

GENERAL PRACTITIONERS AT THE DEEP END

LOOKING BACK 2009-2015

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SUMMARY

- General Practitioners at the Deep End work in the 100 most deprived general practice populations in Scotland.
- The Deep End Project is 6 years old.
- 74% of Deep End practices have taken part in at least one national conference or roundtable discussion. For practical reasons, engagement has been strongest in Glasgow.
- The experience and views of Deep End practitioners have been captured and disseminated in 26 reports, 18 journal articles and numerous invited presentations.
- The inverse care law in NHS Scotland has been clearly characterised as the lack of clinical capacity, relative to need, in very deprived areas and the consequences for patients, practitioners and other parts of the health service.
- The identity and profile of General Practitioners at the Deep End are now firmly established, as shown by numerous references in official documents and invitations to contribute evidence to policy-related discussions.
- The inverse care law and its implications for patients and practitioners have been recognised in reports by RCGP Scotland, RCGP UK, the English Primary Care Workforce Commission, Audit Scotland and the Public Audit and Health and Sport Committees of the Scottish parliament.
- There has been no recognition or commitment by the Scottish Government to address the inverse care law in NHS Scotland as part of its policies to address health inequalities.
- Deep End proposals for primary care development in very deprived areas have been disseminated via manifestos in 2011 and 2013, and incorporated as part of Vision Statements for Primary Care Development by RCGP UK and the Scottish Government.
- The Scottish Government has provided consistent financial support for the Deep End Project via locum-funded meetings and conferences and support for projects in the Deep End.
- A series of Deep End projects has led to the establishment of the 5 year Link Workers Programme, involving embedded community links practitioners and other additional resources in 7 Deep End practices.
- The involvement of 8 Deep End general practices in the Care Plus Study has helped to provide scientific evidence of the cost-effectiveness of additional consultation time for patients with complex problems.
- The Glasgow Alcohol and Drug Programme has embedded alcohol nurses in 6 general practices in north west Glasgow.
- The Scottish Association for Mental Health is establishing a new programme linking its local resources and activities with Deep End practices.
- The Govan SHIP Project involves additional clinical capacity, attached social workers, support for multidisciplinary team meetings and enhanced GP leadership in 4 Deep End practices.
- The majority of Deep End practices are no better off, in resource terms, than they were at the start of the Deep End Project.
- BMA Scotland has not included measures to address the inverse care law in Scotland in its inputs to the development of the new Scottish GP contract in 2017
- Renewed advocacy is required in the run up to the Scottish general election in May 2016

Introduction

General Practitioners at the Deep End, also known as the Deep End Project, began with a national conference in September 2009.

Six years later, in advance of the 3rd national Deep End conference, it is timely to review what has been achieved by the project.

This report summarises the activities, achievements and shortcomings of the Deep End Project.

ENGAGEMENT WITH DEEP END PRACTICES AND PRACTITIONERS

Conferences and roundtable meetings

Between 2009 and 2015, Deep End activities, to which Deep End GPs have been invited with locum funding for clinical backfill, comprised two national conferences and 22 smaller meetings (numbers of Deep End GPs attending in brackets).

