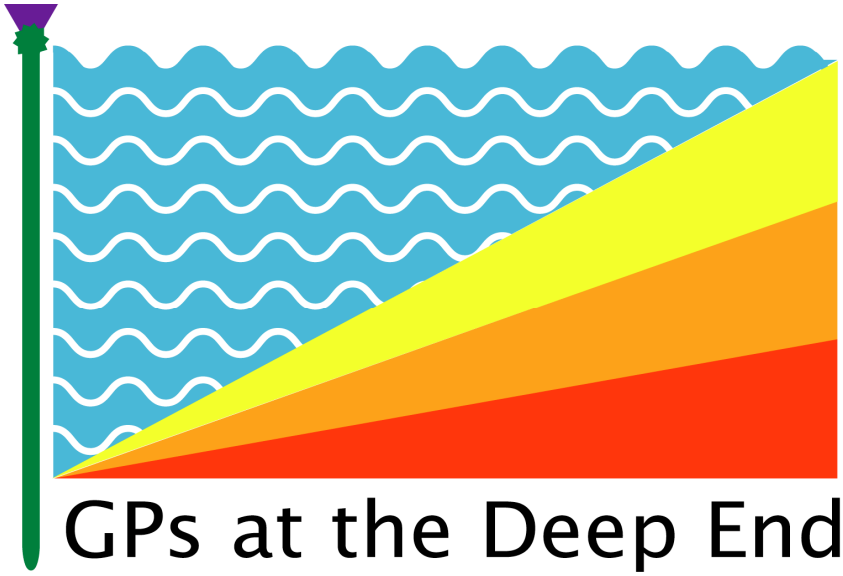

General Practitioners at the Deep End

Final report of a special meeting held on 16 September 2009 at Erskine Bridge Hotel

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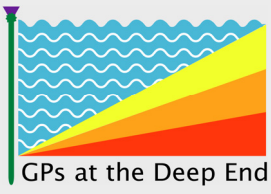

“General Practitioners at the Deep End” *work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Royal College of General Practitioners (Scotland), the Scottish Government Health Department, the Glasgow Centre for Population Health, and the Section of General Practice & Primary Care at the University of Glasgow.*

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INTRODUCTION

63 general practitioners from the 100 most deprived general practice populations in Scotland met for a special “Open Space” meeting at Erskine on Wednesday 16 September, to share experience and views on the challenges facing primary care in such areas. This was the first time in the history of the NHS that such a group had been convened and consulted.

The meeting was planned by the Short Life Working Group of RCGP Scotland, which wished to take account of the views of practitioners from the front line before making recommendations to address inequalities in health in Scotland. The meeting was made possible via locum funding provided jointly by RCGP Scotland and the Scottish Government.

Apart from a brief introduction, the format of the meeting involved 100% participation via plenary and group sessions. This report describes the meeting and its general conclusions and will feed into the report of the RCGP Scotland Short Life Working Group on Health Inequalities.

BACKGROUND

Little progress has been made in Scotland in the last decade in narrowing the large differences in life expectancy across the socio-economic spectrum.

On average, the most deprived 10% of the Scottish population, comprising the majority of patients served by the top 100 practices, has 70% more male and female deaths under the age of 70 than the most affluent 10%.

Analyses carried out as part of the Primary Care Observatory Project by the University of Glasgow Department of General Practice and the Glasgow Centre for Population Health has demonstrated the relatively flat distribution of general practitioner manpower across the socio-economic spectrum, despite a 2.5-3 fold increase in the prevalence of health problems.

Other research has shown the practical consequences of this mismatch of resource and need. Consultations in the most deprived practices are 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

The title of the meeting *General Practitioners at the Deep End* refers to the common experience of practitioners serving deprived areas in having insufficient time and other resources to address the volume of need and demand.

Identifying the 100 most deprived practices

Current NHS policy in targeting areas of severe socio-economic deprivation is to target people living in the most deprived 15% of Scottish postcode datazones.

Practices were ranked, therefore, according to the proportion of registered patients living in the most deprived 15% of Scottish postcode datazones.

All practices in the top 100 have at least 50% of their patients in this category, rising to over 90% in the most deprived practice population.

Of the most deprived 10% of the Scottish population, 50% are registered with the 100 most deprived practices as described above, while the other 50% are registered with about 700 other general practices in Scotland. About 200 practices have no patients from the most deprived section of the Scottish population.

The meeting focused on issues affecting practices serving areas of concentrated (as opposed to diluted) deprivation, therefore, with a strong emphasis on actions that could be taken by general practices singly, collectively or in partnership with others.

