

**CONNECTING WITH GENERAL PRACTICE TO  
IMPROVE PUBLIC HEALTH**

**Findings of the Primary Care Observatory and  
Deep End projects**

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**July 2011**

## **Executive Summary**

This report links two activities funded wholly and partly by the Glasgow Centre for Population Health (GCPH), namely the Primary Care Observatory (PCO) Project and the Deep End Project.

Their common aim has been to establish a better understanding of the contact and coverage of general practices with the populations they serve and the potential value of these contacts to the NHS in its attempts to improve health and narrow inequalities.

### **Primary Care Observatory Project**

The PCO Project carried out numerous desk-based studies of the epidemiology of general practice resources, activity and outcomes, based on GP list denominators, whose main findings were summarised in the GCPH report *The Shape of Primary Care*.

Practices serving areas of blanket deprivation were shown to be scattered across many Community Health Partnership areas, and to have high levels of disease prevalence, a mismatch of manpower resource relative to need and associated evidence of unmet need.

More generally there were substantial variations in care, such as rates of emergency admission to hospital and outpatient referral rates, which were not explained by demographic factors or by deprivation.

Small practices taking part in two or more optional activities (e.g. teaching, training, research, enhanced record keeping or service development) achieved similarly in the Quality and Outcomes Framework (QOF) as larger practices, while small practices taking part in one or no such activities achieved less.

Further investigation is needed to address the issues of resource allocation, unmet need and variations in practice size, activity and outcome.

### **Deep End Project**

Further work, described as the Deep End Project, explored the potential value of focusing on groups of general practices serving similar types of population, irrespective of geographical location.

PCO data were used to identify and engage successfully with three quarters of the 100 most deprived practices in Scotland. The experience and views of GPs from these practices were captured and summarised in a series of meetings, resulting in 15 reports and serialisation of the findings in the British Journal of General Practice.

The continuation of the Inverse Care Law in Scotland is explained not by the difference between good and bad care between different social areas, but by the difference between what practices serving deprived areas can achieve and what they could achieve, if resourced in relation to need. Key contributory factors are the shortage of time within consultations to address patients' needs and dysfunctional relationships with other professions and services, leading to inefficient, fragmented care.

Six inter-connected solutions are proposed:

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 patients' health.
3. Local systems of care should be based around the natural and sustainable **hub function** of general practices (combining contact, coverage and continuity)
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. The Deep End Project has shown the way.
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*. The Primary Care Observatory function should be an important part of this support system.
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.

A combination of these initiatives could make significant headway in addressing the problem of increasing fragmentation in health care delivery. This successful model of engagement with general practices could be applied to other policy areas, such as integrated care for elderly populations.

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4<sup>th</sup> July 2011

# Connecting with General Practice to improve Public Health

## Introduction

This report links two activities funded wholly and partly by the Glasgow Centre for Population Health, namely the Primary Care Observatory Project and the Deep End Project, respectively.

The project has been unusual in the way that it has evolved, complementing the original plan for desk-based epidemiology with a subsequent series of reports, drawing on the experience and views of general practitioners serving very deprived populations.

The common link to these two types of activity has been a better understanding of the contact and coverage of general practices with the populations they serve and the potential value of these contacts to the NHS in its attempts to improve health and narrow inequalities.

The combined effect of these two strands of work has been to establish a better basis for engaging with general practices and supporting the contribution they can make to health improvement.

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## 1. Context

Policies for improving population health may be considered as those requiring direct contact with the public and those that do not.

Policies requiring contact may require single contacts or serial contacts. Whereas the first type of policy only requires population coverage, the latter also requires continuity, coordination and flexibility.

**Coverage** is necessary to ensure that all are included and that interventions are not delivered to selected or self-selected groups, with potential for widening health inequalities.

**Continuity** is necessary when interventions cannot be delivered effectively in a single encounter e.g. by screening. Continuity of contact also provides multiple opportunities for engagement and to acquire, share and use relevant information.

**Co-ordination** is necessary to avoid the fragmentation which occurs when patients have many problems and are potentially in contact with many professionals and services

**Flexibility** is necessary in order to engage with patients concerning their problems in an order and at a pace which suits them.

When contact is required for more than one policy, efficiency may be obtained by using single contacts for several purposes.

General practice has a particular type of population contact, based on the fact that over a relatively short period (1-3 years) most people make contact with the service for help with current problems.

This cumulative type of coverage needs to be distinguished from the 'cold calling' approach of screening, when people are contacted at a time and for a purpose determined by others.

In services providing universal coverage (i.e. access to health care without financial barriers), the sum of clinical contacts with patients may provide a high level of population coverage. Whether such contacts are used to maximum effect depends on many factors, including the time available for encounters, the number and complexity of health and social problems requiring attention before additional issues can be addressed, the expectations of patients and practitioners and the availability of other support services.

In the UK, the general practice model has intrinsic features of continuity, coordination, flexibility, long term relationships and trust. These features are not exclusive to general practice, nor do they feature to the same extent in

every practice, but insofar as public health. polices require contact with the public, general practice is an important delivery system, whose strengths, weaknesses and opportunities merit thorough assessment.

The Primary Care Observatory (PCO) project began by describing the nature of the contact that general practices have with local populations as a result of the system whereby virtually the whole of the UK population is registered with general practices as their first point of contact with the NHS.

In rural settings, these clinic populations may also have a geographical basis, whereby everyone in a locality is registered with the same general practice or health centre, but in larger towns, cities and conurbations, a distinction may be drawn between “**communities of place**”, based on geography, and ‘**communities of interest**’, based on their point of contact with the NHS.

## 2. Findings from the Primary Care Observatory project

This section provides an overview of the findings, which are presented in greater detail in Appendix B and in the report *The Shape of Primary Care* (SOPC).

As many of the PCO reports are no longer topical, this section refers mainly to key findings as included in *The Shape of Primary Care*.

- i. **Structure**
- ii. **Size of general practices**
- iii. **Demography**
- iv. **Socio-economic deprivation**
- v. **Contact and coverage**
- vi. **Disease prevalence**
- vii. **Health care activity**
- viii. **Unexplained variation**
- ix. **Coronary heart disease**
- x. **GP training v non-training practices**
- xi. **Participation in optional activities**
- xii. **Manpower**
- xiii. **Unmet need**
- xiv. **Sampling frames for research**
- xv. **Conclusions**

### i. Structure

*The Shape of Primary Care* observes that while the two systems of primary care denominators, based on geography and GP lists, should in principle add up to the same total population, in practice they differ, due to “list inflation” whereby the number of people registered with general practices usually exceeds census-based population estimates (by 7% in Greater Glasgow and Clyde), usually due to lags in the processes of registration and de-registration as people die, or move (SOPC p12).

At a very local level within conurbations, there is substantial mismatching between general practice and geographical denominators (SOPC, p62). For example, the Parkhead postal area of Glasgow has 7033 residents, who are registered with 75 general practices throughout Glasgow. The four general practices based in the Parkhead area serve a total population of 17,217 Glasgow residents, of whom 19% are resident within Parkhead, where they comprise 46% of the Parkhead population. The “mismatching” is exaggerated by focusing on a relatively small area. Most patients who live in the East of Glasgow are registered with general practices in the East of Glasgow. On average, only 11% of patients live more than two kilometres from their general practice (SOPC p9).

## **ii. Size of general practices**

The average list size of a general practice in GGC is 4250, and is served by three general practitioners, two practice nurses, two attached district nurses and one attached health visitor (SOPC p9).

A feature of general practice in the West of Scotland conurbation is the large number of small practices, with about half having three or less GP partners. 21% of Greater Glasgow and Clyde general practices were single-handed in 2008, their combined list populations comprising 9% of the population (SOPC, p35).

Although concerns have been expressed about the ability of single-handed practices to deliver high quality care, analyses of QOF performance showed no evidence of under-achievement by single-handed or small practices in meeting quality targets for cardiovascular disease. Small practices did achieve fewer quality points in relation to aspects of practice organization (2).

In another analysis, although single-handed practices taking part in two or more additional activities, such as teaching, training or research, achieved the same number of QOF points as larger practices, single-handed practices taking part in one or no additional activities achieved significantly fewer QOF points (3).

## **iii. Demography**

*The Shape of Primary Care* reports Scottish Practice Team Information (mostly from general practices outside GGC) which shows a direct relationship between increasing age, increased contact rates and thus workload in general practice (SOPC, p42). It also shows that the increased health care needs of older populations fall on all general practices. While 8.9% of patients in the least deprived population decile in GGC are aged 70 or over, the proportion of such patients in the most deprived population decile is 7.3% (SOPC p65). On average, the most affluent practices have 22% more elderly patients than the most deprived practices.

## **iv. Socio-economic deprivation**

Whereas most list populations are socially heterogeneous, with the majority of practices including only a minority of patients living in deprived areas (so called “pocket deprivation”), a significant number of practices in Glasgow serve areas of “blanket deprivation” (SOPC, p61). For example, the 100 most deprived practice populations in Scotland have from 44-88% of their patients living in the 15% most deprived postcode data zones in Scotland. 76 of these practices are in Glasgow City, seven are in Inverclyde and one is in Renfrewshire.

A consequence of grouping general practices geographically for administrative purposes (e.g. within Community Health Partnerships) is that the most deprived 100 practices are distributed across 10 CHP areas in Scotland, and are a majority in only two of them (Glasgow East and North).

## **v. Contact and coverage**

*The Shape of Primary Care* cites Scottish data to report that most patients are in regular contact with their general practice, with about 90% coverage annually (SOPC p41).

## **vi. Disease prevalence**

The report describes many health conditions that are more prevalent (typically more than twofold) in deprived compared with affluent populations, especially mental health problems. For example, comparing typical deprived and least deprived general practices, more than three times as many antidepressants and bronchodilators were dispensed per 1000 patients living in deprived areas (SOPC p52).

## **vii. Health care activity**

While the epidemiology of need in deprived areas is reflected in higher levels of health service use for routine GP appointments, A&E attendances and emergency hospital admissions (SOPC, p55), similar social gradients are not seen for outpatient referrals (SOPC p56). Typically, the least deprived practice has outpatient referral rates 23% above the Glasgow average. In contrast, the most deprived practice has referral rates 14% above the Glasgow average.

## **viii. Unexplained variation**

*The Shape of Primary Care* describes fourfold variation between GGC practices in the rates at which their patients are admitted to hospital as medical emergencies (SOPC p54), which were not explained by differences in demography or deprivation.

## **ix. Coronary heart disease**

*The Shape of Primary Care* goes on to describe the epidemiology of CHD in general practice, based on groups of practices serving similar types of population. For example, using CHD prevalence data from the Local Enhanced Service for Chronic Disease Management in Greater Glasgow, practices serving the most deprived 20% of the population had, on average, 29% more CHD patient per whole time equivalent (WTE) general practitioner than practices serving the most affluent 20%. Practices serving deprived areas also have 2.5 to 3 times more CHD patients under the age of 70, in whom more effective delivery of effective treatments could improve longevity and narrow social differences in life expectancy (SOPC, p70). The levels of anxiety and depression reported by such patients is twice as high as in practices serving the most affluent 20%.

Simple comparison of numbers of CHD cases in affluent and deprived practice populations is confounded by different age and gender profiles. For example, the incidence and prevalence of CHD rises with age, increasing the number of CHD cases in more affluent practice populations and reducing the differences due to deprivation. Thus, while comparison of CHD mortality rates and emergency hospital admission rates for myocardial infarction shows a three-fold increase between the least and most deprived fifth of practice populations under 70, the gradient reduces to 1.4 for practice populations as a

whole (SOPC, p71). It is important to note that CHD prevalence figures reported as part of the Quality and Outcomes Framework (QOF) show the latter pattern. It follows that measures to reward the care of all patients with CHD within a practice population may provide only a blunt instrument with which to reduce health inequalities due to premature CHD mortality.

Although it is desirable to review health care activity and outcome for CHD patients (e.g. treatment with cholesterol-lowering statin drugs) on the basis of need, so that like may be compared with like, current routine information systems do not permit such detailed analyses. For example, although it is known that the crude rate of statin prescribing in practice populations has increased more than fourfold, with a largely unchanging social gradient (1.4 higher in the most deprived compared with the least deprived practice populations), it is not known how these levels of prescribing are patterned by age, gender and clinical indications (SOPC, p 71-72).

An exception is the unusually detailed Coronary Disease Register established as part of the Have a Heart Paisley project (SOPC, p73), which showed how statin prescribing is distributed, on an approximate 50/50 basis, between men and women, patients below 70 and 70+, and between secondary and primary prevention (with and without a CHD diagnosis).

#### **x. GP training v non-training practices**

A comprehensive comparison of training and no-training practices found no significant differences in cardiovascular prescribing or outcomes. These findings were not published. As a result of there being no difference in CVD prescribing, we did not proceed, as originally planned, to analyse differences in the median age of CVD events occurring in 'high' and 'low' quality practices.