1. First National meeting, 16th September 2009 (n=63)
2. Coping with needs demands and resources, 22nd January 2010 (n=9)
3. The GP role in working with vulnerable families, 22nd January 2010 (n=10)
4. Experience and views of Keep Well and ASSIGN, 29th January 2010. (n=20)
5. Single-handed general practice, 7th May 2010 (n=9)
6. Patient encounters in very deprived areas: what can be achieved and how? 14th May 2010. (n=15)
7. General practitioner training in very deprived areas, 4th June 2010 (n=11)
8. Social prescribing (postal survey of Deep End GPs), September 2010.(n=10)
9. Learning Journeys, 17, 18 and 20th August 2010. (n=10)
10. Care of elderly patients, 26th August 2010.(n=5)
11. Alcohol problems in adults under 40, 27th August 2010.(n=14)
12. Working together for vulnerable children and families, 9th September 2010. (n=19)
13. The Access Toolkit : views of Deep End GPs, 14th January 2011.(n=8)
14. Reviewing progress in 2010 and plans for 2011, 25th January 2011.(n=32)
15. Palliative Care in the Deep End, 22nd February 2011. (n=15)
16. Detecting cancer early, 20th April 2012. (n=11)
17. 2nd National meeting, leading to report on Integrated Care 15th May 2012. (n=47)
18. Access to Specialists, 15th February 2013. (7)
19. Joint meeting with Chest Heart and Stroke Scotland (CHSS), 8th August 2013
20. Mental health issues in the Deep End, 25th October 2013. (n=10)
21. What are the CPD needs of GPs working in Deep End practices? 14th March 2014.(n=11)
22. Strengthening primary care partnership responses to the welfare reforms, 22nd May 2014. (n=11)
23. Generalist and specialist views of mental health issues in very deprived areas, 26th September 2014. (n=7)
24. Joint meeting with the Scottish Association for Mental Health (SAMH) 27th February 2015

The total number of GPs attending was 374 (many GPs attending more than one meeting). 23 GPs attended only one meeting.

General practice participation

Although the Deep End was defined originally, and arbitrarily, as the 100 most deprived general practice populations in Scotland, based on the percentage of patients living in the 15% most deprived data zones, the practices identified by this criterion have changed from year to year, partly due to practice closures and mergers, but also changes to the Scottish Index of Multiple Deprivation (SIMD).

Between 2009 and 2014, 120 general practices have met the criterion, of which 85 have featured in the “top 100” in every year. Their geographical distribution is shown below.

Area	No of practices consistently in the Deep End	Practices listed in some years	Total	Participating (%) in Deep End meetings
Glasgow City	69	8	77	61 (79%)
Inverclyde	5	5	10	1 (10%)
Elsewhere in GG&C HB	2	8	10	1 (10%)
Ayrshire and Arran HB	3	4	7	1 (14%)
Edinburgh	3	3	6	5 (83%)
Dundee	3	2	5	1 (20%)
Lanarkshire	0	3	3	0 (0%)
Aberdeen	0	1	1	1 (100%)
Fife	0	1	1	0 (0%)
TOTAL	85	35	120	71 (59%)

63 of the 85 (74%) consistent practices took part in at least one Deep End activity, compared with 13 of the 35 (37%) of the practices which were less consistently in the 100 most deprived practices.

Non-participating practices included 16 in Glasgow City (21%), 9 elsewhere in GG&C (90%), 6 in Inverclyde (60%), 6 in Ayrshire and Arran (86%), 1 in Lothian (17%), 4 in Dundee (80%), 3 in Lanarkshire (100%) and 1 in Fife (100%).

CAPTURING VIEWS AND EXPERIENCE

The following Deep End Reports have been compiled to reflect and convey the views and experience of Deep End GPs.

1. General Practitioners at the Deep End. Final report of a special meeting. September 2009 Report 1
2. Coping with needs demands and resources, January 2010 Report 2
3. The GP role in working with vulnerable families, January 2010 Report 3
4. Experience and views of Keep Well and ASSIGN, January 2010. Report 4
5. Single-handed general practice, May 2010. Report 5
6. Patient encounters in very deprived areas: what can be achieved and how? May. Report 6
7. General practitioner training in very deprived areas, June 2010. Report 7
8. Social prescribing (postal survey of Deep End GPs), September 2010. Report 8
9. Learning Journeys, August 2010. Report 9
10. Care of elderly patients, August 2010. Report 10
11. Alcohol problems in adults under 40, August 2010. Report 11
12. Working together for vulnerable children and families, September 2010. Report 12.
13. The Access Toolkit : views of Deep End GPs, January 2011. Report 13
14. Reviewing progress in 2010 and plans for 2011, January 2011. Report 14.
15. Palliative Care in the Deep End, February 2011. Report 15.
16. GP experience of the impact of austerity on patients and general practices in very deprived areas (survey of Deep End GPs), March 2012. Report 16
17. Detecting cancer early, April 2012. Report 17
18. 2nd National meeting, leading to report on Integrated Care May 2012. Report 18
19. Access to Specialists, February 2013. Report 19
20. What can NHS Scotland to prevent and reduce health inequalities? (Deep End Manifesto), April 2013. Report 20
21. GP experience of welfare reform in very deprived areas (survey of Deep End GPs), October 2013. Report 21
22. Mental health issues in the Deep End, October 2013. Report 22.
23. The contribution of general practice to improving the health of vulnerable children and families (Report written by Dr Anne Mullin, June 2014. Report 23
24. What are the CPD needs of GPs working in Deep End practices?, March 2014. Report 24.
25. Strengthening primary care partnership responses to the welfare reforms, May 2014. Report 25
26. Generalist and specialist views of mental health issues in very deprived areas, September 2014. Report 26