Features of the 100 most deprived practices

- 85 of the top 100 practices are based in Glasgow City, with 5 in Inverclyde, 5 in Edinburgh, 2 in Dundee, 2 in Ayrshire and 1 in Renfrewshire. 91 practices are in NHS Greater Glasgow and Clyde Health Board, within 7 Community Health Partnership (CHP) or Community Health Care Partnership (CHCP) areas.
- 46 of the practices are based in two CHCP areas in Glasgow East and North, where they comprise 84% of all practices. The other 54 practices are a minority within the CHPs in which they are situated.
- The 100 practices have a combined list population of 431,614, with an average list size of 4316.
- Although the five Edinburgh practices comprise only 5% of the number of practices, they are large group practices and serve about 10% of the population served by the 100 most deprived practices.
- 20 practices are single-handed and 60% of practices comprise 3 general practitioners or less. However, the average number of general practitioners per practice is 3.6 and two thirds of the 360 GPs in the 100 practices work in practices with 4 or more GP partners.
- There is no difference in the number of points achieved in the Quality and Outcomes Framework between practices serving the most deprived, most affluent or intermediate tenths of the Scottish population.
- About a half of practices take part in undergraduate teaching, a quarter in postgraduate training, two thirds in research (via the Scottish Primary Care Research Network) and primary care development (via the Scottish Primary Care Collaborative) and one third in Keep Well, the Scottish national demonstration project for anticipatory care.
- Of the 85 practices from Glasgow, 40 (47%) take part in three or more of the following activities, which are additional to contractual requirements namely, participation in undergraduate teaching (n=41), postgraduate training (n=21), research (n=40), SPICE (n=19), the primary care collaborative (n=57) or Keep Well (n=25). 29 practices take part in less than two such activities, including 7 practices which take part in none.

Participants in the meeting

63 general practices were represented at the meeting (Appendix A), including :-

- 19 from Glasgow East CHCP (9 others were invited but did not attend)
- 13 from Glasgow North CHCP (5 did not attend)
- 9 from Glasgow West CHCP (7 did not attend)
- 9 from Glasgow South-West CHP (5 did not attend)
- 6 from Glasgow South-East CHCP (3 did not attend
- 2 from Edinburgh (3 did not attend)
- 2 from Inverclyde (3 did not attend)
- 2 from Ayrshire
- 1 from Dundee (1 did not attend)
- 0 from Renfrewshire (1 did not attend)

In addition, there were 4 representatives from practices for the homeless in Edinburgh and Glasgow, and 4 representatives of rural practices with a significant number of deprived patients in their registered populations.

Characteristics of the participating and non-participating practices from Glasgow were:

	Participating	Non-participating
Number of practices	56	29
List size	4850	3219
Undergraduate teaching	61%	28%
Postgraduate GP training	31%	14%
Research (SPCRN)	25%	14%
Primary care collaborative	76%	52%
Keep Well	34%	21%

Of the 13 practices in Glasgow serving populations of less than 2000 patients, only 5 were represented at the meeting – the only category of practice in which there were fewer participants than non-participants. The 8 non-participating practices include 5 of the 7 practices in the top 100 which do not take part in any additional activities (primary care collaborative, teaching etc).

75% of the participating practices and 48% of the non-participating practices from Glasgow take part in two or more additional activities.

THE MEETING

The meeting was confined to a single general practitioner from each invited practice. The number of observers was restricted to three, from the Scottish Government and NHS Health Scotland, in order to promote free and open discussion, with ownership of the problems and solutions discussed. The meeting was chaired by Alan McDevitt, secretary of the Glasgow Local Medical Committee, and facilitated by Andrew Lyon, of the International Futures Forum. A team of general practitioners, mostly from practices outside the top 100, acted as facilitators for group discussion. Practical arrangements were co-ordinated by RCGP Scotland.

Format

A short presentation explained how and why the 100 practices had been identified (Appendix B)

An “open space” plenary session allowed participants to raise the following 24 issues for discussion:

- Practice workload
- Practice autonomy - employment of staff
- Premises/infrastructure
- Concordance
- Patient expectations
- Contract changes
- Vulnerable families
- Mental health
- Primary care and secondary care interface
- Information overload/IT use
- Research
- Enhanced service provision
- Medical workforce
- Re-distribution of resources between practices
- Access/continuity
- Shifting balance of resource
- CPD
- Values
- Political goalpost changing
- Evidence base
- Practice time
- Those dying at home
- Dilution/pockets of deprivation
- Unemployment and health

By indicating their first preferences, participants selected 8 topics for the first session of group discussion:

- Practice Workload
- Practice autonomy (2 groups)

- Concordance
- GP support – continuity/burn out
- Increase of Patient Expectation
- Contract Changes
- Vulnerable Families & Mental Health
- Non-aligned (any topic)

Groups itemised problems and opportunities in relation to their chosen issue, and communicated this to the rest of the meeting via a wall poster covered with "post-it" notes. All participants reviewed all wall posters, highlighting the post-it notes they considered most important by attaching self-adhesive back dots. Issues receiving the most votes were then organised under 8 headings for the second group discussion:

NOTE *The numbers below in brackets indicate the number of votes given to each issue and, therefore, the importance attributed to each issue by the 74 participants at the meeting (63 from the top 100, 4 from rural practices, 4 from homeless practices and 3 observers)*