#### **xi. Participation in optional activities**

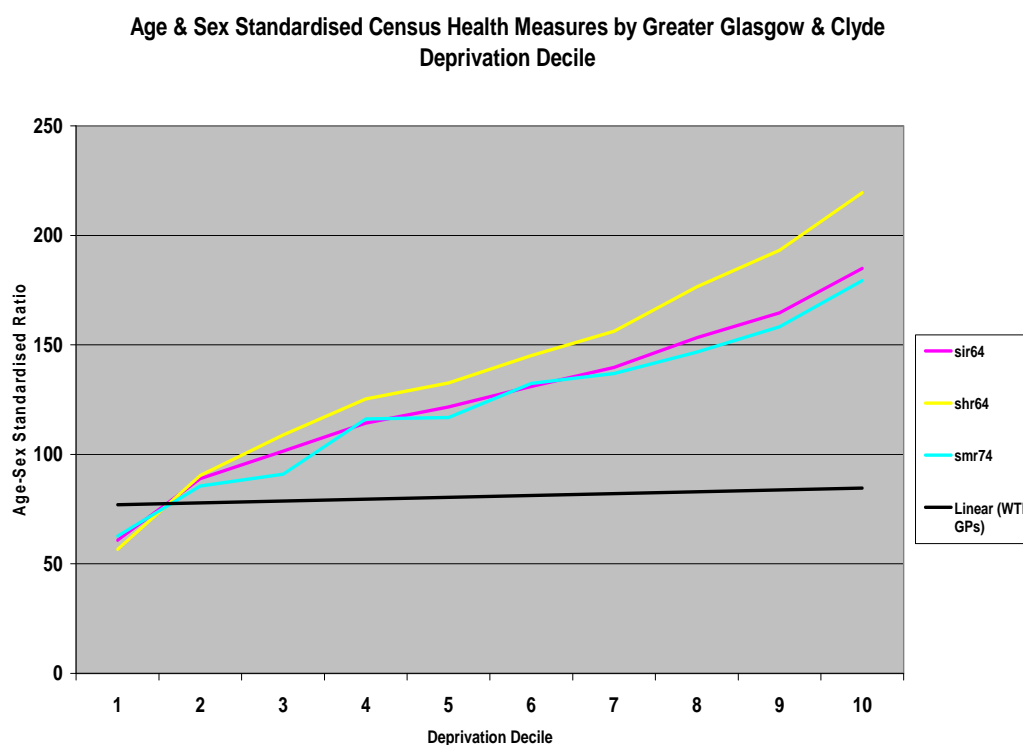
Comparing general practices serving the most affluent and most deprived tenths of the Scottish population (3), participation rates in optional activities was broadly similar for participation in SPICE (enhanced collection of clinical information)(31.0 v 30.8%), SPCRN (the Scottish Primary Care Research Network)(37.0 v 33.1%), SPCC (the Scottish Primary Care Collaborative) (32.0 v 33.3%) and undergraduate teaching (47.0 v 42.1), but higher in affluent areas for GP training (42.0 v 28.7) and the RCGP Quality Practice Award (QPA)(10.0 v 4.9%).

The proportion of practices taking part in two or more activities was similar in the most and least deprived deciles (52.4 v 57.0%).

#### **xii. Manpower**

Despite steep social gradients in the prevalence of disease and ill health, the distribution of GP manpower is virtually flat (the black line in Figure 1), with similar WTE of GPs per head of population in every decile of the distribution of the Scottish Index of Multiple Deprivation (SOPC p67).

**Figure 1**



### **xiii. Unmet need**

The contrast in social patterns of unscheduled care (i.e. routine appointments, A&E attendances and emergency admissions) and scheduled care (outpatient referrals, non-emergency admissions) is one example of comparing observed with expected. In another example, while statin prescribing was observed to be 1.4 times higher, comparing the most and least deprived quintiles of patients, the same comparison of CHD mortality rates showed a ratio of 2.5.

### **xiv. Sampling frames for research**

When PCO data were used as a sampling frame to study the content and outcome of 3044 patient encounters in general practices serving the most and least deprived quartiles of the GGC population, the consequences of the flat distribution of manpower were stark (4). Consultations in deprived areas were characterised by:

- Higher demand
- Shorter time available
- Greater psychological and physical morbidity
- More multi-morbidity
- Less enablement reported by patients with complex problems
- Greater GP stress

### **xv. Conclusions**

The PCO project was based on the observation that the lists of patients registered with general practice provide the NHS with its most effective means of continuous contact with the general population. The project began by

describing the nature of these population denominators and how they relate to denominators defined by geographical area.

GP lists often lack geographical focus. Not only do people within a defined locality tend to be registered with large numbers of general practices outside the area; local general practices also serve patients from a wide range of areas. General practice lists serve *communities of interest*, rather than *communities of place*, contrasting with other primary care services which are organized and delivered on a geographical basis.

General practice lists are also socially heterogeneous with respect to the socio-economic status associated with constituent patient postcodes. While most practice populations comprise a similar *range* of socio-economic circumstances, they vary substantially in the *mean* level (SOPC p124-132). The net effect is that while severe socio-economic deprivation and affluence are concentrated within some practices, patients living in such circumstances may be found in most practices, thus complicating the tasks of reviewing health care activity and targeting resource distribution.

It follows that different but complementary information systems, based on GP list and geographical denominators, are required in order to understand, review and plan primary care services in a particular locality.

The PCO project has illustrated the potential value of this approach; for example, in describing unexplained variations in the use of emergency and non-emergency hospital services.

Social heterogeneity is also found at the level of Community Health and Social Care Partnerships (CHCP), some of which display high levels of deprivation, or of affluence, but most of which comprise a wide social range (SOPC p63). It follows from the above that while CHCPs are the main organizational unit via which primary care is reviewed, planned and funded, additional perspectives may be obtained by comparing groups of practices serving similar types of population.

The main worked example of this approach concerned the epidemiology of “blanket” (i.e. concentrated) socio-economic deprivation. Greater Glasgow and Clyde was shown to include 84 of the 100 most deprived general practice populations in Scotland, scattered across seven CHP areas. As a result of this concentration of blanket deprivation within Greater Glasgow and Clyde, the organisation and delivery of primary care in areas of blanket deprivation is essentially a GGC problem rather than a Scottish problem, requiring local solutions, informed by local evidence and evaluated by local enquiry.

*The Shape of Primary Care* was the first attempt to provide a comprehensive description of primary care in NHS Greater Glasgow and Clyde and demonstrated gaps in basic information concerning staffing, activity and expenditure. It also highlighted a list of issues requiring further investigation

- The PCO observation of the mismatch of medical manpower and health need in practices serving areas of blanket deprivation, led to research showing the consequent time constraints, reduced expectations, poorer outcomes and practitioner stress.
- The disaggregated nature of general practice is associated with large variations in activity and outcome, which are not explained by factors such as age, gender and deprivation. Better information is needed to understand and reduce such variation.
- Several examples of comparing observed and expected health care activity in GGC point to the existence of unmet need e.g. the lack of social gradients in outpatient referral rates. Additional effort is needed to explore, quantify and explain this observation.
- Over half of the population of NHS Greater Glasgow and Clyde is served by general practices comprising 2-4 general practitioners, while a further 9% is served by single-handed GPs. There is a need for better understanding of the strengths and weaknesses of these patterns of working

The Primary Care Observatory project illustrated the type of insights and questions which may be generated by an epidemiological approach, based on GP list denominators. Future challenges include:

- To re-establish the Primary Care Observatory function
- To consider the relationship between the Primary Care Observatory function, based on GP list denominators, and the Public Health Observatory function, based on geographical denominators
- To establish the necessary infrastructure whereby observatory findings can be brought to the attention of relevant user groups, including front-line practitioners.

### 3. Findings from the Deep End Project

A major conclusion of the Primary Care Observatory Project was the potential value of focusing on groups of general practices serving similar types of population, so that common problems and solutions in health care delivery could be addressed. An opportunity to pursue this idea arose via the Deep End Project.

- i. **Origin of the Deep End Project**
- ii. **Targeting deprivation**
- iii. **Social patterning of premature mortality**
- iv. **Where are the 100 most deprived general practices?**
- v. **How big are Deep End practices?**
- vi. **How many GPs are there in Deep End practices?**
- vii. **Performance of Deep End practices in the Quality and Outcomes Framework**
- viii. **What do Deep End practices volunteer for?**
- ix. **Practice participation in the Deep End project**
- x. **Phase one of the Deep End Project**
- xi. **General aspects of practice in the Deep End**
- xii. **Specific objectives**

#### **i. Origin of the Deep End Project**

When the RCGP Scotland short-life working group on health inequalities set out early in 2009 to produce a report on what general practice could do to improve health and narrow health inequalities, it took three initial decisions.

1. Not to duplicate the many existing reports on health inequalities, reviewing the limited research literature

Ten years previously, the Arbutnott Report *Fair Shares for All* had commented on the dearth of research evidence concerning inequalities in health care in Scotland (5). More generally, the limited research that does exist also tends to be biased (6). Not only is the availability of research evidence socially patterned, tending to exclude populations with the greatest degree of health need; research also tends to focus on narrow research questions, concerned with specific problems, rather than the effectiveness and efficiency of primary care as a whole system.

2. Not to provide general practices with a “toolkit”

Toolkits had been criticised by the World Health Organisation in its 2008 Report *Now More Than Ever*, as an approach favoured by technocrats, but unsuited to systems requiring complex decisions at ground level based on local knowledge (6). Toolkits can also have the effect of imposing an external agenda on general practices, without addressing the issue of how the recommended activities can be addressed.

Increasingly, primary health care teams have been encouraged to embark on short term interventions of unproven effectiveness, outside their traditional

areas of activity, for which the opportunity cost has been failing to improve the delivery of interventions of proven or more likely effectiveness within their traditional areas of activity (5)

### 3. To listen to practitioners working in the most deprived areas

The first rule of engagement is to listen to what others have to say. Also, in the absence of much pertinent research, and to avoid a top-down approach, it was decided to tap the experience and views of practitioners, as an important but neglected source of evidence.

#### ii. Targeting deprivation

The work of the Primary Care Observatory project made it easy to identify and characterise general practices in the front line. Three patterns of exposure to deprivation were identified:

1. **Blanket deprivation** where the majority of patients in a practice list live in areas of severe socio-economic deprivation (50% of people living in the Scottish Government's target zone of the 15% most deprived postcode data zones are served by 100 general practices, in whom the proportion of such patients ranges from 88-44%)
2. **Pocket deprivation** where a minority of patients in a practice list live in areas of severe socio-economic deprivation (the other 50% of the target zone are served by 700 other general practices in Scotland)
3. **Hidden deprivation**, where there are too few people living in circumstances of severe socio-economic deprivation to influence the socio-economic profile of a postcode-based datazone (this situation applies particularly in some rural settings, but can occur anywhere)

As the best ways of providing resources to support practices with blanket deprivation, and a high prevalence of health and social problems, are unlikely to be the same as for practices serving areas of pocket or hidden deprivation, the Deep End project focused primarily on the 100 most deprived practices in Scotland, with a combined list size of 429,584, and comprising 8% of the Scottish population.

The "Deep End" epithet refers to the depth of need in severely deprived areas and the difficulty of addressing such needs within relatively short consultations.

Even in the Deep End, general practice populations are socially heterogeneous. On average 69% of patients in the most deprived 100 practices come from quintile five (the most deprived 20% of the population), 14% from quintile four, 7% from quintile three, 6% from quintile two and 4% from quintile one.

### iii. The social patterning of premature mortality

The following table, produced by the Platform Project, shows the proportion of all deaths in 2001-2002 occurring under the age of 70, in deciles of general practice populations in Scotland, ranging from the most affluent to the most deprived.

<b>Deprivation decile</b>	<b>No of Practices</b>	<b>% of female deaths &lt;70</b>	<b>% of male deaths &lt; 70</b>
1	89	14.4%	24.6%
2	104	16.4%	29.0%
3	110	16.3%	29.0%
4	107	16.4%	31.9%
5	92	18.8%	30.6%
6	102	18.9%	32.9%
7	97	20.0%	33.6%
8	108	22.2%	35.0%
9	100	22.3%	38.0%
10	122	24.2%	43.4%
<b>ALL</b>	<b>1031</b>	<b>19.2%</b>	<b>33.3%</b>

By preventing premature mortality, Deep End practices are strategically placed to improve health in deprived areas and to narrow differences in life expectancy.

### iv. Where are the 100 most deprived general practices?

The original 100 practices, classified according to the 2006 version of the Scottish Index of Multiple Deprivation (SIMD) were based in 10 community health (and social care) partnerships. The 2009 version of SIMD resulted in 14 new practices joining the top 100. Six of the original practices had either merged or dissolved. It was decided to continue to include the eight 'displaced' practices in the Deep End group (shown in brackets below), while retaining all of the original 100 practices.

NHS area	All general practices	Number of Deep End general practices	
		SIMD 2006	SIMD 2009
Glasgow East CHCP	35	28	27 (2)
Glasgow North CHCP	19	18	18
Glasgow West CHCP	45	16	15 (2)
Glasgow South-West CHCP	27	14	12
Glasgow South-East CHCP	29	9	4 (3)
Inverclyde CHP	16	5	7
Renfrewshire CHP	30	1	1
Edinburgh	71	5	5 (1)
Dundee	27	2	4
Ayrshire	57	2	3
Lanarkshire	98		3
Grampian	82		1
<b>TOTAL</b>		<b>100</b>	<b>100 (8)</b>

Seventy six Deep End practices are in Glasgow City and 84 in Greater Glasgow and Clyde. Notwithstanding the 16 other Deep End practices based outside GGC, scattered across five health boards, it is clear that the problem of meeting health care needs in areas of blanket deprivation is mainly a GGC rather than a Scottish problem.

#### v. How big are Deep End practices?

List size	No of Practices
<1500	7
1500-2499	16
2500-4499	42
4500-7499	23
7500+	12

The average list size is 4300. The average list size of the Edinburgh Deep End practices is 8524. Overall, the Edinburgh practices have a larger combined list size than the 20 single handed practices in Glasgow. Eight Deep End practices in NHS GGC have list sizes over 7500.