DISSEMINATING VIA PRINT MEDIA

The findings of many Deep End Reports were included in a series of 12 articles in the British Journal of General Practice in 2011. This series was subsequently collated with other BJGP articles in RCGP Occasional Paper 89 with forewords by Dr Richard Horton and Dr Julian Tudor Hart.

Journal publications

2011

- Watt G. Inventing the wheel in general practice. *British Journal of General Practice* 2011 61(592), 685.
- Watt G. A social institution based on mutuality and trust. *British Journal of General Practice* 2011 61, 741.
- Watt G. Time to make a difference. *British Journal of General Practice* 2011 61(590), 569.
- Watt G. The tortoise and the hare. *British Journal of General Practice* 2011 61 (591), 629.
- Sambale P, Mandeville B The Keppoch Medical Practice: reporting from the Deep End. *British Journal of General Practice* 2011; 61(588):463.
- Lyon A, Watt G. Learning journeys. *British Journal of General Practice* 2011; 61(589):519.
- Watt G. Alcohol problems in very deprived areas. *British Journal of General Practice* 2011; 61(587):407.
- Cawston P. Social prescribing in very deprived areas. *British Journal of General Practice* 2011;61(584):350
- Watt G. Anticipatory care in very deprived areas. *British Journal of General Practice* 2011; 61(584):228.
- Watt G. Working with vulnerable families in deprived areas. *British Journal of General Practice* 2011; 61(585):298.
- Watt G. Patient encounters in very deprived areas. *British Journal of General Practice* 2011; 61 (583):146.
- Watt G. GPs at the Deep End. *British Journal of General Practice* 2011; 61(582):66-67

2012

- Graham Watt, Georgina Brown, John Budd, Peter Cawston, Margaret Craig, Robert Jamieson, Susan Langridge, Andrew Lyon, Stewart Mercer, Catriona Morton, Anne Mullin, Jim O'Neil, Euan Paterson, Petra Sambale, Andrea Williamson *General Practitioners at the Deep End: The experience and views of general practitioners working in the most severely deprived areas of Scotland* Occas Pap R Coll Gen Pract. 2012 April; (89): i-viii, 1-40. [Published 2012, Available online 2013]
- Watt G. Reflections at the Deep End. *British Journal of General Practice* 2012 62 (594) 6-7
- Blane, D., and Watt, G. (2012) Altogether now? Austerity at the deep end. *British Journal of General Practice*, 62 (600). pp. 374-375. ISSN 0960-1643 (doi:10.3399/bjgp12X652463)

2013

- Blane, D.N., Hesselgreaves, H., McLean, G., Lough, M., and Watt, G.C.M. (2013) Attitudes towards health inequalities amongst GP trainers in Glasgow, and their ideas for changes in training. *Education for Primary Care*, 24 (2). pp. 97-104. ISSN 1473-9879
- Watt G (2013). What can the NHS do to prevent and reduce health inequalities? *British Journal of General Practice* 63 (614), 494-495. doi:10.3399/bjgp13X671803

2015

- McVicar R, Williamson AE Cunningham DE, Watt G. (2015) What are the CPD needs of GPs working in areas of high deprivation? Report of a focus group meeting of "GPs at the Deep End". *Education for Primary Care*; 26:139-145