GROUP 1 Practice autonomy – employment of staff

- CPN attachment to GP (52)
- Direct employment of HV, DN, SW, CPN (41)
- HV attachment to GP (37)
- Social Workers in GP practices (budget for) (31)
- Review of maternity services was imposed with no consultation with GPs (27)
- GP employment of attached staff (27)
- Loss of attached staff (26)
- Recruitment & retention of health visitors (25)

GROUP 2 Mental health

- Practice-based mental health nurses (39)
- Parenting (38)
- Practice based psychology/counselling team members (33)

GROUP 3 Interface with Secondary Care

- Effective communication with secondary care (38)
- Interface with hospitals (26)
- Loss of the general physician (24)
- 'Consultant Hour' – a definite slot when a consultant can discuss (19)
- Discharged after DNA (18)

GROUP 4 Infrastructure and premises

- Updated IT data of local services (55)
- Support for premises development from health board (23)

GROUP 5 Patient empowerment and concordance

- Improve patients self-esteem and self-worth (34)
- Empathy and enablement require appropriate manpower resources (30)

- Known staff (relationships) (21)
- Continuity for patients (13)

GROUP 6 Allocation of resources

- GP protected valued time (52)
- Unequal distribution of GPs according to need (41)
- Improve GP numbers (34)
- TIME! (33)
- A deprivation payment (32)
- A lot of work is not “QOF-able” (31)
- Weight QOF points in favour of deprivation (26)

GROUP 7 Learning, education and support for GPs

- Deprivation interest groups (46)
- Routine support for GPs as people (24)
- GP education (22)

GROUP 8 Primary care structure and collaboration

- CHCPs are a problem (25)
- Lack of engagement by CHCP/social work (16)
- Political action on social determinants (14)

The discussion of each group is briefly summarised below by the facilitators. Two sessions repeated morning topics and reports of these groups are also reported below.

Practice autonomy – employment of staff

There was a strong feeling that attached staff, district nurses, health visitors and possibly community psychiatric nurses, should be employed by practices. If individual practices were small, a geographical coalition of practices could employ and share these staff. Benefits would be better inter-professional communication, less duplication of effort, appropriate skill mix, better control of activity.

CHCPs were criticised for not engaging with GPs, poor communication, creeping erosion of the PHCT and responding to Scottish Government initiatives but not initiatives from GPs

Some participants would be prepared to pilot the employment of attached staff, at practice or coalition level.

Practice autonomy (2)

There was a strong focus on problems at the interface with CHCP management, which was considered out of touch with practices. Specific issues included coercive management styles, de-motivation of the nursing workforce, a lack of understanding of achievements of practices, allocation of resources to management structures rather than to “coalface workers” and a general suspicion of GPs.

Proposed solutions included the formation of federations of practices with GP leadership. A central function would be the development of well managed directly employed nursing and social work teams. Pilot work would need to be done and tightly worded service level agreements developed.

Mental health

Community projects like Stress Centres were perceived as potentially very helpful but long waiting lists make them less meaningful to patients in acute distress.

One practice had been involved in a research project with CPN attachment to a general practice and the evaluation was positive. There was a discussion why this evidence did not lead to a roll out of CPN attachments to general practice.

Access barriers and segregation of mental health services lead to patients being lost in referral systems (e.g. patients with addiction problems and psychiatric co-morbidity). Whereas some services (e.g. ESTEEM) with adequate funding deliver excellent care.

Vulnerable families

Ways of highlighting vulnerable children within IT systems were discussed (e.g. Read Codes or a teddy bear system), but limitations were highlighted (e.g. the lack of family tree information in current systems). The model of HV attachments to general practices was felt to be paramount. There was acknowledgement that the recruitment crisis and retention of health visiting staff are matters of urgency with the need for redistribution of funding to areas of greatest need. Solutions were sought in regards to case conferences (e.g. holding these in practice premises or faxing invites to the surgeries to give GPs time to make attendance arrangements or write a report).

Primary/secondary care interface

The discussion touched on patient access, referral pathways and communication between GPs and consultants.

GPs asked for more access to investigations and wanted consultant opinion on referrals for some disease areas, instead of patients ending up lost in care pathways.

Possible solutions to patients failing to attend appointments were discussed (e.g. a more reliable ambulance service, text reminders and support workers facilitating attendance).

Secondary care has to share responsibility for the follow up of some DNA patients and at a minimum to detail reasons for referral on DNA letters. Suggestions for improving communication included e-mailing discharge letters, or actionable tasks and specifying medication changes.

There was a strong desire to engage with consultants locally and to have the option to “consult” secondary care via designated phone-in times. GPs perceive an

increasing lack of a holistic approach in secondary care due to increasing specialisation and quicker turnover.

Lothian had a pilot with consultants taking receiving calls from GPs - most admission requests were considered appropriate. The pilot opened a communication pathway with consultants offering advice and flexibility concerning urgent outpatient appointments. The group felt this should be further explored and possibly rolled out in other areas.

