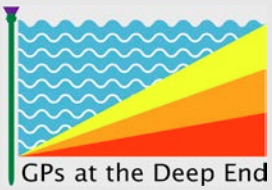
DEEP END SUMMARY 18

Integrated care

This report and recommendations draw on research evidence, previous Deep End reports and discussion groups at the second national Deep End conference at Erskine on 15 May 2012.

- To avoid widening inequalities in health, the NHS must be **at its best where it is needed most**.
- The arrangements and resources for integrated care should reflect the **epidemiology of multimorbidity** in Scotland, including its earlier onset in deprived areas.
- Better integrated care for patients with multiple morbidity and complex social problems can **prevent or postpone emergencies**, improve health and prolong independent living.
- Policies to provide more integrated care must address the **inverse care law**, whereby general practitioners serving very deprived areas have insufficient time to address patients' problems.
- Patients should be supported to become more **knowledgeable and confident** in living with their conditions and in making use of available resources, for routine and emergency care.
- The key delivery mechanism for integrated care is the **serial encounter**, mostly with a small team whom patients know and trust, but also involving other professions, services and resources as needs dictate.
- The intrinsic features of general practice in the NHS, which make practices the **natural hubs of local health systems**, include patient contact, population coverage, continuity of care, long term relationships, cumulative shared knowledge, flexibility, sustainability and trust.
- Health and social care professionals working in area-based organisations (e.g. mental health, addiction and social work services) should be **attached to practices**, or groups of practices, on a **named basis**.
- Practices should be supported to make more use of community assets for health via a new lay **link worker** role.
- The quality and timeliness of hospital discharge information should be a consultant responsibility and audited as a **key component of the quality of hospital care**.
- Practices needed **protected time** to share experience, views and activities, to connect more effectively with other professions, services and community organisations, to develop a collective approach and to be represented effectively.
- **Collective working** between general practices is best achieved with groups of 5/6 practices, as shown by the Primary Care Collaborative and Links Project. Larger groupings are less likely to achieve common purpose.
- **Locality planning arrangements** should be based on representation (not consultation), mutual respect and shared responsibility.

"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, the Scottish Government Health Department, and the Department of General Practice and Primary Care at the University of Glasgow.*



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Full report available at http://www.gla.ac.uk/departments/generalpracticeprimarycare/deepend