<td>79.7%</td>
<td>57.3%</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>91.9%</td>
<td>93.6%</td>
<td>89.7%</td>
<td>90.6%</td>
<td>87.9%</td>
</tr>
<tr>
<td><strong>NHS Greater Glasgow &amp; Clyde</strong></td>
<td><strong>89.9%</strong></td>
<td><strong>84.9%</strong></td>
<td><strong>78.8%</strong></td>
<td><strong>77.0%</strong></td>
<td><strong>71.1%</strong></td>
</tr>
<tr>
<td>NHS Highland</td>
<td>95.6%</td>
<td>96.6%</td>
<td>94.0%</td>
<td>96.0%</td>
<td>87.6%</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td>89.0%</td>
<td>85.6%</td>
<td>82.3%</td>
<td>82.7%</td>
<td>76.8%</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>83.4%</td>
<td>77.3%</td>
<td>68.7%</td>
<td>76.3%</td>
<td>76.2%</td>
</tr>
<tr>
<td>NHS Orkney</td>
<td>96.4%</td>
<td>93.5%</td>
<td>97.7%</td>
<td>98.3%</td>
<td>97.2%</td>
</tr>
<tr>
<td>NHS Shetland</td>
<td>94.7%</td>
<td>97.0%</td>
<td>92.9%</td>
<td>94.7%</td>
<td>95.1%</td>
</tr>
<tr>
<td>NHS Tayside</td>
<td>97.8%</td>
<td>95.3%</td>
<td>90.2%</td>
<td>95.4%</td>
<td>87.3%</td>
</tr>
<tr>
<td>NHS Western Isles</td>
<td>100.0%</td>
<td>95.9%</td>
<td>96.8%</td>
<td>99.3%</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>NHS Scotland</strong></td>
<td><strong>89.7%</strong></td>
<td><strong>86.9%</strong></td>
<td><strong>81.1%</strong></td>
<td><strong>83.3%</strong></td>
<td><strong>78.0%</strong></td>
</tr>
<tr>
<td><strong>NHS Scotland excluding NHS Lothian</strong></td>
<td><strong>91.1%</strong></td>
<td><strong>88.9%</strong></td>
<td><strong>83.5%</strong></td>
<td><strong>84.6%</strong></td>
<td><strong>78.4%</strong></td>
</tr>
</tbody>
</table>

- 85.5% of attendances at A&E services were seen and resulted in a subsequent admission, transfer or discharge within 4 hours.
- 14% patients spent more than 8 hours in an A&E department.
- 43% patients spent more than 12 hours in an A&E department.

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**Note:** Data are based on the numbers of attendances at Accident and Emergency departments in Scotland, which is a subset of NHS Scotland.

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Source: ISD Scotland Weekly A&E Data Extract

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[Provided Website Link](http://www.isdscotland.org/Health-Topics/Emergency-Care/Publications/2018-09-18/Summary-Weekly/index.asp)
THE SMALL PICTURE- A&E ATTENDANCES OF A GOVAN PRACTICE PATIENTS. APRIL AND MAY 2015

• **69 patients** = 98 A&E attendances
• **6 patients attended 3 or more times.** 2 patients were in the age group **25-44**, 2 patients were in the age group **45-64**, 2 patients were in the age group **65-74**.
• **Stratified sampling 22 patients** - descriptive evaluation of the factors that may have precipitated attendance at A&E
• **11 patients had 4 or more physical** conditions that are commonly managed in general practice e.g. CKD, Heart failure, Hypertension, COPD, Diabetes. 6 of these patients had a mental health issue ‘**multimorbidity**’
• **10 patients** are prescribed 10 or more repeat medications ‘**polypharmacy**’

**FREQUENT ATTENDERS (6 Patients)**

**P1**: Palliative patient. Died in hospice 12 months later.

**P2**: 4 A&E attendances in April. Mental health issues (discharged from psychiatric ward 2 days before 2nd A&E attendance), institutionalised behaviour

**P3**: Alcohol problems

**P4**: Patient with end stage renal failure

**P5**: Non cancer palliative care patient (resident in a care home)

**P6**: Patient with MH issues self harming (serial attender)
A LIFETIME OF TRAUMA- THE STORY OF A SERIAL ATTENDER(P6)

• Male
• < 5 years placed in a children’s centre-no details in medical records.
• Child Health review ‘rate of growth slow...learning difficulties...range of difficulties, physical, social and learning’
• > 18 years -review at endocrine clinic when homeless. Lost to follow up when incarcerated.
• >18 Diagnosed with a seizure disorder
• 2010-2015 100 A&E contacts: 8 orthopaedic admissions: 12 Medical admissions : 39 Psychiatry contacts :5 psychology contacts: 10 plastic surgery contacts
• Discussed at SHIP MDT on several occasions-8 professional and key workers
• Patient found dead at home ( <25 years) in supported accommodation. Cause of death unclear- no immediate evidence of drug paraphernalia.