Patient empowerment

The ideal is that patients should be able to take charge of their health in a self actualised manner by being able to make informed choices. It is not about being passive or being a rampant consumer of health care.

Engagement with patients we do see in practice: GPs should ensure they treat all patients with respect and promote their self efficacy in the consultation. Caring for ourselves (i.e. GPs) will allow GPs to remain sensitised to this and help create a positive culture in the practice and a cohesive practice team. This can be aided by teambuilding days with external facilitators (e.g. a team building day cleaning up a littered area on a community walking route, with an accompanying article in the local paper).

Engagement with the patients who don't come in to the practice: GPs believe that community development needs to return to the grassroots in helping to generate social capital in their practice areas. GPs and practices can be an important part of this on a range of levels. GPs have an important positive role to pay in the community. If locum funding were available it could enable GPs to participate in publicised community events.

GPs need to find out what activities and supports are in the community; but this can be difficult, when not living in their practice areas.

There is a need for research on how health and social work can cooperate to support children.

Concordance

The group discussed how patients and GPs can develop a shared action plan that the patient will feel is worth adhering to. Key issues were values, relationships and engagement.

The core values of practitioners and practices may be determined by self and group appraisal. GPs also need to understand and be empathetic towards the values held by patients.

The group highlighted the importance of trusting relationships amongst all involved with patient care (as many as possible and at least the 'core' team) and the significance of existing relationships between GPs (and other health care professionals) and the patient as a potent motivational force.

There is a need to explore how best to engage with patients. All stages of education should include communication and motivational skills. GPs and practice staff should be catalysts for change. There is a particular need to explore other ways to

encourage people with low expectations (of self, society and health care) to 'concord'. The group highlighted the importance of getting it right with/for children

The aim is a tight, self aware team that 'understands' its population and is willing to meet this population on its own terms

Allocation of resources

GPs know where differences can be made, but others control the budget. GPs know who is falling through the gaps (e.g. patients with combined mental health problems and addiction) and could deliver services locally and faster, in a building familiar to patients. This would improve attendance and continuity of care. GPs feel they need financial recognition of their demanding role. This will help to bring other GPs on board. A very small number of GPs let the side down by providing poor care to a massive patient list and this should be capped. In summary: Give us the tools and we will finish the job!

Learning, education and support

The group was clear that a formal mechanism of support was required, sharing-best practice and further education.

Several of the delegates discussed the intensive mentoring, reflection and support received by current GP registrars, and felt that some components of their ongoing peer support would be beneficial (and fill a "void") for GPs post-CCT.

GPs spoke of the need for meaningful and personal protected time with other GPs (not "alone in a room in the surgery") to facilitate the above support, and highlighted that the days of attending evening meetings voluntarily are gone.

Sharing-best practice both within practices and with neighbouring practices was another theme. Some GPs wanted to know how 'successful' others in their practice were in terms of achieving positive outcomes. Delegates felt that sharing this data locally would facilitate the adoption of best and more efficient practice (including staffing structure, telephone triage, house call requests, follow-up visits, reception team role, use of health-care assistants etc)

There was discussion as to whether having an appointed health inequality GP for each practice (similar to a special interest) would be beneficial The group felt that a support group (even if this was virtual) akin to the Lothian Deprivation Interest Group, would definitely be beneficial.

Primary care structure and collaboration

Problems with CH(C)Ps were highlighted and solutions posed. Levels of disengagement of CH(C)P and social work management with practices, and problems of attached nursing staff vary between areas. Within the existing structure it was considered essential that senior managers should be subject to performance review by clinicians. In general, practice employed staff are retained for many years and have low levels of sickness absence.

Federations of practices, led by elected GPs, could save money, maintain morale, retain staff and reduce sickness absence. They would improve inter-professional communication. They could also inform and improve the development of secondary care, but there was disagreement about whether taking over the management of social care was desirable. Communication between practices would be improved by protected learning time, and there would be educational and service development opportunities from involving consultants. Their development could be seen as a threat by CH(C)P management and federations would need development in pilot sites.

COMMENTARY

The meeting involved practitioners from two thirds of the 100 most deprived practices in Scotland, representing a good majority but not necessarily representing the views of practices which did not attend, which tended to be smaller, and less likely to take part in additional activities.

The meeting was largely based on the sharing of experience and views. Many of the participants knew each other well from other activities. However, the focus on practices serving populations with concentrated deprivation and the absence of colleagues representing other types of practice were novel. In the summary session, several commented on the almost immediate and strong group identity of practitioners from the 100 most deprived practices and the positive nature of the meeting.

It was clear that Scotland does not have many of the problems of general practice in deprived inner city areas, which have provided the context for much primary care development in England. Despite the heavy burden of health needs and demands, and their impact on both patients and staff, general practice serving areas of concentrated deprivation in Scotland is characterised by high quality (as measured by the QOF), high morale (as demonstrated by involvement in additional professional activities) and high commitment to improving services for patients (as evident by the discussions at the meeting).