Deep End Progress Reports

- Summary of Deep End activity in 2013 (www.gla.ac.uk/deepend)
- Summary of Deep End activity in 2014 (www.gla.ac.uk/deepend)

Other reports

- Welfare benefits and general practice (A study at Keppoch Medical Practice, Possilpark Health and Care Centre) Sarah Littler, 2015

Other media coverage

- Horton Richard. Offline: face to face, side by side *Lancet* 2011 377(9773):1224
- Article in *Holyrood* <http://www.holyrood.com/articles/2011/09/19/deep-end/>
- Doctors warn austerity is damaging patients' health *The Herald* 15 May 2012
- Mental health of benefit claimants is put at risk by welfare reform *The Guardian* 20 June 2012
- GPs' warning over service in poor areas *The Herald* 05 July 2012
- Government must throw GPs in at Deep End *The Scotsman* 10 July 2012
- General practice and social deprivation *BMJ blog* by Domhnall MacAuley, June 2013
- Welfare cuts could see further 60,000 Scots kids being dragged into poverty *Daily Record* 16 November 2013
- Docs "can't spend time with the poor" *Evening Times* April 2014
- Counting GP consultations does not give full picture *The Herald* 10 July 2014
- Lead article in "Health Equalities" Issue 2 (abridged version of Austerity Report)
- At the Deep End: what are the problems with welfare reforms? *Health Equalities* Issue 3, 2014 <http://www.thebha.org.uk/healthequalities>
- Graham Watt was interviewed about the Deep End and Health Inequalities on *Scotland 2014* on BBC2 Scotland on 09/12/2014 <http://www.bbc.co.uk/iplayer/episode/b04v5hj8/scotland-2014-09122014>
- GPs urged to help patients affected by benefit cuts *The Herald*, 3 January 2015

Project Reports

- Links Project Report *Developing the connections between general practices and their communities* Scottish Government 2012
- *Planning capacity of welfare benefit advice in GP practice: a toolkit* London Regional Public Health Group, London Health Inequalities Network. 2013
- The Bridge Project. Enabling health and wellbeing among older people: Capitalising on resources in deprived areas through general practice. Snook, Glasgow 2013.

PRESENTATIONS AT MEETINGS

Conference presentations have included sessions at:-

- national conferences of RCGP UK in Liverpool (2011), London (2013) and Glasgow (2012 and 2015)
- national conference of Scottish Directors of Social Work (2013)
- invited presentations at conferences and meetings in Cardiff, Nottingham, Newcastle, London, Dublin, Toronto, Sydney and Vermont.
- Numerous invited presentations to various audiences in Scotland

ADVOCACY CONCERNING THE INVERSE CARE LAW

Engagement with the political process

The Deep End steering group has regularly engaged with :-

- Health Ministers (Alex Neil MSP, Michael Mathieson MSP, Jamie Hepburn MSP)
- Politicians (Aileen Macleod MSP, Neil Findlay MSP, Richard Simpson MSP, Jackie Baillie MSP, John Mason MSP, Bob Doris MSP, Patricia Ferguson MSP,
- Senior civil servants (Angiolina Foster, Andrew Scott)
- Deputy Directors of the Primary Care Division, Scottish Government Health Department (Frank Strang, Lesley Fraser, David Thomson)
- Chairs of Scottish Council of RCGP Scotland (Drs Ken Lawton, John Gillies, Miles Mack)
- Chairs of the Scottish General Practitioner Committee, BMA Scotland (Dr Alan McDevitt)
- Medical civil servants (Dr Harry Burns, CMO; Dr Frances Elliott, deputy CMO, Dr John Nugent, SMO; Dr Bill Gunnyeon, CMO DWP)

Visits to Deep End practices (Govan, Possilpark and Drumchapel) have been arranged for :-

- Alex Neil MSP
- Aileen Macleod MSP
- Bob Doris MSP
- Professor Mike Pringle (President of RCGP UK)
- Professor Aidan Halligan (Well North, University of Manchester)
- Dr Bill Gunnyeon, CMO DWP

The Deep End steering group has been represented on the RCGP UK Standing Group on Health Inequalities via individual contributions from Professor Una Macleod, Dr Andrea Williamson and Dr David Blane,