#### vi. How many GPs are there in Deep End practices?

No of GPs per practice	No of Practices	No of GPs
1	20	20
2	21	42
3	19	57
4	7	28
5	15	75
6	4	24
7	3	21
8	5	40
9	4	36
13	1	13
<b>TOTAL</b>	<b>99</b>	<b>356</b>

60 Deep End practices have three or fewer GPs, including 20 which are single-handed.

#### vii. Performance of practices in the Quality and Outcomes Framework

There was no difference in 2007 between the total, clinical and non-clinical points earned by practices serving affluent and deprived populations (e.g. groups of practices serving tenths of the Scottish population all earned between 984 and 974 points: the most affluent group earned 984 while the most deprived group earned 977).

#### viii. What do the Deep End practices volunteer for?

	No of practices
Undergraduate teaching	45
Postgraduate training	27
Research (SPCRN)	46
Primary Care Collaborative (SPCC)	67
SPICE	23
RCGP Quality Practice Award (QPA)	4
Keep Well (Phase 1)	24
Keep Well (Phase 2)	13

### **ix. Practice participation in the Deep End Project**

63 Deep End GPs attended the first meeting at Erskine, plus four GPs from homeless practices in Edinburgh and Glasgow and four GPs from rural practices. Practices took part in subsequent meetings as follows:

<b>Deep End meetings and activities</b>	<b>GPs attending</b>
1. Initial meeting at Erskine	71
2. Needs, Demands and Resources	9
3. Vulnerable Children and Families	10
4. Experience of Keep Well and ASSIGN	20
5. Single-handed practice	9
6. Patient encounters	15
7. GP training	11
8. Social prescribing	10
9. Learning journeys	10
10. Care of the Elderly	3
11. Alcohol problems in Adults under 40	14
12. Working together children and families (organised jointly with NHS Greater Glasgow and Clyde)	20
13. The Access Toolkit: views of Deep End GPs	8
14. Reviewing progress in 2010 and plans for 2011-06-16	32
15. Palliative care in the Deep End	5
<b>Total (Meetings 2-15)</b>	<b>176</b>

### **x. Phase one of the Deep End Project**

The major initial achievement of the project was to establish a common identity and purpose for practices serving the most deprived areas in Scotland, who had never previously been convened or consulted. 73 practices have taken part so far.

The major activity during phase one of the project has been to capture and communicate the experience and views of Deep End practitioners. Appendix C comprises bullet point summaries of meetings 2-15, most of which addressed particular service issues. The rest of this section draws together common messages from these meetings. These also feature in the Deep End Manifesto 2011 (Appendix D).

GCPH funding has been crucial in providing GP locum funding, which has allowed a wide range of practices to be represented at these meetings.

While it was important to begin with meetings restricted to Deep End GPs, more recent meetings on vulnerable families, alcohol problems and palliative care have been multidisciplinary.

The next stage is to build on the engagement with practices and to pursue the many issues which have been raised (Appendix D).

### **xi. General aspects about practice in the Deep End**

The first task of general practitioners is to respond unconditionally to the problems which patients bring. When these problems have been addressed, it is often possible for the GP to address other issues, including anticipatory care.

The common and dominant experience of general practitioners at the Deep End is shortage of time within consultations to address the needs of patients, especially patients with multiple morbidity and social complexity.

The incentives and priorities of the Quality and Outcomes Framework focus largely on measurable aspects of the mass delivery of evidence-based medicine. Many patients also need unconditional, holistic and continuing support for a wide range of problems. The new GMS contract provides little support for this, despite high levels of need in areas of blanket deprivation.

Multiple morbidity occurs at younger ages in deprived areas. Patients with multiple problems are most in need of comprehensive, co-ordinated care, taking place over a long period of time with practitioners whom they know and trust.

Many NHS policies, including those for anticipatory care and self help, are simplistic and flawed in relation to the capacity for quick behavioural change. General practice works cumulatively, addressing patients' problems consistently over serial encounters.

The many contacts of the practice team with patients over time also result in substantial ***cumulative knowledge***, which can be important in identifying problems at an early stage and in knowing the best way to help a particular patient or family. Such information needs to be shared within the team. When staff leave due to burn out or organisational change, such knowledge is lost and may take years to replace.

Individual GP encounters with patients are often insufficient and need to be complemented by referral to other professionals and services, which may be within the practice, local NHS or community. Many such contacts are dysfunctional as a result of lack of information, poor professional relationships, discontinuity or lack of coordination. Patients in deprived areas are often reluctant to attend services which are unfamiliar or distant.

In practices serving areas of blanket deprivation, with high levels of need, GPs consider that attached workers can be the key to providing well integrated care, improving the acceptability and uptake of referrals.

## xii. Specific objectives

The following objectives were agreed at a review meeting in January 2011 and included in the Deep End manifesto.

1. NHS Scotland should commit at its highest level to the support of General Practices at the Deep End as **the front line of its policies and efforts** to improve health and narrow inequalities.
2. General Practices at the Deep End should be **central**, rather than peripheral, to NHS planning, development and support.
3. General practices at the Deep End should be supported in developing **local systems of care**, in which their patient contact and population coverage is complemented by links to other professions, services and resources.
4. Political commitment is required to provide Deep End practices with the **additional consultation time** needed to address the needs of patients with multiple health and social problems.
5. **15 minute appointments** should be standard in Deep End practices, as is already the case in many practices serving non-deprived areas.
6. Better use could be made of existing resources, by addressing the problems of **fragmentation in health care delivery**, and linking other professions and services to the general practice hub.
7. Every Deep End practice should have an **attached mental health worker**, capable of helping patients with psychological, alcohol and/or addiction problems (justified by the volume of cases and the need for additional help to be available locally and quickly)
8. **Health visitors** should be attached to Deep End practices, with capped case-loads and numbers distributed according to need.
9. There should be a **National Enhanced Service for Vulnerable families**, based on the prevalence of vulnerable families within practices and enabling Deep End practices to hold regular, multidisciplinary meetings, based on their substantial knowledge and contact with patients.
10. Practices need to be linked more effectively to **support services** for vulnerable families, so that advantage is taken of the knowledge and concerns of practice teams.
11. General practices should be supported to make better use of non-medical community resources (**social prescribing**).

12. General Practices at the Deep End should be supported as a **Learning Organisation**, dedicated to the improvement of services for patients and providing opportunities to share experience, information, evidence and views, so that good practice can be spread and variations in service are reduced.
13. The disbanded **Primary Care Collaborative**, which involved two thirds of Deep End practices, provided a mechanism whereby local groups of practices were supported to address developments in service. This approach should be re-introduced.
14. National NHS support organisations, such as Health Scotland, Quality Improvement Scotland, NHS Education in Scotland, the Information Services Division and the Chief Scientist Office should provide **an integrated package of support** for the Learning Organisation (avoiding the fragmented and ineffective approach of multiple policies, all lacking focus on the most deprived areas).
15. The imbalance in the distribution of GP training in Scotland should be rectified by increasing the numbers of **training practices and GP trainees** in very deprived areas and ensuring that all GP trainees have exposure to the challenges of primary care in very deprived areas.
16. The NES **GP Health Inequality Fellowship Scheme** should be increased in size (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 experience GPs to take on leadership roles.

## 4. List of Publications

### Scientific papers

1. Wang Y, O'Donnell CA, Mackay DF and Watt GCM. Practice size and quality attainment under the new GMS contract: a cross sectional analysis. *British Journal of General Practice* 2006;56(532):830-835.
2. McLean G, Guthrie B, Watt G, Gabbay M and O'Donnell CA. Practice postcode versus patient populations: a comparison of data sources in England and Scotland. *International Journal of Health Geographics* 2008;7:37.
3. Tomlinson J, Mackay D, Watt G, Whyte B, Hanlon P and Tannahill C. *The Shape of Primary Care in NHS Greater Glasgow and Clyde*. Glasgow: Glasgow Centre for Population Health, 2008.  
[http://www.gcph.co.uk/assets/0000/0423/The\\_Shape\\_of\\_Primary\\_Care\\_FinalFull.pdf](http://www.gcph.co.uk/assets/0000/0423/The_Shape_of_Primary_Care_FinalFull.pdf)
4. Mackay DF and Watt GCM. General practice size determines participation in optional activities: cross-sectional analysis of a national primary care system. *Primary Health Care Research and Development* 2010;11:271-279.

### 2011 series of articles in the British Journal of General Practice

1. Watt G. GPs at the Deep End. *BJGP* 2011;61:66-67
2. Watt G. Patient encounters in very deprived areas. *BJGP* 2011;61:146
3. Watt G. Anticipatory care in very deprived areas. *BJGP* 2011;61
4. Watt G. Working with families in very deprived areas. *BJGP* 2011;61:298
5. Cawston P. Social prescribing in very deprived areas. *BJGP* 2011;61:
6. Watt G. Alcohol problems in very deprived areas. *BJGP* 2011;61:350
7. Sambale P Mandeville R. The Keppoch Medical Practice – reporting from the Deep End. *BJGP* 2011;61(in press)
8. Lyon A Watt G. Learning journeys: Where to, who with and how? *BJGP* 2011;61:(in press)

Four other articles are in preparation.

## 5. Conclusions and implications for future work

The Primary Care Observatory and Deep End Projects have been linked by their common interest in the contact and coverage of general practices with the populations they serve and the potential value of these contacts to the NHS in its attempts to improve health and to narrow inequalities.

Although health policies requiring direct contact with the general public are not the only or most important policies for addressing inequalities in health, insofar as such policies require contact, coverage and continuity, general practices are an important and relatively neglected resource. There was no direct reference to general practice in the launch of *Equally Well*, the Scottish Government's flagship policy for addressing health inequalities.

### The Primary Care Observatory project

The Primary Care Observatory project has described the epidemiology of primary care, based on general practice denominators, complementing the work of public health observatories, based mostly on geographical denominators.

General practice denominators represent communities of interest, rather than communities of place; they vary in size, with a preponderance of small practices; and they are mostly heterogeneous with respect to their socioeconomic profiles.

Three main patterns were identified: *blanket deprivation*, where the majority of a practice population live in very deprived areas; *pocket deprivation*, where a minority live in such areas; and *hidden deprivation*, where the numbers of people living in such areas are too few to register when data are aggregated at data zone level.

Although the epidemiology of disease shows a steep social gradient with 2.5 to 3 times greater prevalence in the most deprived, compared with the most affluent tenths of the population in NHS Greater Glasgow and Clyde Health Board, the distribution of medical manpower, in terms of GP whole time equivalents, is virtually flat.

The PCO has shown some of the consequences of this mismatch of resource and need, such as the larger number of cases of coronary heart disease per WTE GP in practices serving areas of blanket deprivation. The PCO also provided the sampling frame for a research study showing the consequences within GP consultations: high levels of multiple morbidity and social complexity, shortage of time, reduced patient and professional expectations, lower patient enablement (especially for patients with psychological co-morbidity) and practitioner stress.

The PCO showed contrasting social patterns of emergency and non-emergency health care use. While emergency hospital admissions show a steep social gradient, consistent with patterns of health need, outpatient

referrals show no social gradient. It is not known whether this pattern reflects unmet need in deprived areas, excessive demand in affluent areas, or a combination of these explanations

The pattern of emergency admissions also showed fourfold variation between general practices in the rates at which their patients are admitted to hospital as medical emergencies. This variation, which remains after taking demography and deprivation into account, is unexplained.

Further investigation is needed to address these issues of resource allocation, unmet need and variations in practice size, activity and outcome.

The aim of the PCO was to produce such information. Active dissemination of the results was limited to NHS management and Community Health Partnerships. There was no dissemination to general practices.

### **The Deep End Project**

The primary objective of the Deep End Project was to make contact with practices serving areas of blanket deprivation. The Primary Care Observatory Project helped by locating the 100 most deprived practices in Scotland, describing their characteristics and activities and putting the Deep End Project in context. The next objective was to capture GPs' experience and views.

Many of the meetings addressed specific issues, including vulnerable children and families, care of the elderly, palliative care, alcohol problems under 40 and anticipatory care. It is worth noting that while each of these topics involved interfaces with different NHS partners, the general practices had relevant experience of every issue.

In terms of quality indicators, such as achievement in the Quality and Outcome Framework (QOF), and the results of patient satisfaction surveys, Deep End practices compare well with other general practices in Scotland. The problem of practices serving areas of blanket deprivation is not a "*lack of good medical care*" as implied by the Inverse Care Law (which states that the availability of good medical care tends to vary inversely with the need for it in the population served). Rather, the problem is the difference between what practices are currently able to do and what they could do, with additional resource to address unmet need.

With a high quality workforce serving areas of blanket deprivation, NHS Greater Glasgow and Clyde has an internationally important opportunity to show what universal coverage and needs-based health care can achieve in improving population health and narrowing health inequalities.

Deep End meetings have identified two main factors which are responsible for the continuation of the inverse care law in Scotland. First, there is insufficient time available within consultations to address patients' problems. Second,

there are dysfunctional relationships between general practices and other professions and services, leading to fragmentation of patient care.

Well coordinated care is needed most by patients with multiple health and social problems, including the 15% of patients who account for 50% of NHS activity. While a range of criteria may determine eligibility for integrated care (e.g. CVD risk, multiple morbidity, age, vulnerable families etc), the defining contribution of general practice (as opposed to specific care programmes) is personal, flexible and continuing nature for whatever combination of problems a patient may have.