The nature of the meeting was that it raised many more issues than could be addressed in detail. It was not intended or expected that precise recommendations for policy or practice would emerge. The meeting was planned to promote internal discussion and exchange between general practices, as a preliminary to more detailed work, the development of agreed proposals and engagement with the many external agencies and organisations with which general practices work.

The meeting strongly affirmed, indeed took for granted, the strengths of the general practice model, based on contact, coverage, continuity, co-ordination, flexibility, relationships, trust and leadership. There was frustration, however, from lack of resource, lack of support, lack of identity and marginalisation within current NHS arrangements.

A strong theme was the problematic and dysfunctional nature of many external relationships, including those with non-practice-employed staff, local authority services and community health partnerships.

Many practitioners regretted the devaluing of consultations, considered to be the heart of general practice, by the financial incentives of the new GMS contract.

It is noteworthy that there was no mention of Keep Well in the plenary sessions or post-it notes of group discussion. Equally Well, the current Scottish Government policy on Health Inequalities, confines its coverage of the contribution of general practice to narrowing health inequalities to Keep Well, the flagship national anticipatory care programme. Only 37 general practices out of the most deprived 100 practices currently take part in Keep Well (including 25 of the 85 practices from Glasgow and 12 of the 15 practices from outside Glasgow). 19 Keep Well practices were represented at the meeting

The topics selected for final discussion were a mixture of issues particular to deprived areas (e.g. mental health, patient empowerment, resource allocation and support for practitioners) and issues of relevance to all general practices (e.g. multi-professional working, relationships with secondary care, infrastructure and premises and relationships with CHCPs).

A GP from Edinburgh commented, "I was in groups made up entirely of non-Lothian GPs. What was striking was not only that we got on well, but on how much convergence there was in terms of the problems we face. I was in the primary/secondary care group and virtually everything said by Glasgow GPs, I could have said first about Edinburgh – to a surprising level of detail. That problems seem to be so very generic and uniform across the board hopefully means that there might be generic and uniform answers too".

It was noted that practices serving deprived areas could only address the issue of "inequalities" indirectly, by increasing the volume and quality of service for their populations, but that much could be achieved, with and without additional resources, by the NHS making better use of general practice as a force, based on coverage, commitment and trust, to improve the health of patients in deprived areas, and thereby to help narrow inequalities in health.

WHAT NEXT?

The immediate challenge is to build on the engagement, enthusiasm, ideas and precedent generated by this first meeting. Can the extraordinary nature of the meeting be made ordinary, so that the top 100 general practices become a more effective force for improving primary care?

In the short term, a steering group, drawn from participants at the meeting, should coordinate a range of activities involving participants from the meeting and invited others. The Glasgow Centre for Population Health (GCPH) has indicated its willingness to support such a project in the first half of 2010. In the spirit of the initial meeting, the steering group should establish its own agenda out of the day's proceedings, but may wish to consider the following issues and activities.

Liaison is needed with RCGP Scotland, the Scottish Government, NHS national support agencies and local health boards (especially NHS Greater Glasgow and Clyde) to discuss how the work of the 100 most deprived practices can best be supported.

The major issue identified by the meeting is the need to identify and support effective methods of multidisciplinary team work within general practice and primary care, with a particular focus on employment relationships.

The conference also proposed a pilot project to make better use of existing resources within general practices (a stepping stone to the larger issue of whether and how additional resource could best be used).

Additional events involving practices from the top 100, and engaging with significant other groups, could address the several problematic external interfaces identified at the conference (CHCPs, social work, secondary care).

The NHS does not currently provide mechanisms by which practices working in areas of concentrated deprivation can readily share experience, information and evidence concerning the nature of their task. Such collaboration is possible, however, as demonstrated by the high levels of participation (67%) in the work of the Scottish Primary Care Collaborative. It would be useful to review the ways in which the many NHS support organisations (for education, quality, IT, research and development) might work more effectively to support practices in the front line.

Following the example of the GCPH report The Shape of Primary Care in NHS Greater Glasgow and Clyde (which has not so far been distributed within general practice) consideration should be given to whether and how an intelligence function could be established to inform the activities and outcomes of practices serving the most deprived areas, learning from examples elsewhere, such as the Lothian Primary Care Data Group and the Lothian GP Deprivation Interest Group.

A key issue concerns the nature of encounters in deprived areas, involving the heavy burden of need, significant co-morbidity, low expectations and agency, shortage of time and high levels of practitioner stress, and their implications for education, training, research and service development.

Work is also needed on whether there are particular educational, training and continuing support needs for the leadership roles of practitioners working in areas of concentrated deprivation.

In the view of the policy importance but relatively low profile of the Keep Well programme at the meeting, further work might explore the experience and views of practices participating and not participating in Keep Well, including a review of the impact of the new Scottish CVD risk score ASSIGN on caseload and case-mix within general practice.

Finally, although developments are clearly best centred on the leading edge of practices identified by the meeting, special effort should be made to disseminate and discuss this report with the 37 non-participating practices which did not take part in the meeting.