Emerg Med Conf November 2018
• An ACE survey with adults in Wales found that compared to people with no ACEs, those with **4 or more ACEs** are more likely to
  • have been in prison
  • develop heart disease
  • frequently visit the GP
  • develop type 2 diabetes
  • have committed violence in the last 12 months
  • have **health-harming behaviours** (high-risk drinking, smoking, drug use).

http://www2.nphs.wales.nhs.uk:

http://www.healthscotland.scot/population-groups/children/adverse-childhood-experiences-aces/overview-of-aces

Emerg Med Conf November 2018
- ACEs are part of Inequalities
  - 3x more people suffered 4+ ACEs in most deprived versus wealthiest 1/5 of people (UK)
- Just in Deprived Communities
  - More ACEs = More smoking, alcohol misuse, early sexual activity and premature ill health across the life course

Bellis et al. 2014, n=3883
• A retrospective cohort study of all DKA admissions between 2007 and 2012 at a university teaching hospital (ERI).
• Type 1 diabetics admitted with DKA - 628 admissions of 298 individuals.
• Recurrent DKA (more than five episodes) - diagnosed with diabetes at an earlier age had higher levels of social deprivation and higher HbA1c values and tended to be younger (25 [22–36] vs 31 [23–42] years).
• Antidepressant use was greater in those with recurrent DKA compared with those with a single episode.
• A single episode of DKA was associated with a 5.2% risk of death compared with 23.4% in those with recurrent DKA admissions.

Recurrent DKA is associated with substantial mortality, particularly among young, socially disadvantaged adults with very high HbA1c levels.

Diabetologia (2016) 59:2082–2087
DOI 10.1007/s00125-016-4034-0

Emerg Med Conf November 2018
## DKA: THE GLASGOW EXPERIENCE IN 1 YEAR (2017)

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Count of Individuals with episodes and number</th>
</tr>
</thead>
<tbody>
<tr>
<td>GRI</td>
<td>202</td>
</tr>
<tr>
<td>IRH</td>
<td>38</td>
</tr>
<tr>
<td>QEUH</td>
<td>216</td>
</tr>
<tr>
<td>RAH</td>
<td>131</td>
</tr>
<tr>
<td>RHC</td>
<td>51</td>
</tr>
<tr>
<td>STO</td>
<td>3</td>
</tr>
<tr>
<td>VIC</td>
<td>2</td>
</tr>
<tr>
<td>VOL</td>
<td>3</td>
</tr>
<tr>
<td>WGH</td>
<td>4</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>650</strong></td>
</tr>
</tbody>
</table>

**Data source:** Dr Andrew Kernohan, Consultant Diabetic Physician QEUH

### Count of IPE Patient CHI

<table>
<thead>
<tr>
<th>Count of IPE Patient CHI</th>
<th>Column Labels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Row Labels</td>
<td>1  2  3  4  5  6  7  8  9</td>
</tr>
<tr>
<td>1</td>
<td>141 42 11 4 3 5 3</td>
</tr>
<tr>
<td>2</td>
<td>89 12 5 3 2 4 1 1</td>
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<tr>
<td>3</td>
<td>44 7 4</td>
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<td>4</td>
<td>45 5 1 1</td>
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<td>5</td>
<td>38 11 1</td>
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<td>38 6 4 1</td>
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<td>8</td>
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<td>37 4</td>
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<tr>
<td>SIMD</td>
<td>11 4 1 1</td>
</tr>
<tr>
<td>Grand Total</td>
<td>494 97 29 9 6 9 4 1 1</td>
</tr>
</tbody>
</table>
No of individuals with DKA in 2017