The impact of general practice on population health stems not only from the mass delivery of evidence-based medicine, as encouraged by the QOF and by SIGN guidelines, but also from the sum of the largely non-evidence-based continuing care of patients with multiple problems.

The unconditional and long term nature of general practice poses substantial challenges for conventional approaches to NHS policy, management, research, guidelines and evaluation, all of which tend towards short term, condition-specific initiatives.

There is no single or short term solution, The Deep End Project has identified six issues which need to be addressed:

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 patients' health.
3. Local systems of care should be based around the natural and sustainable *hub function* of general practices (combining contact, coverage and continuity)
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. The Deep End Project has shown the way.
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*. The Primary Care Observatory function should be an important part of this support system.
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.

## **Engagement with general practices**

The first challenge addressed by the Deep End Project was engagement with general practices. As the recent Audit Scotland report on Community Health Partnerships observed, this remains a problem (7).

A contribution of the Deep End Project has been to show how general practice engagement is not only possible but is also popular and productive, when based on practices serving similar types of population and, therefore, with similar experience and challenges in health care delivery.

While the Deep End Project has focused on the issues of deprivation and inequalities in health, the same approach could be applied to other priority areas, such as care of the elderly.

A crucial element in the success of the Deep End Project so far, has been the availability of GP locum funding, as provided by the Glasgow Centre for Population Health, which has allowed Deep End GPs to attend daytime meetings. The usual absence of such funding is a major reason why general practitioners serving areas of blanket deprivation had never previously been convened or consulted in the history of the NHS.

The principal conclusion of the Primary Care Observatory Project is that there is a need for complementary information systems, based on GP list and geographical denominators, so that NHS can review the entirety of local health systems.

This complementary approach is also needed with respect to primary care development. While geographical denominators provide the best basis for coordinating and reviewing local health systems, GP list denominators, grouped by common cause, provide the best basis for professional and service development. A re-constituted Primary Care Observatory function should inform such developments. The Scottish Primary Care Collaborative established an acceptable and effective way of supporting groups of general practices to work on service developments.

## **The challenge of health care fragmentation**

A logical next step for the Primary Care Observatory and Deep End Projects would be to address the issue of fragmentation. With ageing populations, widening inequality and resource constraints, the fragmentation and resulting inefficiency of services is a principle challenge facing health systems worldwide.

Fragmentation arises when services address only some of a patient's problems, when serial encounters lack communication, when different services work unconnectedly in parallel and when services reach only part of the population which can benefit.

Hebert and colleagues in Quebec describe an evaluation of key workers and integrated care for frail elderly patients, aiming to keep them out of hospital, which involved no additional resources or restructuring, but a top to bottom commitment to joint working (8). Joint working was assessed as:-

- 0 Professions/services are ignorant of each other
- 1 Professions/services know of each other but are not in contact
- 2 Professions/services are in contact but do not work together
- 3 Professions/services co-operate (on a scale from poorly to very well)
- 4 There is genuine collaboration between professions/services, based on mutual respect and joint planning and review.

In principle, every local system depends on the sum of the relationships of which it is comprised, including not only patient-practitioner relationships but also relationships between practitioners. Currently, there is little “mapping” of these relationships, although their quality is often well known to everyone at ground level and frequently determines how services are provided and used.

Work is needed to describe and audit the essential relationships of local health systems, including:

- General practice teams
- Attached workers
- The wider primary care team
- Relationships with secondary care
- Relationships with community services and organisations

Most Deep End meetings have concluded the importance of inter-professional working, based on personal contact, mutual respect, long term relationships, shared knowledge, informal contact and regular meetings. Despite the importance of such relationships, there is little stock-taking of the social capital which they represent.

The challenge is not only how general practice hubs relate to the rest of the local health system, but also how area based services relate to all of the practices within their area. For example, in the Deep End meeting on Alcohol Problems in Young Adults (Report 11), general practitioners were impressed by the range and quality of services provided by area based Community Addiction Teams. However, by their own admission, such teams deal with only about 40% of people with severe alcohol problems in their areas. Health systems audit needs to aim at taking account of 100% of the population which is eligible for the service.

Fragmentation is also apparent in the lack of connectedness between general practices serving areas of blanket deprivation, making it unusual for practices to share experience, discuss information (such as that produced by the PCO) and address variations in practice.

Finally, fragmentation is apparent in disjointed leadership of the NHS, whereby leadership at practice level is weakly linked to leadership at area (CHP) and Health Board levels.

On the basis of the above, future activity might comprise:

1. Re-establishing the Primary Care Observatory project, with infrastructure to allow links to the Public Health Observatory function, to NHS management and to general practices
2. Protected time to connect practices serving areas of blanket deprivation e.g. sharing experience and information, addressing variations in practice
3. Audit of the social capital represented by inter-professional relationships and joint working
4. Audit of local health systems, based on GP list and geographical denominators
5. Demonstration projects for attached workers in general practice e.g. in mental health, addictions, social work etc
6. Demonstration projects, combining groups of small practices with area-based services
7. Support for leadership in the building of local health systems around general practice hubs

## 6. References

1. Tomlinson J, Mackay D, Watt G, Whyte B, Hanlon P and Tannahill C *The Shape of Primary Care in NHS Greater Glasgow and Clyde*. Glasgow: Glasgow Centre for Population Health, 2008.
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6. Watt G. The Inverse Care Law Today. *Lancet* 2002;360:252-254.
7. Audit Scotland. *Review of Community Health Partnerships*. Edinburgh: Audit Scotland, 2011.
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## 7. Appendices

### A. A narrative account of the two projects

#### Desk-based studies – the Primary Care Observatory Project

This work first began in 2001 with the Platform Project, based at the University of Glasgow Department of General Practice and funded by the Chief Scientist Office, whose purpose was to demonstrate the added value that could be obtained from epidemiological analyses of routine data from primary care (principal investigator: Dr Matt Sutton; researcher: Dr Danny Mackay).

This was followed by analyses of general practice-based data carried out in 2005-2006 for the Cardiovascular Managed Clinical Network in Greater Glasgow Health Board (researcher: Dr Danny Mackay).

On the basis of this work, Professor Graham Watt was successful in obtaining funding for continued desk-based primary care epidemiology from the Glasgow Centre for Population Health

<b>Title</b>	Epidemiological underpinning for the primary care contribution to public health
<b>Grantholder</b>	Professor Graham Watt
<b>Funding</b>	£71,379
<b>Duration</b>	1 <sup>st</sup> April 2006 – 31 <sup>st</sup> March 2008

#### Original aims

1. To establish an observatory function for public health aspects of primary care
  - a) to complement epidemiological perspectives based on geographical areas (e.g. health boards, community health partnerships), with information based on primary care denominators, grouping practices serving similar types of area.
  - b) to inform policy and practice, addressing inequalities in health via increased investment in practices serving areas of severe socio-economic deprivation.
2. To assess the impact of primary care in deprived areas on CHD events
  - a) to describe the median age of onset of CHD events (including deaths and unscheduled hospital care), the distribution of CHD deaths between community and hospital settings, and post MI case-fatality in patients from practices serving areas of severe socio-economic deprivation
  - b) to assess the impact on CHD events, as described above, of CHD prescribing, training practice status and practice size.

This grant was complemented by two additional elements of funding:

- £30,000 from Greater Glasgow Health Board (GGHB), for analyses of “unmet need”. This four month project preceded the main study.
- £71,379 from Argyll and Clyde Health Board (ACHB), for a parallel series of analyses, matching previous analyses in Greater Glasgow.

All three sources of funding were processed via a single grant of £172,758 awarded by the GCPH and based at the University of Glasgow. Although the project was originally planned to finish in 2008, the grant account at Glasgow University was not finally closed until March 2011.

Dr Danny Mackay was employed as the project data analyst, working with Professor Graham Watt at the University of Glasgow Department of General Practice.

A project steering group was established and met on six occasions during 2006 -2007 with the following membership:-

Linda De Caestecker (chair)	Director of Public Health, GGHB
Carol Tannahill	Director of GCPH
Iain Findlay	Consultant Cardiologist, RAH
Adam Redpath	Information Consultant, ISD
John Nugent (deputy Patrick Trust)	Clinical Director, Glasgow CHP
Daniel Mackay(DM)	Data Analyst
Graham Watt(GW)	Professor of General Practice
Marjorie Gaughan	Have a Heart Paisley, ACHB
Kate Macintyre	Senior Lecturer in Public Health
Joy Tomlinson(JT)	Registrar in Public Health
Bruce Whyte(BW)	Data analyst, GCPH
Lorna Kelly	Head of Policy, GGHB

DM also attended regular meetings of the Public Health Observatory team at GCPH.

An early programme of analyses on aspects of unmet need for CVD care in Greater Glasgow was agreed with Dr De Caestecker and submitted on 17<sup>th</sup> September 2006 (Appendix A).

DM and GW also met with colleagues at ACHB to review the part of the project based on Paisley general practices. With the dissolution of Argyll and Clyde Health Board, and the departure of staff who had been involved in commissioning the project, it proved difficult to complete this part of the project, which was later subsumed within the work considered by the project steering committee.

The first year of the project produced a series of reports of local data, with executive summaries (Appendix B), which were circulated within GGHB/GGC. The local nature of these reports precluded publication in scientific journals.

The key findings were collated, however, and included in a compendium report on *The Shape of Primary Care in NHS Greater Glasgow and Clyde*, which combined project output with basic descriptive data on the nature and volume of primary care resources and activity. A working group of JT, DM, BW and GW prepared the report, with JT expanding the general practice-based output of the Primary Care Observatory Project to include other aspects of primary care.

This report was published in April 2008 and disseminated within the GGC management structure, including Community Health Partnerships. Insufficient copies were printed to allow dissemination to general practices. The report provided much of the background information for GGC's new Primary Care Strategy.

In February 2008, DM left the project, about seven months before its planned end, having obtained more secure employment in the University Department of Public Health. The nature of his role, requiring detailed knowledge and use of local primary care data sets, precluded the possibility of a quick replacement. Although Dr Gary Mclean was appointed on a half-time basis for the first three months of 2009, describing the epidemiology of GP participation in the Scottish Primary Care Collaborative, the main analytic and reporting work of the project ended in March 2008. Effectively, the publication of *The Shape of Primary Care* marked the end of the Primary Care Observatory project and the project steering group did not meet after that.

Scientific publication required a broader focus than a single Health Board. The main scientific paper produced by the project expanded local analyses to include all general practices in Scotland (the first analysis of this type), describing the extent to which their involvement in optional activities and achievement in the Quality and Outcomes Framework of the new GMS contract were determined by practice size, rather than by the deprivation characteristics of the populations served.

Part of the analyses for this paper, showing the steeply socially patterned nature of GP training in Scotland, was used to inform the case for NHS Education in Scotland to allocate 30 new GP training places in the West of Scotland.

During the course of the Primary Care Observatory project, Professor Watt made a large number of invited presentations based on the project's findings, including presentations within Greater Glasgow and Clyde, Lanarkshire and Ayrshire and Arran Health Boards, the Scottish Government Keep Well Programme and academic and research meetings on inequalities in health care.

## Practice-based activities – The Deep End Project

With about £27k of the original grant funding remaining, permission was obtained to use the unspent balance to support a series of small meetings involving general practitioners working in the 100 most deprived general practices in Scotland ('General Practitioners at the Deep End').

As part of the preparation of the RCGP Scotland report on Health Inequalities *Time to Care Health Inequalities, Deprivation and General Practice in Scotland*, the RCGP and the Scottish Government Health Department had jointly funded, at a shared cost of about £35k, a meeting of "Deep End GPs" in September 2009, attended by 63 of the 100 practices – the first time this group had ever been convened or consulted, plus GPs from four practices for the homeless in Edinburgh and Glasgow and four GPs from deprived rural areas<sup>1</sup>.

The success of this meeting prompted a series of smaller meetings, funded by the Glasgow Centre for Population Health (at a total cost of about £19k) and capturing the experience and views of Deep End GPs on a range of topics:

- Coping with needs, demands and resources
- The GP role in working with vulnerable families
- Single-handed general practice
- Patient encounters in very deprived areas: what can be achieved and how?
- General practitioner training in very deprived areas
- Social prescribing
- Care of elderly patients
- Reviewing progress in 2010 and plans for 2011
- Palliative care in the Deep End

(See Appendix C for short summaries and web-link for full reports 2-8, 10, 14, 15 [www.gla.ac.uk/departments/generalpracticeprimarycare/deepend](http://www.gla.ac.uk/departments/generalpracticeprimarycare/deepend))

During the same period, five activities were funded by other organisations:

- Experience and views of Keep Well and ASSIGN (funded by NHS Health Scotland)
- Learning Journeys (funded by SGHD)
- Alcohol problems in adults under 40 (funded by SGHD)
- Working together for vulnerable children and families (funded by SGHD and GGC)
- The Access Toolkit: views of Deep End GPs (organised by RCGP Scotland with SGHD funding)

The initial findings of the Deep End Project are now being serialised, with 12 articles in the British Journal of General Practice during 2011.

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<sup>1</sup> [www.gla.ac.uk/departments/generalpracticeprimarycare/deepend\\_Report1](http://www.gla.ac.uk/departments/generalpracticeprimarycare/deepend_Report1)

In June 2011, the Deep End Project is ongoing, and pursuing a manifesto of objectives to address the Inverse Care Law in Scotland (Appendix D). No funding is currently available to permit further meetings of Deep End practices.