The following group planned the meeting and agreed the final report, in consultation with participants and on behalf of the RCGP Scotland Short Life Working Group on Health Inequalities

- Andrew Lyon
- Dr Alan McDevitt
- Professor Stewart Mercer
- Professor Graham Watt

30th October 2009

APPENDIX A PARTICIPANTS

General practitioners

Name	Location
Adams-Strump, Barry	Midlock Medical Centre, Glasgow
Aitken, Ian	Crail medical practice, Glasgow
Alguero, Dr	Possilpark Health Centre, Glasgow
Ali, Ashfaq	Bridgeton Health Centre, Glasgow
Best, Wilma	Gorbals Health Centre, Glasgow
Black, Roger	Whitevale Medical Group, Glasgow
Boyle, Roger	Springburn Health Centre, Glasgow
Brown, Hugh	The Health Centre, Dalmellington
Brown, Iain Grant	Fernbank Medical Centre, Glasgow
Burns, Ronnie	Parkhead Health Centre, Glasgow
Burton, Dr	Woodside Health Centre, Glasgow
Campbell, Debbie	Port Glasgow Surgery
Candy, John	Springburn Health Centre, Glasgow
Cawston, Peter	Drumchapel Health Centre, Glasgow
Connelly, Jane	Drumchapel, Glasgow
Craig, Margaret	Springburn Health Centre, Glasgow
Davidson, Karen	Kyleshill Surgery, Saltcoats
Dhami, Davinder	Easterhouse Health Centre, Glasgow
Doak, Dr	Arran GP Surgery, Glasgow
Douglas, James	Tweeddale Medical Practice, Fort William
Duffy, Maria	Pollock Health Centre Glasgow
Dunn, Geraldine	Bridgeton Health Centre, Glasgow
Geddes, Pamela	Milton Medical Centre, Glasgow
Ghaus, Pervez	Pollock Health Centre Glasgow
Goldie, John	Easterhouse Health Centre, Glasgow

Name	Location
Henderson, Ian (half day shared with Rod Shaw)	Kingsway Medical Practice, Glasgow
Herron, John	The Green Practice, Govan, Glasgow
Jamieson, Mairi	Tollcross Medical Practice, Glasgow
Jamieson, Robert	Bridgeton Health Centre, Glasgow
Kennedy, I	Hyndland St, Glasgow
Lam, William	Gilbertfield Medical Centre, Glasgow
Langrdige, Dr	Possilpark Health Centre, Glasgow
Lannigan, Ruth	The Ker Practice, Glasgow
MacDonald, Lynne	Drumchapel Health Centre, Glasgow
MacKenzie, James	Maryhill Health Centre, Glasgow
MacPhee, Dr	Parkhead Health Centre, Glasgow
MacPherson, Stephen	Bridgeton Health Centre, Glasgow
Magee, Brendan	Westerhailes, Edinburgh
Manson, Patrick	Teviot Medical Practice, Hawick
McAlavey, Pauline	Glenmill Medical Practice, Glasgow
McArthur, Alan	Braidcraft Medical Centre, Glasgow
McCorkindale, Clare	Kelso Street Surgery, Glasgow
McGinley, Anne	Easterhouse Health Centre, Glasgow
McHugh, Owen	Parade Group Practice, Glasgow
McNicol, Iain	Dunvegan, Argyll
Michie, Brian	The Group Practice, Stornaway
Milligan, Kerry	Homelessness Health and Resource, Glasgow
Mills, Cathy	Gorbals Health Centre, Glasgow
Mohammed, Yasin	Westmuir Medical Center, Glasgow
Montgomery, J	Blackwood Partnership, Glasgow
Morgan, Anne	Drumchapel Health Centre, Glasgow
Morton, Catriona	Craigmiller, Edinburgh
Mullin, Anne	Govan, Glasgow

Name	Location
O'Neil, Jim	Lightburn Medical Practice, Glasgow
Pegg, Steven	Whitfield Medical Centre, Dundee
Pettigrew, Anna	Springburn Health Centre, Glasgow
Rashid, M.A.	12/14 Tullis Street, Glasgow
Reid, Allison	Possilpark Health Centre, Glasgow
Robertson, Douglas	20 Pennan Place, Glasgow
Shaw, Roderick (halfday shared with I Henderson)	Kingsway Medical Practice, Glasgow
Simpson, Marianne	Yellow Practice, Govan Health Centre, Glasgow
Spencer, Ruth	Homelessness Health and Resource, Glasgow
Stoddart, Donald	Shettleson Health Centre, Glasgow
Thomson, Margaret	Roxburgh Practice, Greenock
Watson, David	Springburn Health Centre, Glasgow
Wiggins, Peter	Castlemilk Group Practice, Glasgow
Willox, David	Croftfoot Road, Glasgow
Winter, Alan	Edinburgh Road, Glasgow
Wright, Linda	Toryglen, Glasgow