Glasgow DKA 2017

Dose Adjustment For Normal Eating (DAFNE)
DKA  ADMISSION OF A GOVAN PATIENT

- **MALE PATIENT** multiple GP attendances. **DIAGNOSED IDDM IN HIS 20s** (attendance at A&E with 2y symptoms)
- **GP data entry** ‘does not appear to attend any diabetic clinics’. GP letters patient (repeating pattern)
- **NEVER CHECKS BMS, VARIABLE COMPLIANCE WITH INSULIN**
- **MULTIMORBIDITY- DEPRESSION** for several years
- **DNAS RETINAL SCREENING**
- **ATTENDS A&E** WITH CELLULITIS & DIABETIC ULCER-DECLINES ADMISSION – URGENT DIABETIC REVIEW
- **SUBSEQUENTLY ADMITTED DKA**
HORIZON 1 SINKING IN THE DEEP END

- Pre-established team working but no strategic support
- Collective memory of working with attached social worker - a positive experience. Loss of organisational memory
- Clunky communication systems - an ongoing frustration
- Fragmented data systems
- GP contract - minimises maternity, paediatric and family health care
- No specific role for GPS in care of vulnerable children & families despite being the ‘hub’ and point of contact for other services / outside agencies
- Vulnerable adults often don’t reach thresholds of service provision. Boundaries to service provision are barriers to access to service
- Very little research to argue our case. GPS don’t write things down, difficult to quantify ‘non events’
- Experience doesn’t seem to count

HORIZON 2

Navigating Horizon 2

HORIZON 3 SAILING ON CALM WATERS

- Protected time - case planning
- Professional relationships - face-to-face discussions - blurring the boundaries – all working as generalists,
- Infrastructure - e.g. MDT meetings, JSTs, whole systems approach, 1Y & 2Y Care Interface, steering group
- Multimorbidity database
- Documentation - minuted meetings, diaries admin support
- Patient engagement
- Research that fits working practices (e.g. evaluation report)
- Bigger picture - links workers, mental health, education, 3Rs sector management (understanding budgetary constraints and planning networks)
- Normalising the project work through connectivity, embedded knowledge, knowledge exchange – an ecology of learning
Putting It All Together – SHIP MDT

- Workstreams
- Children & Families
- Frail & Elderly
- Unscheduled Care
- Information Management
- Other

As Required
- 2y care
- Education
- Housing
- Carer Support
- Welfare
- Well being
- Social isolation

FOCUS Patient / Client Child/Parent /Family unit

Social Care Worker

Mental Health

District Nurse

Health Visitor

Rehabilitation/Physiotherapist

Links Worker

General Practitioner (GP)
Govan SHIP – Frail / Elderly Case Study-the System Is Working

- Female Age>70
- Unexplained weight loss, escalating pain issues, psychological distress, non-compliance with current meds.
- PMHx- Depressive Disorder , Chronic pain, COPD
- Relevan Social Hx: Husband admitted to hospital with a terminal illness. Patient increasingly distressed and not coping. Found wandering outside house, multiple OOH contacts.
- Family discussed at several SHIP MDTs to anticipate care arrangements for son (LD). Emergency placement for son in a care setting.
- Patient referred urgently to DME and seen within 2 days with urgent investigations, dietician review and follow up appointment organised. GP referral to psychogeriatricians for assessment of capacity.
- Coordinated approach between 1y and 2y care. Avoidance of admission because of urgent assessment at DME and GP protected time to manage and coordinate care plan with SW colleagues.
- Professionals involved- DNs, GPs (practice and OOH), SW, DME, Psychogeriatrician
Analysis of overall GP Demand between the practice populations of the Govan SHIP Project and equivalent comparator practices. The comparator practices were selected for similar characteristics such as population size and deprivation.
A BROADER PERSPECTIVE

• Communication networks, Trusting relationships
• Joined up thinking between 1y/2y care clinicians
• Health care planned from the frontline
• Hands off management
• Whole systems approach
• Less bureaucracy
• Allow to take risks, OK to drop things that aren’t working
• More time. Time to think is time to care, plan and manage
• Challenge the status quo
• Look forward but understand your history
• Be political!

Emerg Med Conf November 2018
‘More equal societies bring major reductions in almost all the problems that become more common lower down the social ladder. A more equal society would enjoy better physical and mental health, higher standards of child well-being, less violence, fewer people in prison, less drug addiction and more equal opportunities for children. A more equal society is conducive to the psychosocial well-being of whole populations’ Wilkinson and Pickett (2018, P264)

THANKYOU ANY QUESTIONS?