### **Deep End Steering Group**

Steering group meetings are open to all Deep End practices but have been attended most regularly by the following practitioners, meeting every six to eight weeks to review and plan activity.

Georgina Brown	Springburn Health Centre, Glasgow
John Budd	Edinburgh Homeless Practice, Glasgow
Peter Cawston	Drumchapel Health Centre, Glasgow
Margaret Craig	Allander Street Surgery, Glasgow
Susan Langridge	Possilpark Health Centre, Glasgow
Catriona Morton	Craigmillar Health Centre, Edinburgh
Anne Mullin	Govan Health Centre, Glasgow
Jim O'Neill	Lightburn Medical Centre, Glasgow
Euan Paterson	Govan Health Centre, Glasgow
Petra Sambale	Keppoch Medical Centre, Glasgow
Graham Watt	University of Glasgow
Andrea Williamson	Glasgow Homeless Practice

#### *Also attending*

Andrew Lyon (chair)	International Futures Forum
Alan McDevitt	Clydebank Health Centre
Paul Alexander	RCGP Scotland

## **B. Summary of report on unmet need**

### **Greater Glasgow unmet need pilot: Interim Report (17/09/2006)**

This report summarises initial findings from analyses of the NHS Greater Glasgow chronic disease management programme in primary care, based on data collected as part of the Local Enhanced Services (LES) initiative.

1. There are 40,037 men and women in Greater Glasgow with at least one CHD diagnosis, comprising 4% of all patients in general practice, of whom 84% have angina, 36% are MI survivors and 16% have heart failure.
2. 20% of patients with a CHD diagnosis are under 60, 29% are aged 60-69, 35% are aged 70-79 and 17% are aged 80-89.
3. The numbers of patients with a CHD diagnosis increase with socio-economic deprivation, particularly in people under 70, in whom the most deprived population quintile contains over twice as many CHD patients as the most affluent quintile.
4. In general, there are more elderly CHD patients in affluent quintiles and more younger CHD patients in deprived quintiles. Under the age of 60, the most deprived quintile includes twice as many MI survivors and three times as many patients with angina or heart failure as the most affluent quintile.
5. Overall, the number of CHD patients per whole-time general practitioner ranged from 65 in the most affluent quintile to 84 in the most deprived quintile – an excess of 29%.
6. Approximately 25% of CHD patients have recently completed a HADS assessment. There is strong socio-economic patterning in the prevalence of anxiety/depression in the under 60 and 60-69 year age groups.
7. The excess prevalence of CHD and associated psychological co-morbidity seems likely to have implications for the quality of care that can be provided for CHD patients in deprived areas.

**Linda De Caestecker, Acting Director of Public Health  
NHS Greater Glasgow and Clyde and  
Graham Watt and Daniel Mackay, General Practice and Primary Care  
Division of Community-based Sciences,  
University of Glasgow, G12 9LX**

## **C. Abstracts of Primary Care Observatory Reports**

### **Report One: The location of general practices serving the most deprived populations in Scotland and NHS Great Glasgow**

1. General practices serving populations with severe socio-economic deprivation are in the front line of the Scottish NHS in its efforts to address preventable morbidity and premature mortality.
2. There are two patterns to the distribution of these practices within Scotland – involving concentrated and scattered groups of practices.
3. Concentration is demonstrated by the number and severity of deprived practice populations, both within NHS Greater Glasgow and within two Community Health and Social Care Partnerships within Greater Glasgow.
4. Scattering is demonstrated by the number of other severely deprived practice populations which are distributed across other CHSCPs in Greater Glasgow and across other Health Board areas in Scotland.
5. A feature of many CHSCP areas is their socially heterogeneous composition – some comprising practices from as many as six deciles of the Scottish distribution of socio-economic deprivation.
6. This analysis demonstrates where severe deprivation is most prevalent and where measures to address preventable morbidity and premature mortality are most needed.
7. Different support mechanisms may be required for groups of severely deprived practice populations which are either concentrated or scattered in their geographical distribution.

### **Report Two: The prevalence of coronary heart disease in General Practices serving the most deprived populations in Scotland and NHS Greater Glasgow**

8. Severe socio-economic deprivation is associated with steep gradients in CHD mortality, emergency medical admissions (EMA) for CHD and the estimated prevalence of angina in people under 70, and with shallower gradients in people aged 70-79.
9. The highest rates of CHD mortality and EMA are observed in 50 general practices within Greater Glasgow.
10. Although there is a 120% to 180% excess in these proxy CHD prevalence measures, comparing practice populations in the most affluent and deprived deciles of the Scottish population, there is only a 40% excess in the prevalence of CHD reported by practices for the Quality and Outcomes

11. Further enquiry is needed to explain the discrepancy between these measures of CHD prevalence.

**Report Three: The distribution of coronary heart disease deaths, attributable to socio-economic deprivation, in General Practices in Scotland and NHS Greater Glasgow**

13. 37% of CHD deaths in Greater Glasgow men under 80, and 34% of CHD deaths in Greater Glasgow women, are associated with socio-economic deprivation.

14. Although relative risks associated with socio-economic deprivation are highest in people under 70, the higher absolute levels of risk in people aged 70-79 mean that a substantial proportion of attributable male deaths (43%) and the majority of female deaths (69%) occur in people aged 70-79.

15. Resources to tackle inequalities in CHD mortality should be targeted, therefore, at deaths under 80.

16. 53 Greater Glasgow practices, serving 30% of the local population, have CHD mortality rates in men which are similar or below the rates observed in the most affluent quintile of the Scottish population. 56 practices, serving 31% of the population, have CHD mortality rates in women which are similar or below rates observed in the most affluent Scottish quintile.

17. CHD deaths in men attributable to socio-economic deprivation are concentrated mostly in the most deprived 164 practices in Greater Glasgow, while the same deaths in women are concentrated in the most deprived 72 practices.

**Report Four: The prescribing of statins in General Practice serving the most deprived populations in Scotland and NHS Greater Glasgow**

18. Drug treatment with statins is a highly effective method of reducing CHD morbidity and mortality by 20-30% in high risk individuals.

19. Statin prescribing quadrupled between 2001-2002 and 2004-2005 within Scotland and NHS Greater Glasgow.

20. Gradients in statin prescribing across deciles of the distributions of socio-economic practice populations within Scotland and NHS Greater Glasgow were small.

21. Gradients increased between 2001-2002 and 2004-2005, but remain substantially out of step with the gradients for premature CHD mortality, emergency hospital admissions for CHD and for angina
22. The level of statin prescribing in practices serving populations with severe socio-economic deprivation is substantially lower than expected.

**Report Five: The distribution of coronary heart disease interventions with respect to socio-economic deprivation in Scotland and NHS Greater Glasgow for 2001 and 2004**

24. Angiographies and revascularisations increased with deprivation for males and females aged under 70 in Scotland in 2001 and 2004.
25. Severely deprived males in Scotland aged over 70 were less likely to access revascularisation and angiography services in 2001 and this inequality increased in 2004.
26. Within Glasgow access to angiographies and revascularisations increased with deprivation for males and females under 70 but for the most deprived males over 70 these rates declined with deprivation.
27. Females in Glasgow over 70 years of age fared better than their male counterparts but their angiography and revascularisation rates fell in 2004 too.

**Report Six: The distribution of coronary heart disease in Glasgow with respect to socio-economic deprivation**

28. For angina and MI survival, the majority of cases are in older age groups in practices serving affluent populations, and in younger age groups in practices serving deprived populations.
29. For heart failure, most cases are in older age groups irrespective of the type of population served.
30. For all conditions, the 70-79 age group has more cases than any other age band.
31. Within age groups, most cases of all conditions under 80 are in practices serving deprived populations. There is no such gradient in people aged 80 and over.
32. In general there are 30% more CHD cases (angina, MI or Heart failure <90y) per WTE GP in practices serving the most deprived quintile, compared with the most affluent quintile.

## **Report Seven: Analysis of local enhanced services (LES) data within Greater Glasgow: Coronary heart disease, mental health and lifestyle behaviour**

33. Smoking prevalence increases with deprivation and is greatest for those aged under 60 years.
34. Smoking cessation advice increases with deprivation but the deprivation gradients are lower than for those for smoking prevalence.
35. The prevalence of obesity increases with deprivation and is different across case-mix, being greatest in younger patients with heart failure.
36. The prevalence of anxiety is more common amongst angina and AMI sufferers than those with heart failure.
37. Anxiety increases with deprivation though this relationship appears to be more complex in the case of heart failure.

### **Additional papers**

#### **Paper One:**

Distribution of Scottish general practices by health board and by deciles of the Scottish population stratified by mean practice population deprivation scores.

#### **Paper Two:**

Trends in the distribution of general practices in Scotland by health board and decile of the distribution of deprivation, based on the 2006 version of the modified Scottish Index of Multiple Deprivation.

#### **Paper three:**

Distribution of socio-economic status by practice within community health and social care partnerships in NHS Greater Glasgow.

#### **Paper four:**

Variation in deprivation between and within community health partnerships.

#### **Practice Five:**

Practice-based analysis of Parkhead residents and location of their health care.

#### **Paper Six:**

Top 50 most deprived practices in Scotland and the CHD and population characteristics.

#### **Paper Seven:**

The social distribution of patients with coronary heart disease in Glasgow by age and quintile of socio-economic status, and implications for general practice.

Paper Eight:

The prevalence of clinical anxiety and depression in patients with coronary heart disease who completed a HADS assessment.

Paper Nine:

Description of Prevention 2010 (Keep Well) practices.

Paper Ten:

Distribution of general practices involved in undergraduate medical education in Scotland, 2006.

Paper Eleven:

Comparing GP, practice and population characteristics of Scottish primary care collaborative and Scottish practices.

Paper Twelve:

Do training practices provide better care for coronary heart disease?

### **List of reports by the Primary Care Observatory project (Argyle and Clyde)**

Ways of describing the Paisley population

CHD caseload and statin treatment in Paisley patients with and without a CHD diagnosis, by quintile of deprivation.

Summary of work completed for Have a Heart Paisley.

## D. Executive Summaries of Deep End meetings

### General Practitioners at the Deep End

*This appendix comprises the summaries of fourteen Deep End meetings held between January 2010 and February 2011 (summaries 2-15).*

'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 Royal College of General Practitioners (Scotland), the Scottish Government Health Department, the Glasgow Centre for Population Health, and the Section of General Practice & Primary Care at the University of Glasgow.

Meetings funded by the Glasgow Centre for Population Health are indicated in italics. Other reports are included for completeness:

1. *Coping with needs demands and resources*
2. *The GP role in working with vulnerable families*
3. Experience and views of Keep Well and ASSIGN (funded by NHS Health Scotland)
4. *Single-handed general practice in deprived areas*
5. *Patient encounters in deprived areas: What can be achieved and how?*
6. *General practitioner training in very deprived areas*
7. *Social prescribing*
8. Learning journeys (funded by the Scottish Government)
9. *Care of elderly patients*
10. Alcohol problems in adults under 40 (funded by the Scottish Government)
11. Working together for vulnerable children and families (funded by the Scottish Government and Greater Glasgow and Clyde HB)
12. The Access Toolkit: views of Deep End GPs (funded by the Scottish Government)
13. *Reviewing progress in 2010 and plans for 2011*
14. *Palliative care in very deprived areas*

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(Full reports available at  
<http://www.gla.ac.uk/departments/generalpracticeprimarycare/deepend>)

## **Deep End Summary 2**

### **Coping with needs, demands and resources**

*Nine GPs met on Friday 22 January 2010 at the University of Glasgow for a workshop on needs, demands and resources in general practice in very deprived areas.*

- Unmet need in deprived areas is huge and the demand on general practice seems unrelenting. Patients' medical needs are intimately interwoven with emotional, psychological, financial and social problems. GPs strive to work holistically across the entire gamut of bio-psycho-social domains, often swimming against the tide and commonly feeling stressed, rushed, and exhausted.
- Complexity and multi-morbidity are the norm rather than the exception in deprived areas and this occurs at a younger age than in the general population. The interface with secondary care is often problematic for a variety of reasons.
- GPs have an important advocacy role, as well as a generalist medical role, in helping their patients deal with their numerous and complex problems. This is possible because of the nature of general practice, and the values of the GPs who choose to work in deprived areas. Continuity of care provides 'constancy' to patients which is unique but requires active work and tenacity on the part of the GP.
- Potential ways forward include enhancing the primary care team based in the practice in order to address the mismatch of need and demand, and enhance efficiency of current services. For example having mental health staff, social workers, alcohol counsellors, financial advisors, etc based 'in-house' in the practice which would improve attendance rates of patients and inter-agency working.
- Ways of improving closer working with secondary care included joint GP/consultant clinics, consultant advice on difficult cases (to reduce referrals) and allocated times for telephone or email advice.
- Ways of enhancing the management of complex patients by the GP and primary care team include enhanced continuity and targeted longer consultations.
- Professional support for GPs in deprived areas should include the establishment of a Deprivation Interest Group (DIG) across Scotland based on the Lothian model.
- Remuneration of GPs should include a deprivation weighting in the global sum, QOF and enhanced services that accurately reflects the context of working in a deprived area and the extra resources it takes to attain quality patient care.