Facilitators/personnel

- Dr John Gillies
- Professor Stewart Mercer
- Professor Graham Watt
- Dr Alan McDevitt
- Dr Andrew Lyons
- Dr Ken Lawton
- Dr John Budd
- Dr Andrea Williamson
- Dr Phil Wilson
- Dr Max Cooper
- Dr Michael Norbury
- Dr Alan Bennie
- Dr Petra Sambale
- Dr Euan Patterson
- Dr Phil Donnelly

Observers

- Mary Allison (NHS Health Scotland)
- Kay Barton (Scottish Government)
- Dr Mini Mishra (Scottish Government)
- Ruth Wallace (RCGP Scotland)

Staff in attendance

- Paul Alexander
- Josie Westley
- Bally Pabla

APPENDIX B WHY FOCUS ON THE 100 MOST DEPRIVED PRACTICES?

This conference focuses on the top 100 practices in Scotland in which socio-economic deprivation of registered patients is most concentrated. Half of the most deprived patients (i.e., those in the top 10% of deprivation for the whole of Scotland) are registered with these practices (See Annex below for more explanation of this).

The conference does not try to address the challenges faced by practices in which deprivation is a less dominant feature (i.e. the 900 practices with whom the other 50% of the most deprived 10% of people in Scotland are registered). However it does include (in addition to the top 100) a limited number of practices serving deprived populations in rural areas, which tend to be missed out by classifications of deprivation based on postcodes.

The 100 most deprived general practice populations have a combined list size of 429,584 with an average list size of about 4300. 60 of the practices have three or less GPs, including 20 which are single-handed.

Most general practice populations are socially heterogeneous. On average 69% of patients in the most deprived 100 practices come from quintile 5 (the most deprived 20% of the population), 14% from quintile 4, 7% from quintile 3, 6% from quintile 2 and 4% from quintile 1.

Of course, many ways of addressing the poor health of deprived populations do not require contact with individuals, but insofar as poor health can be addressed via individual contacts, general practice is the only serious, practicable option. While researchers are generally satisfied with response rates of 60-70%, general practice has to look after 100% of the population, with many incentives requiring over 90% coverage.

Health characteristics of the most deprived populations

The following table, produced by the Platform Project, shows the proportion of all deaths in 2001/02 occurring under the age of 70, in deciles of general practice populations, ranging from the most affluent (decile 1) to the most deprived (decile 10).

Note that the 100 most deprived practices are all contained in decile 10.

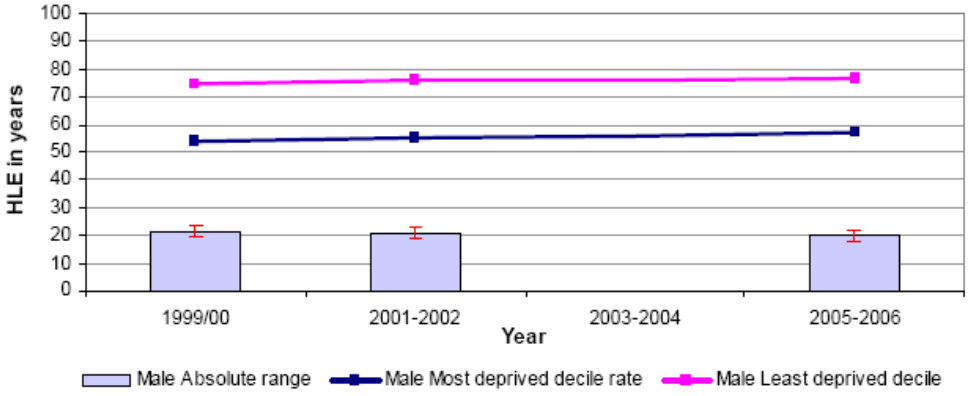
Decile	No of practices	% female deaths <70	% male deaths <70
1	89	14.4%	24.6%
2	104	16.4%	29.0%
3	110	16.3%	29.0%
4	107	16.4%	31.9%
5	92	18.8%	30.6%

Decile	No of practices	% female deaths <70	% male deaths <70
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%
ALL	**1031**	**19.2%**	**33.3%**

Health inequalities are not narrowing

The figure below, from a presentation by Professor John Frank, shows that the difference in healthy life expectancy between males in the most and least deprived deciles of the Scottish population did not change between 1999/00 and 2005/06.

