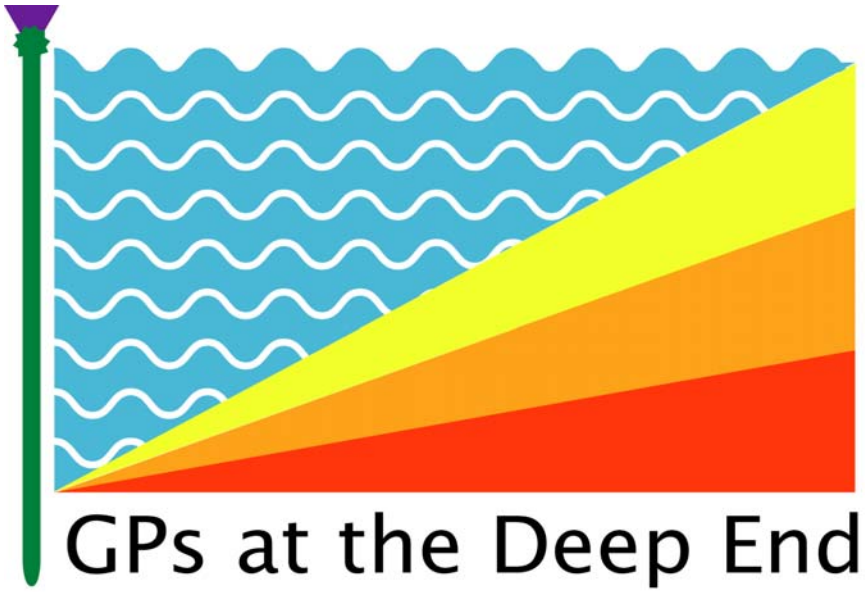


MANIFESTO 2011

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 Heath 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 heath 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 ***infinitessimal 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.

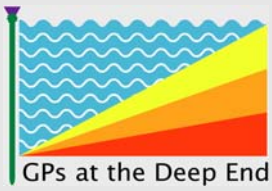
There is still ***work to do*** to deliver this objective in very deprived areas.

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?



"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 Academic Unit of General Practice & Primary Care at the University of Glasgow.*

Contacts for further information

Paul Alexander *RCGP Scotland* palexander@rcgp-scotland.org.uk
John Budd *Lothian Deprivation Interest Group* John.Budd@lothian.scot.nhs.uk
Petra Sambale *Keppoch Medical Practice, Glasgow* psambale@btinternet.com
Graham Watt *University of Glasgow* graham.watt@glasgow.ac.uk