### **Deep End Summary 3**

#### **The GP role in working with vulnerable families**

*Ten Glasgow GPs met on Friday 22 January 2010 at the University of Glasgow for a workshop on the contribution of general practice on deprived areas to the care of vulnerable families.*

- Working with vulnerable families is an everyday aspect of general practice in severely deprived areas.
- Through many types of contact, practice teams have substantial knowledge about the most vulnerable families in their registered population. Several recent NHS developments have under-mined this knowledge.
- General practices offer constant, accessible, informal and unconditional contact and support (irrespective of age), referral to other services when necessary, and continuing support when other services cannot respond.
- The case-finding approach in general practice appears an insufficiently valued mechanism for matching need to service provision and preventing, delaying or ameliorating more serious problems.
- The withdrawal of child surveillance in deprived areas is considered a mistake, given the high yield of health and social problems.
- The current 'rationalisation' of health visiting appears to devalue the importance of shared knowledge, continuity, relationships and trust, concerning the wider "at risk" population of vulnerable families.
- Practices should have effective ways of regularly sharing information about vulnerable families; they need regular updates concerning the availability of other local services; they also need improved working relationships with social work and the school health service, based on personal continuing contact with individual social workers and school health nurses.
- Practices should identify their lead professional for vulnerable families, co-ordinating activities within their practice and considering the ways in which they could work more effectively with other practices and other agencies.
- It is important for the system to take account of the views and experience of families using services.
- There is a need for more effective and quicker dialogue between practices providing front-line services and those responsible for local and national policy on child welfare and vulnerable families.

## **Deep End Summary 4**

### **Experience and views of Keep Well and ASSIGN**

*Twenty GPs from Glasgow, Edinburgh and Inverclyde met on Friday 29 January 2010 for a workshop on their experience and views of Keep Well, including their experience of using the new Scottish cardiovascular risk score ASSIGN. The meeting was funded by NHS Health Scotland.*

- Keep Well has largely worked well, providing a boost for preventive activities via increased ascertainment and provision of specific health improvement activities.
- Ascertainment is not yet complete and there is uncertainty as to how much effort should be expended in maximising response rates.
- Government commitment is needed to maintain the work that has been started.
- In Keep Well practices, there is a need to provide continuing support as the focus shifts from initial ascertainment to long term support and follow up.
- Keep Well should also be initiated in the large number of severely deprived practices which have not so far taken part in the programme.
- The arrangements required for continued follow-up and support are different from those required for initial ascertainment and need to be more closely integrated within routine practice activity.
- To avoid fragmentation of services, with predictable effects on patient uptake, it is desirable that key health improvement services are provided 'in-house', within practice settings, via staff attached from other agencies.
- There is an urgent need to develop such an approach in response to the increasingly serious and prevalent health effects of alcohol misuse.
- ASSIGN provides a welcome opportunity to increase and improve the targeting of CVD risk in deprived areas, for men and women, but effort is needed to standardise its use across practices.
- Without additional resources, commensurate with changes in caseload, it is likely that ASSIGN will be used opportunistically within consultations, rather than for screening.
- For both Keep Well and ASSIGN, there is concern that Government initiatives are leaving deprived practices with lots to do without the resources to do it.

## **Deep End Summary 5**

### **Single-handed general practice**

*Nine GPs from Glasgow, Dundee and Saltcoats met on Friday 7 May 2010 at the Section of General Practice & Primary Care, University of Glasgow, for a workshop on their experience and views of single-handed general practice in very deprived areas.*

- The 100 most deprived general practices in Scotland include 17 single-handed practices serving a combined population of 30,870 patients.
- Single-handed practitioners are passionate about their patients and committed to the personal approach that single-handed practice allows and requires.
- 'Small is beautiful' and there are many aspects of single-handed practice, in terms of continuity, immediacy and patient satisfaction, which embody what Government is trying to achieve for patients in the NHS (e.g. as in The Healthcare Quality Strategy for NHS Scotland).
- Single-handed practice is popular with patients, who choose to be registered with a single handed practitioner.
- It is paradoxical, therefore, that single-handed practice is a tolerated, rather than an actively supported, way of delivering primary care services.
- The price that single-handed practitioners accept in order to practice in this way includes financial disadvantage (mainly due to diseconomies of scale), being tied to the practice, lack of flexibility, professional isolation and marginalisation by management – all of which could be addressed.
- The combined responsibilities of providing clinical care and running a business can be very stressful.
- Single-handed practice is not attractive to the majority of general practitioners, for a variety of reasons, including personal characteristics, but is a favoured option for some and should be supported, capitalising and learning from the strengths of the approach, while providing support to minimise weaknesses.
- More evidence is needed about the long term effects of single handed practice e.g. Do the higher levels of continuity and patient satisfaction translate into longer term health outcomes? Is there a trade off between the higher list size to ensure financial stability and the volume and quality of care that can be offered?

## **Deep End Summary 6**

### **Patient encounters in very deprived areas: what can be achieved and how?**

*Fifteen Glasgow GPs met on Friday 14 May 2010 at the Section of General Practice & Primary Care, University of Glasgow for a workshop on patient encounters in very deprived areas, drawing on experience, evidence and policy, and focusing on what can be achieved and how.*

- Consultations with patients are the largest and most important part of the work of general practitioners.
- In severely deprived areas, consultations are typically characterised by higher levels of need, multiple morbidity (including psychological and social co-morbidity) time constraints and practitioner stress.
- Consultations always address the problems presented by patients on the day (reactive care), but can also address potential future problems (anticipatory care).
- A key aspect of the consultation is the relationship between the patient and the doctor, who often know each other from previous consultations. Maintaining this relationship and ending the consultation on a positive note are important outcomes of the consultation.
- Research has shown that patients in deprived areas are less likely than patients in affluent areas to wish to have an active role in decisions concerning their care. Patients may also be less interested and ready to address changes in health behaviour.
- Addressing such issues within consultations is time consuming and is often not immediately effective. Explanations may take longer due to problems in health literacy. Practitioners describe “*chipping away*” at these issues, rather than achieving large and sudden changes in behaviour.
- Whether a consultation includes more than reactive care depends on many factors, including appropriateness, having time available, patient and practitioner expectations, and practitioner stress.
- NHS policies tend to underestimate the constraints and difficulties in moving beyond reactive patterns of patient and practitioner behaviour.
- The incentives of the Quality and Outcomes Framework do not reward practitioners for extending consultations beyond a narrow range of targets and the QOF agenda, highlighted via computer alerts, can be felt as an intrusion in the consultation.
- Current NHS initiatives concerning patient self help and self management appear to have poor penetration in deprived areas and were not recognized by practitioners at the meeting.
- Practitioner stress can affect both practitioner and patient behaviour within a consultation, influencing what the patient presents and how the practitioner responds.
- Prior knowledge and experience are important factors in the professional intuition required to know how and when to extend the aims of a consultation.
- Consultations are more likely to be successful if carried out in a systematic way, establishing the patient’s agenda at the outset, picking up clues (“*psycho-social red flags*”) and ending with clear agreement as to what has been decided (plan of action).
- Surgeries (serial consultations) can be made more efficient by good practice organisation, involving clear communication and the involvement of other members of the team including receptionists and practice nurses
- A frequent and important aspect of many consultations is referral to other professionals and services, requiring clear explanation. Referral is most likely to be effective when it is quick and to a familiar local setting.

- Practices provide a hub for referral to a huge range of other professions and services. Many of these pathways are dysfunctional, with poor communication and feedback.
- Multi-professional working across organizational boundaries works best via established relationships with named individuals, with regular, reliable contact and opportunities for professional exchange.
- Practitioners are keen to make use of the full range of possible services and sources of help for patients (e.g. via ALISS), but frequently lack accurate and up to date information about what is available locally.
- Patients also need ready access to health information and resources available within the local community.
- When a referral is made, some patients would benefit from additional help, support and reminders, to increase the probability of the referral being taken up.
- Evaluated experiments are needed in ways of providing access to consultations, of teamwork in addressing the needs of patients with complex problems, and in ways of providing and using additional time.
- There are few opportunities for practitioners working in severely deprived areas to share experience and views concerning the conduct of consultations and the organisation of practice.
- Additional education and training is required not only for young practitioners preparing to work in deprived areas, but also for established practitioners, to build on their substantial knowledge, experience and ideas.

## **Deep End Summary 7**

### **General practitioner training in very deprived areas**

*Eleven GP trainers met on Friday 4 June 2010 at the Section of General Practice & Primary Care, University of Glasgow for a workshop on GP training in very deprived areas, drawing on the experience and views of GP trainers and trainees.*

- While 39% of practices in the most affluent 20% of Scotland are involved in GP training, this drops to 24% of practices in the most deprived 20%.
- A major explanation has been the small size of most practices in deprived areas, making it difficult to accommodate training requirements.
- The practical requirements of a training practice, in terms of organisation, record keeping and IT, are considered less of a barrier, now that all practices have addressed such issues, as part of the Quality and Outcome Framework (QOF).
- It was felt that training practices have to be particularly well organized to include training activities within the generally intense nature of general practice in very deprived areas.
- Training status is highly valued by trainers, allowing expression of professional values, and providing a constant stimulus for improvement, regular contact with colleagues and protection against burn out.

- Special features of the clinical environment in deprived areas include problems of alcohol and drugs misuse, multiple morbidity, psychological distress as a major co-morbidity, polypharmacy with risk of side effects and drug interactions, child protection issues and a high prevalence of social problems.
- An increasing aspect of practice is the large number of immigrants to Scotland, speaking foreign languages, with distinct customs and beliefs and who are often concentrated on arrival in very deprived areas.
- Patients are often less articulate than patients in affluent areas and have different views and priorities, for example, concerning anticipatory care and self management. As experienced clinicians, trainers can help trainees acquire the consultation skills to work with such patients.
- Understanding the benefits system is often a steep learning curve for trainees, which is made more challenging by the expert knowledge of patients on this subject and the importance of benefits for economic survival.
- Nothing compares with home visits for trainees to acquire an understanding of the realities of patients' lives in deprived areas.
- Although it is desirable that all GP trainees acquire some experience of general practice in deprived areas, it is not clear how this could be accommodated.
- GPs with substantial experience of practice in deprived areas also have educational and development needs, requiring new arrangements for protected time and professional support.

## **Deep End Summary 8**

### **Social prescribing**

*Ten Deep End general practitioners from Glasgow, Dundee and Ayrshire took part in this postal project on social prescribing, by providing reports on their practice's use of non-medical community resources to respond to the needs of their patients.*

- GPs in Deep End practices routinely encourage their patients to make use of non-medical community resources to address their health and social needs.
- Helping patients to become more self reliant and able to control and improve their own health is a core value for GPs in Deep End practices.
- Current processes to distinguish between deserving and undeserving poor on the basis of medical assessments are perceived to produce disability and dependence and to undermine the doctor-patient relationship.
- Key interventions that would support more effective social prescribing by GPs are:
  - Benefits reform that reflects the realities of life in Scotland's poorest communities.
  - An internet directory of community resources: if user friendly, locally relevant and kept up to date.

- More medical and nursing time in consultations to respond to very challenging needs by clear explanation and guidance.
- Clear guidance for patients and organisations approaching GP practices for reports or advocacy support.
- Increased funding to voluntary and local agencies in deprived communities.
- GPs with substantial experience of practice in deprived areas also have educational and development needs, requiring new arrangements for protected time and professional support.

## **Deep End Summary 9**

### **Learning journeys**

*During August 2010, ten Deep End GPs took part in day long learning journeys, in two groups of five, visiting three different surprise settings, and followed by a joint half day discussion shortly afterwards.*

### **Key Learning**

- Enormous talent and resources exist in communities of all kinds if one knows where to look and how to behave.
- People work effectively when their motivation comes from inside themselves rather than only outside.
- It is never too late to make a difference.
- Changing context is an effective way of changing behaviour.
- Personal contact matters to outcomes.

### **Key Action Points**

GPs at the Deep End:

- must find ways to communicate more effectively with each other and others in the service of patients. This should include exploration of new media.
- might usefully develop more effective connections to activity both in their own localities and more generally. This might include trusted guides and more regular meetings with relevant others.
- should explore further how to innovate in an accountable way.
- need to develop more effective leadership roles in their local areas.
- could explore more fully the ethos and nature of general practice as a socially orientated enterprise.

**Note** – The learning journeys preceded proposals by the English Department of Health concerning ‘social enterprises’ in primary care. These specific proposals were not discussed during the learning journeys, nor is it imagined that these proposals are the only or necessarily a desirable way to progress “

## Deep End Summary 10

### Care of elderly patients

*Five Glasgow GPs met on Thursday 26 August 2010 at the Section of General Practice and Primary Care at the University of Glasgow for a discussion about policies and practices for elderly patients, drawing on their experience, commenting on a policy review by researchers at Stirling University, and considering what types of intervention would be feasible and acceptable in maintaining independent living at home.*

- Most national policies and top down initiatives, including SPARRA and HEAT targets, have little profile and impact in general practices addressing the practical needs of patients on a day to day basis.
- Care has become increasingly fragmented, with acute hospitals becoming less helpful in providing comprehensive care, often addressing only some of a patient's problems, with early discharge and inadequate communication to the practice.
- Joint working between professions and services in the community is patchy, but can work well, especially when colleagues know each other by name and have developed mutual respect and trust.
- District nurses and health visitors are an invaluable source of cumulative knowledge about elderly patients, their problems, preferences and circumstances. If shared effectively, such knowledge protects against impersonal, fragmented care.
- Patient expectations and family resources are lower in deprived areas, providing different types of challenge for primary care teams.
- GPs are hesitant to adopt a proactive approach, because of pressure of work, lack of resources and patient's reluctance to see themselves as vulnerable and needing care.
- Screening of elderly patients is only justified if it provides new information and if needs can be met; practitioners prefer a case-finding approach, making use of routine contacts to provide individual advice.
- Additional services could be made known to patients in this way, if primary care staff were better informed about what is available locally.
- In severely deprived areas, 'elderly people' are younger, in terms of having less healthy life expectancy at a younger age.
- The Keep Well target age range of 45-64 is appropriate, therefore, for measures to promote healthy living and maintain independence in elderly people in deprived areas.
- Keep Well has worked best in deprived areas when delivered in close collaboration with practices.
- An expanded service is possible, but only if core services are secure.