Figure 1 *Absolute range: Healthy life expectancy Males – Scotland 1999/00 to 2005/06* (Data not available 2003/04)



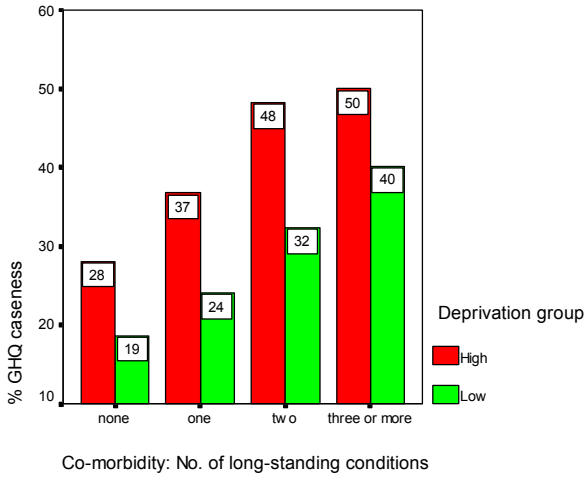
SOURCE Scottish Government Health Analytical Services (2008) *Long-term monitoring of health inequalities*

General practice consultations in deprived areas

Consultations in the most deprived practices are characterised by:

- Higher demand
- Shorter time available
- More multimorbidity
- Less enablement reported by patients with complex problems
- Greater GP stress

Figure 2 *Relationship between psychological distress (GHQ-caseness) and co-morbidity (number of chronic conditions) in high and low deprivation areas*



Mercer SW Watt GCM. The inverse care law : clinical primary care encounters in deprived and affluent areas of Scotland. *Annals of Family Medicine* 2007;**5**:503-10

Performance in the QOF

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).

Where are the 100 practices?

The 100 practices are based in 10 community health (and social care) partnerships.

CHP	No of top 100 practices in CHP	% of all practices in CHP
Glasgow East CHCP	28	84
Glasgow North CHCP	18	
Glasgow West CHCP	16	39
Glasgow South-West CHCP	14	
Glasgow South-East CHCP	9	
Inverclyde CHP	5	7
Edinburgh CHP	5	
Dundee CHP	2	
Ayrshire CHP	2	
Renfrewshire CHP	1	
TOTAL	**100**	**28%**

Although Edinburgh practices comprise only 5% of the 100 top practices, their list sizes are twice the average in the group, so that their registered populations comprise 10% of the total served by the top 100 practices.

How deprived is deprived?

The most deprived 15% of the population (based on SIMD scores) is generally used as the target population for health policy concerning inequalities in heath.

The proportion of patients meeting this criterion ranges from 48% of patients in the 100th most deprived practice to 91% of patients in the most deprived practice. In general, therefore, the threshold for being in the top 100 practices is that more than half of the practice population is in the most deprived 15% of the Scottish population.

Less than half of the top 100 practices currently take part in Keep Well, the national project promoting anticipatory care in deprived populations (see below).

How big are the 100 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 5 Edinburgh practices is 8524. Overall, the 5 Edinburgh practices have a larger combined list size than the 20 single handed practices in Glasgow. 8 practices in NHS GG&C have list sizes over 7500.

How many GPs?

No of GPs per practice	No of practices	No of GPs
1	20	20
2	21	42
3	19	57

No of GPs per practice	No of practices	No of GPs
4	7	28
5	15	75
6	4	24
7	3	21
8	5	40
9	4	36
13	1	13
TOTAL	**99**	**356**

What do the 100 practices volunteer for?

Voluntary activity	No of practices
Undergraduate teaching	45
Postgraduate teaching	27
Research (SPCRN)	46
Primary care collaborative	67
SPICE	23
QPA	4
Keep Well (Phase 1)	24
Keep Well (Phase 2)	13

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ANNEX 1 EXPLANATION OF THE "TOP 100"

The Scottish Index of Multiple Deprivation characterises datazones, based on local postcodes, in terms of collations of routine data in 7 different domains – income, employment, education, housing, health, crime, and access (defined as distance from main services).

For example, the variables that make up the health domain (with weightings attached to each factor) are :-

- Standardised mortality ratio (0.09)
- Hospital episodes related to alcohol use (0.14)
- Hospital episodes related to drug use ((0.06)
- Comparative illness factor – based on cont of numbers of recipients of Disability Living Allowance, Attendance Allowance, Incapacity Benefit and Severe Disablement Allowance (0.33)
- Emergency admissions to hospital (0.32)
- Proportion of population being prescribed drugs for anxiety, depression or psychosis (0.05)
- Proportion of live singleton births of low birth weight (0.02)

Scotland is divided into 6505 datazones, each containing on average about 850 people. Individual datazones may have substantially more or less than the average figure.

Every patient postcode in Scotland has a SIMD score, based on the datazone in which it is located.

It is not necessarily the case that individual circumstances will match the mean value of all postcodes within the data zone, but on average, localities are well characterised by this approach.

A particular exception concerns pockets of deprivation in rural areas which are often too small to influence the average SIMD score of a datazone.

The 100 most deprived general practices in Scotland are based on a ranking of the mean SIMD score of all patient SIMD scores within general practice lists.

Because of the social heterogeneity which is found within all general practice populations, the most deprived 100 practices also include patients who live in less deprived areas.

50% of people living in the most deprived postcodes in Scotland are registered with the 100 most deprived practices; the other 50% are registered with the remaining 900 or so other general practices in Scotland, in which deprived patients are a minority.

As the most deprived 100 practices include many small practices (see below), the most deprived 10% of practices do not cover the most deprived 10% of the population, which is actually covered by 129 practices.

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