## **Deep End Summary 11**

### **Alcohol problems in adults under 40**

*Fourteen Deep End GPs and 16 alcohol professionals from Glasgow and Edinburgh met on Friday 26 August 2010 at the Teacher Building, St Enoch Square, Glasgow, for a discussion about policies and practices for adults under 40 with alcohol problems.*

- Alcohol misuse in young adults is a huge problem which needs to be addressed at many levels. This meeting focused mainly on the contributions of general practice and community addiction services, with additional inputs from the acute and voluntary sectors and from public health practitioners.
- The NHS allocates fewer resources than might be expected to address alcohol problems, given their impact on individuals, families, the NHS and the economy.
- For people needing help there are many possible entry points to the system. There needs to be clarity about the paths they may then follow.
- Pathways are important for planning, integrating and evaluating services, but people with alcohol problems often lead chaotic lives, so there is also a need for continuity and flexibility based on ongoing relationships with professionals whom they know and trust.
- Effective links between services are the key to integrated care. General practices and community addiction services should actively review their links in terms of professional relationships, communications and record of joint working.
- Shared information concerning the progress of patients through systems is also essential, and can be helped by improvements in IT, although there are issues concerning confidentiality (whether people are content to have their personal information shared) and professional engagement (general practitioners vary in how they respond to information communicated from third parties).
- Community addiction teams also vary in what they do and how, but have developed a range of innovative services, some of which are not well known to GPs.
- The caseload of CATs in Glasgow is thought to cover about 40% of people with major alcohol problems, which leaves about 60% using other services, including general practice.
- The role of GPs is to assess risk, provide brief interventions, minimize harm, manage physical problems and co-morbidity and act as a signpost to other NHS, local authority and voluntary services.
- It is not clear whose role it is to provide practices with bespoke information on the range of services in their area.
- Current and future NHS staff need more education and training on alcohol and addiction issues at undergraduate, postgraduate and continuing professional levels.
- Professional experience of working on the front line is an important source of evidence to inform advocacy. Practitioners need to find their collective voice in this respect

- The meeting raised many unanswered questions including the effectiveness of brief interventions in young adults, and arrangements for detoxification, joint working, sharing information and practice-attached alcohol workers.
- The meeting demonstrated the value of the exchange of views and experience between professionals and between services, as the first step in developing a more integrated care system for young people with alcohol problems.

## **Deep End Summary 12**

### **Working together for vulnerable children and families**

*81 practitioners and managers from Greater Glasgow and Edinburgh, including 19 Deep End GPs, met on Thursday 9 September 2010 at the Beardmore Conference Centre, Clydebank, for a discussion about policies and practices for children and families.*

- Practitioners and managers agree that there are not enough resources to respond to need, resulting in a focus on fire fighting, raised thresholds for engagement and missed opportunities for early intervention.
- Local teams are often aware of vulnerable children and families before serious problems develop, but lack the resources to intervene and to make a difference. Investments are needed in home support, free nursery places and other ways of supporting families.
- The many suggestions made in this report can result in greater efficiency, especially via better joint working, but do not address the fundamental problem of resources.
- Hundreds of professional teams are involved in providing care for vulnerable children and families, and all need to work well, both individually and as components of an integrated system.
- The system needs accurate information on the numbers and distribution of vulnerable children and families, including but not restricted to children on child protection registers, as a basis for resource distribution, audit and review.
- Effective joint working depends on colleagues being well informed concerning each others' roles, how they may be contacted locally and the constraints under which they work.
- Information about the progress of particular cases needs to be shared between professions and services, so that each is aware of what is happening. There is an urgent need for bespoke IT which links systems and professionals.
- Pregnancy is an important opportunity to demonstrate the integration of professionals and services working to identify and help vulnerable mothers and their families.
- Professionals and services should be accountable not only for their own contribution but also how this connects with the contributions of others.

- Professionals acquire local knowledge and develop trusted relationships with families that are crucial for long term preventive care. There is a need to support and retain such staff, to value the relationships they have developed and to use the information they acquire, via regular multidisciplinary meetings.
- The hallmarks of a caring system are not only the quality of encounters between practitioners and families, but also the extent to which the system measures itself in providing needs-based support to all who need it, matches rhetoric about joint working by measures to support and review joint working, provides continuity of care and assesses itself against a range of outcomes, including the views of parents and children.
- A caring system should also care for its staff, ensuring reasonable caseloads, sharing the burden and finding practical ways of encouraging and rewarding commitment and continuity.
- An important determinant of service integration is the commitment of senior managers in encouraging, supporting and rewarding joint working by staff within their service.
- The GP contract and/or enhanced service agreements should explicitly support practices in working with vulnerable families in ways that are commensurate with the numbers of vulnerable families within practices.
- Clarity is needed about specific interventions for specific needs at specific points, and whose responsibilities these are.
- The system needs to learn and share examples of how existing resources can best be used, based on experience, audit and evidence.
- The meeting provided an example of how practitioners and managers from different services can learn from each other, share experience, correct misperceptions and discuss how services can be improved.
- The extraordinary nature of the meeting needs to be made ordinary, as part of a learning organization, dedicated to supporting professionals and services working with vulnerable children and families.

### **Deep End Summary 13**

#### **The Access Toolkit: views of Deep End GPs**

*Eight GPs met on Friday 14 January 2011 in the Academic Unit of General Practice and Primary Care at the University of Glasgow for a presentation and discussion on the RCGP Improving Access Toolkit and its applicability in practices serving very deprived areas.*

- Deep End practices had achieved similar ratings in recent Government surveys of patient satisfaction with general practice as other practices in Scotland.

- The problem of 'poor patient access' as defined by the lowest scoring 10% of practices is not a particular problem of deprived areas.
- Deep End GPs consider that the Access Toolkit includes many useful suggestions as to how patient access may be improved, not only in practices with low survey ratings but also in all practices seeking to improve their services.
- On the other hand, there are aspects of general practice populations in very deprived areas which the Access Toolkit does not take into account and which limit the applicability of some suggestions.
- Telephone access can be problematic and there is a greater expectation of same day appointments, with less use of forward planning. Behaviour change can be slow.
- The meeting demonstrated the value of occasions when practitioners can share experience, information and views, as a basis for reviewing and developing local practice. Several different ways of organising access were described.
- The Primary Care Collaborative was felt to have provided a useful mechanism for practices to work together in developing their services for patients.
- A summary of the problems and possible solutions described at the meeting will be added to the Treating Access website.
- Implementing the Access Toolkit in Scotland will work through facilitated workshops with locum cover for GPs.

#### **Deep End Summary 14**

#### **Reviewing progress in 2010 and plans for 2011**

*32 general practitioners and three observers met on Tuesday 25 January 2011 at the Beardmore Centre, Clydebank for a meeting to review Deep End activity in 2010 and to discuss activity in 2011.*

- The Deep End Project has been successful in raising the profile of general practices serving areas of blanket deprivation, boosting the identity and morale of Deep End practitioners and stimulating interest and support from NHS organisations.
- 73 of the 100 most deprived practices have taken part in at least one meeting, and there is work to do in engaging with other practices, including those outside the central belt.
- The project has captured the experience and views of Deep End practitioners, as a basis for developing a shared view, for engagement with others and as a basis for joint advocacy e.g. the letter to the Herald on minimal alcohol pricing.
- Deep End practices are witness on a daily basis to the "slow motion car crash" of poor starts in life resulting in poor health and social outcomes in

- A feature of the project has been its focus on improving services for patients, which is part of its attraction to colleagues in NHS policy and management.
- Little progress has been made in addressing the fundamental problem of the inverse care law, as experienced on a daily basis, via shortage of time for consultations.
- It was felt that the current GP contract 'works against' general practice in deprived areas and needs to be brought into line with the needs and demands of patients and services in the Deep End.
- It was also agreed that secondary care 'does not work' for deprived areas. There is a need to engage with specialists so that they contribute more effectively to meeting the needs of patients in very deprived areas.
- Key points for the Deep End manifesto, addressed to political parties addressing the May Scottish elections, are the need for 15 minute appointments, better recognition of deprivation in NHS resource allocation formulae, the need for help (e.g. attached mental health workers) in developing an integrated approach to mental health and addiction problems and investment in the primary care team as the hub of local systems of care.
- Key Points for a Scottish GP contract, which most feel is now inevitable, include more clinical time in deprived areas, measurable proxies of high quality care for patients living in very deprived areas, recognition of the length of time and engagement needed to achieve good outcomes in very deprived areas, and recognition of the higher prevalence of multiple morbidity, including mental health problems at younger ages in very deprived areas.
- Key points for the imminent Greater Glasgow Deprivation Interest Group (DIG) include the need for advocacy to influence NHS policy at national and local levels, the need for activities and infrastructure to support the sharing of best practice across the front line of practices service the most deprived areas, and the involvement of all members of the primary care team.
- There was concern that the task of the Glasgow DIG is much bigger than that of the successful Lothian DIG, and that the resources available to the Glasgow DIG may be insufficient.
- It was considered important that the Deep End Project retains a national profile, given the national importance of deprivation-related health and the fact that many important issues can only be addressed at a national level.

### **Next Steps**

1. Prepare a Deep End manifesto for distribution to political parties contesting the May Scottish parliamentary elections.
2. Maintain links with the Scottish Government Health Department, with a view to continued joint activities.

3. Maximise the opportunities for multi-professional development and knowledge exchange provided by the Glasgow Deprivation Interest Group
4. Report Deep End activities to the Glasgow Centre for Population Health, with a view to identifying a future programme of joint activity.
5. Engage with RCGP Scotland to pursue professional development issues, such as those highlighted by the Learning Journeys (Deep End Report 9).
6. Maintain engagement with the Keep Well project, via Deep End representation on the National Primary Prevention Steering Committee and local involvement in the planning of phase 2 of the Keep Well project in NHS Greater Glasgow and Clyde.
7. The Steering Group will meet with the Chief Medical Officer, Dr Harry Burns, on 23rd February 2011.
8. Complete the LINKS Project and pursue its implications for social prescribing and joint working with the Long Term Conditions Collaborative and with NHS Greater Glasgow and Clyde.
9. Raise the international profile of the Deep End Project via 12 articles in the British Journal of General Practice, and presentations at national meetings.
10. Hold a multi-professional Deep End meeting on the challenges of palliative care in very deprived areas.
11. Support Deep End practice participation in the R&D project "Living Better with Multiple Morbidity", involving additional time for consultations and support for both patients and professionals.
12. Lobby NES for additional GP training capacity in very deprived areas.
13. Lobby NES for an integrated GP Fellowship scheme, including fellowships for young GPs, additional clinical capacity for Deep End practices and supported sessions for professional development and leadership involving experienced Deep End GPs.
14. Repeat the formula of the Beardmore meeting on Working with Vulnerable Children and Families for a meeting on Mental Health Issues.
15. Pursue the conclusions of Deep End Reports 11, on Alcohol Problems in Young Adults and 12, on Working with Vulnerable Children and Families, with NHS Greater Glasgow and Clyde.
16. Lobby for a national enhanced services scheme to support registers and multi-professional practice meetings concerning vulnerable families.
17. Pursue opportunities to develop and evaluate models of good practice concerning attached workers in general practice.
18. Secure additional support for the Deep End Steering Group, including locum support for daytime meetings, to pursue and coordinate the above activities.
19. Lobby for a review of the support that central NHS services (ISD, NES, HS, QIS, CSO) provide for Deep End Practices (10% of Scottish practices serving the most deprived of practice populations).
20. If funds allow, extend the project to include the 27 non-participating Deep End practices, and practices serving areas of pocket and hidden deprivation.

## Deep End Summary 15

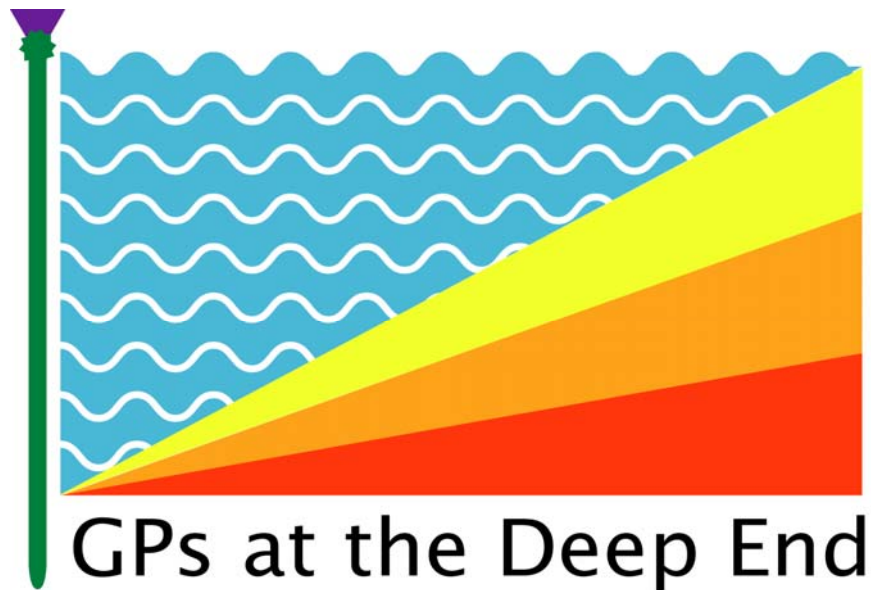
### Palliative care in the deep end

*Fifteen practitioners, from general practice, community nursing and specialist palliative care met on Tuesday 22 February 2011 in the Academic Unit of General Practice and Primary Care at the University of Glasgow for a roundtable discussion and review of the challenges of delivering palliative care in severely deprived areas.*

- The essential key to delivering effective palliative care in the community is the trust established between district nurses and general practitioners, who know each other well, understand each other's roles and can contact each other quickly as the need arises.
- Neither the GP, nor the district nurse on her own, are "enough". GPs feel that district nurses are central to palliative care and fear the loss of attached district nurses more than any other staff.
- The work of palliative care in the community is increasing, but staff are not being replaced as they leave or retire, putting greater pressure on the remaining staff. No new district nurses have been trained in the last year.
- The group considered that all GPs should be active in palliative care, meeting patient and family expectations, and sharing the work of palliative care within the practice. A "GP who doesn't visit" was considered by district nurses to be a huge obstacle to providing high quality care ("Like having our hands tied behind our back").
- Effective joint working needs an 'open door policy' whereby district nurses can always access the relevant GP when necessary.
- The over-riding problem for GPs is pressure of work and lack of time so that it may sometimes be impossible to visit a patient at home.
- It is reassuring for patients to know and see that the district nurse and GP are communicating with each other. The sooner the team is involved the better, establishing initial contact and relationships before urgent needs take over. 'Reassurance' is less effective without a prior relationship.
- The trust and confidence of patients and their families in the palliative care team arises from successive positive experiences of teamwork in action.
- Palliative care for non-malignant conditions is much harder to arrange than palliative care for cancer, where the starting point and agenda are more easily understood and addressed.
- The group anticipate an increase in the need for palliative care for non-malignant conditions, especially as deaths increase from alcoholic liver disease.
- Hospices tend to have substantial expertise and resources, especially for palliative care of cancer, and a key issue is how these could be better deployed in supporting community care.
- Specialist nurses are valued, but can de-skill existing teams and interfere with their relationships with patients. Building up good relationships between general practice and outreach staff takes time.

- Families in very deprived areas are less demanding, often not knowing what is available (including financial help). They also have fewer skills in accessing professionals and may also have fewer resources, such as reliable telephones and cars.
- There is a culture of expecting the patient's 'own GP' to visit.
- At the end of palliative care, the patient's home can be "*like Piccadilly Circus*" as a result of the number of professionals visiting to provide specific components of care. In general, the smaller the number of professionals involved in providing continuity of care the better.
- Social work was not represented at the meeting, despite invitations. It was noted that social work has no sub-speciality expertise in palliative care.
- It was said that community carers and their managers "*don't understand what district nurses do*" in assessing clinical aspects of care, and tend to withdraw as the end of life draws near. It was felt that community carers could be a very important part of the caring team, but that district nurses are best placed to lead the team.
- Current GP contractual arrangements supporting palliative care include 'essential services', a Designated Enhanced Service (DES) and part of the Quality and Outcomes Framework.
- Minimum elements of care are inclusion on a register (so that care can be planned and reviewed), minuted regular multi-professional meetings and the availability and passage of relevant information for use out of hours.
- The DES is considered "*too much a data collection exercise*" and sometimes out of touch with the needs of the service at ground level, where flexibility and discretion are part of the art of tailoring care to individual needs.
- GPs described how it was sometimes "better not to put some patients on the palliative care list", because of the bureaucratic implications.
- The previous Gold Standard Framework had involved 80% of practices, without reward or incentives, but had been "torpedoed" by the DES.

## E. Deep End Manifesto 2011



### MANIFESTO 2011

***The NHS should be seen at its best where it is needed most.***

This manifesto from General Practitioners at the Deep End, serving the 100 most deprived populations in Scotland, argues that the NHS could be much more effective in improving health in deprived areas and in narrowing inequalities in health.

An integrated package of measures is required to make best use of NHS resources in serving Scotland's most deprived populations.

#### **Context**

General practitioners at the Deep End work in the **100 most deprived general practices** in Scotland.

They are **the front line of NHS Scotland** in addressing the health needs of people living in very deprived areas.

Collectively, they serve **8% of the Scottish population** and as many people living in the most deprived 15% of postcode datazones (the Government's target population for addressing health inequalities) as the 700 next most deprived practices.

Routine **contacts** with patients, accessing general practices with a wide range of problems, provides over 90% **coverage** of the population. Serial contacts provide **continuity, flexibility, coordination, sustainability, long**

**term relationships** and **trust**. No other part of the NHS has these **essential intrinsic features**.

Such features make general practice the **natural hub** for NHS activity, especially in very deprived areas. The challenge is to **link** this hub with other professions and services so that patients receive **co-ordinated, integrated care**, according to their needs.

## The Problem

General practice is **under-resourced** to deliver what the NHS could achieve in improving health in very deprived areas and in narrowing health inequalities.

Across the spectrum of socio-economic circumstances in Scotland, there is a steep slope of need, with over 2.5 times the burden of health needs in the most deprived 10% compared with the most affluent 10%, but a flat distribution of general practitioners.

Attempts to distribute NHS resources in primary care according to population need have been unsuccessful, partly because of the lack of routine data reflecting levels of **unmet need**.

Research shows that consultations with patients in very deprived areas are **characterised by multiple health and social problems, a shortage of time, reduced expectations, lower health literacy, lower patient enablement** (especially for patients with psychological problems) and **practitioner stress**.

**Multiple morbidity** occurs at younger ages in deprived areas. Patients with multiple problems are most in need of **comprehensive, co-ordinated care**, taking place over a long period of time with practitioners whom they know and trust.

Many NHS policies, including those for anticipatory care and self help, are **simplistic**, in relation to the capacity for quick behavioural change, and underestimate the **importance of long term productive relationships**.

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. However, the problem described by the inverse care law in Scotland is not the difference between good and bad medical care.

General practices at the Deep End perform as well as other general practices in Scotland in terms of the Quality and Outcomes Framework and Patient Satisfaction Surveys. A large proportion also take part in professional activities, such as undergraduate teaching, GP training and research, and in service developments such as the Primary Care Collaborative and Keep Well.

The problem described by the inverse care law in Scotland is the difference between what general practices at the Deep End are **able to do** and what they **could do** if properly supported to address the problems of their patients.

### The Deep End Project

It is significant that the Deep End Project is the **first occasion** in the 60 year history of the NHS that these practices have been convened or consulted.

Issues affecting general practices serving very deprived areas have been hidden from view, partly because Deep End practices are **scattered** across a dozen Community Health Partnerships, and are a majority of practices in only two.

Establishing an **identity** for this group of practices has been an important achievement. 73 practices have taken part so far.

For the first time, the Deep End Project has enabled the **sharing of experience and views across the front line** of the NHS in addressing the health problems of the most deprived areas.

**The Project has also opened up a much needed process of engagement** between general practices in the front line and other parts of the NHS, locally and nationally.

The amount of activity in the first year of the Deep End project has shown not only the **productivity** of the project but also the **potential** for a much more effective and coordinated approach to improving health in Scotland's most deprived areas.

### The Deep End as part of the picture

General Practitioners at the Deep End are under no illusion as to the importance of **social and economic factors** in determining poor health, and the need for policies outside the health sector to address Scotland's health problems.

The Deep End Project will continue to advocate health and social policies which improve health in very deprived areas. The most pressing such issue at present is the need for measures to **reduce the availability and use of cheap alcohol**.

Deep End practitioners also welcome the Government's commitment to Early Years and its policies **investing in the health, education and development of young children**.

Working in the front line, Deep End practitioners see on a daily basis the problems and patterns of behaviour in young children whose long term effects are **sadly predictable**.

This **contact and knowledge** is crucial, but frustrated by lack of access to resources and services, such as **home support and free nursery places**, which can make a difference at an early stage.

General Practitioners at the Deep End could be a much more important and effective part of policies to **support vulnerable children and families**.

At the same time as practices are being encouraged to link more effectively with community resources ("**social prescribing**") the funding of many voluntary and local agencies is under threat. It is especially important to retain such services in very deprived areas.

General Practitioners at the Deep End are concerned at **changes to the benefits system** which appear to seek to distinguish between the deserving and undeserving poor on medical grounds. Benefits reform should reflect the realities of life in Scotland's poorest communities, and guarantee a basic standard of living for all.

### **Implications for NHS policy**

General practice is one of the few **public services in daily contact** with people living in very deprived areas, but is hardly mentioned in **Equally Well**, the Scottish Government's policy on improving health in deprived areas and narrowing inequalities in health.

NHS Scotland should commit at its highest level to the support of General Practices at the Deep End as **the front line of its policies and efforts** to improve health and narrow inequalities.

General Practices at the Deep End should be **central**, rather than peripheral, to NHS planning, development and support.

General practices at the Deep End should be supported in developing **local systems of care**, in which **patient contact** and **population coverage** is complemented by **links to other professions, services and resources**.

In times of resource constraints, it makes sense to consolidate the achievements of **Keep Well** and to **focus resources in the areas of greatest need**, where anticipatory care can make most difference to individuals and to population health.

## Implications for NHS resources

Political commitment is required to provide Deep End practices with the **additional consultation time** needed to address the needs of patients with multiple health and social problems.

**15 minute appointments** should be standard in Deep End practices.

Better use could be made of existing resources, by addressing the problems of **fragmentation in health care delivery**, and linking other professions and services to the general practice hub.

**Health visitors** should be attached to Deep End practices, with **capped case-loads** and numbers distributed according to need.

There should be a **National Enhanced Service for Vulnerable families**, based on the prevalence of vulnerable families within practices and enabling Deep End practices to hold regular, multidisciplinary meetings, based on their substantial knowledge and contact with patients.

Practices need to be linked more effectively to **support services** for vulnerable families, so that advantage is taken of the knowledge and concerns of practice teams.

Every Deep End practice should have an **attached mental health worker**, capable of helping patients with psychological, alcohol and/or addiction problems (justified by the volume of cases and the need for additional help to be available locally and quickly)

General practices should be supported to make better use of non-medical community resources (**social prescribing**).

The disbanded **Primary Care Collaborative**, which involved two thirds of Deep End practices, provided a mechanism whereby local groups of practices were supported to address **developments in service**. This approach should be re-introduced.

## Professional Training and Development

General Practices at the Deep End should be supported as a **Learning Organisation**, dedicated to the improvement of services for patients and providing opportunities to share experience, information, evidence and views, so that good practice can be spread and variations in service are reduced.

Most of these activities should be **multidisciplinary**, involving doctors, nurses, practice managers, receptionists and other NHS staff.

There is also 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.

National NHS support organisations, such as Health Scotland, Quality Improvement Scotland, NHS Education in Scotland, the Information Services Division and the Chief Scientist Office provide little support that is apparent to General Practices serving Scotland's poorest communities. Part of their budgets should be redeployed to provide **an integrated package of support** for the Learning Organisation (avoiding the fragmented and ineffective approach of multiple policies, all lacking focus on the most deprived areas).

The imbalance in the distribution of GP training in Scotland should be rectified by increasing the numbers of **training practices and GP trainees** in very deprived areas and ensuring that all GP trainees have exposure to the challenges of primary care in very deprived areas.

The NES **GP Health Inequality Fellowship Scheme** should be increased in size (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 experience GPs to take on leadership roles.

NHS Scotland should establish a **research and development agenda**, addressing the problems of behavioural change, health care delivery and systems development on its front line in the most deprived areas, based on **threeway partnership** between practitioners, managers and researchers

### **Support for the Deep End Project**

The Deep End Project has identified, and has begun to fill, **two important gaps in the organisation of NHS Scotland**

First, there is the **lack of contact, cohesion and communication across its front line** of practices serving very deprived areas. Practices need to be brought together to address the shared task of improving services for patients.

Second, there has been **a lack of effective engagement by NHS policy and management** with general practices working on the front line of the NHS in the most deprived areas.

Part of the explanation of both gaps is the **scattered nature of front line**, across a large number of NHS organisations. No single organisation exists which has responsibility for the front line of NHS Scotland in the most deprived areas.

The administrative and support needs of the Deep End project are an **infinitesimal fraction** of the funds spent on NHS management and support. The support funds provided so far by the Scottish Government and the Glasgow Centre for Population Health have been spent speedily, productively

and efficiently. Continuing support is needed to address both of the above gaps.

## **Conclusion**

Most people agree with the **social objective** of the NHS, providing comprehensive care based on need, which is free at the point of use.

There is still **work to do** to deliver this objective in very deprived areas.

As the NHS in the UK fragments into different approaches to health care organisation and delivery, there is an **internationally important opportunity** for NHS Scotland **to demonstrate what universal coverage and needs-based services can achieve for populations with the poorest health.**

General Practitioners at the Deep End are already in the front line, and a huge resource for such an endeavour.

***The NHS should be seen at its best where it is needed most.***

***Can NHS policy and management rise to the challenge?***

[www.gla.ac.uk/departments/generalpracticeprimarycare/deepend](http://www.gla.ac.uk/departments/generalpracticeprimarycare/deepend)

February 2011

Published by



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