Responses to Government consultations (see www.gla.ac.uk/deepend)

- Alcohol in very deprived areas. *This short paper collates three Deep End statements on alcohol, which were tabled at a meeting on Alcohol Dependency at the Scottish parliament on 15 May 2013, chaired by Jackie Baillie MSP on behalf of the Wellbeing Alliance.*
- Written evidence on Children and Young People and Public Bodies (Scot) Bills *This is the written response backing Dr Anne Mullin's oral evidence to a Holyrood Committee investigating the implications of the Children and Young People (Scotland) Bill and the Public Bodies (Joint Working)(Scotland) Bill at the Scottish Parliament on 04 September 2013.*
- Response to Scottish Government consultation on *Creating a Fairer Scotland* August 2015

Giving evidence to Scottish parliamentary committees

(See transcripts at <http://www.scottish.parliament.uk/parliamentarybusiness/committees.aspx>)

- Dr Susan Langridge, Dr Jim O'Neil and Professor Graham Watt gave evidence to a subgroup of MSPs from the Public Audit Committee, reviewing cardiology services in Scotland on 22nd January 2013
- Dr Peter Cawston, Dr Susan Langridge and Professor Graham Watt give evidence on Health Inequalities to the Public Audit Committee at the Scottish Parliament on 30th January 2013
- Professor Graham Watt gave evidence on Health Inequalities to the Health and Sport Committee of the Scottish Parliament on 5th February 2013 and 1st April 2014
- Anne Mullin gave evidence to the Local Government and Regeneration Committee at a "round table evidence session" on *Health inequalities in the early years : the role of health professionals* on 2nd September 2014.
- Scottish Parliament, Official Report, Equal Opportunities Committee 23 April 2015, contribution by Professor Graham Watt

Advocacy outcomes

Evidence of influencing policy concerning health inequalities includes :-

RCGP Scotland Report on Health Inequalities, Deprivation and General Practice in Scotland : Time to Care, December 2010

This report drew heavily on the first national meeting of General Practitioners at the Deep End in September 2009, which RCGP Scotland also part-funded. This was the first Scottish report on health inequalities to address the inverse care law in Scotland in detail.

CHAPTER SIX - Conclusions and Recommendations

The Top 100 general practices at the Deep End serve a population of 430,000 Scots, including 50% of people living in the 15% most deprived postcode data zones in the country. 50-90% of all patients registered with the 100 practices live in such areas. Most other patients in these practices also live in deprived areas, but with lesser levels of socioeconomic deprivation than the most deprived 15% of the population. It is important however, to recognise that, outside the Deep End, the other 50% of people living in the 15% most deprived postcode data zones are registered with about 700 other general practices in Scotland, which also provide care for more affluent populations.

In this report we have chosen to largely focus on the top 100 practices, not only because they provide care for patients living in the most severe socio-economic deprivation, but principally because they do so for large numbers of patients, to an extent that dominates the work of the practice. They are a key part of the front line of the NHS, in delivering the contribution of health care services to improving health in the least healthy areas of Scottish society and a flagship for what a National Health Service, committed to universal access, evidence-based practice, health improvement and health equity, can achieve.

General practices are not the only providers of health care in deprived areas, but they are the only providers which combine a large degree of population coverage with continuity, flexibility, coordination, commitment and long term relationships based on mutuality and trust. General practice in deprived areas is a huge resource for addressing health and health care problems in severely deprived areas, with the particular strength of focusing on individuals and families over time, irrespective of the specific nature of their health problems. The challenge is to harness the strengths of general practice as part of an integrated, equitable and efficient health care system.

There is much to celebrate in the achievements of general practice in severely deprived areas of Scotland. 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 NHS underachieves in deprived areas, however, for a combination of reasons.

- 1. The relatively flat provision of manpower in deprived areas, compared with increased levels of health burden, means that the system is constrained in what it can deliver. Hence, "General Practitioners at the Deep End" whose prime purpose is to survive and cope, reacting to problems on a day by day basis. A fundamental issue is the lack of capacity to work in other ways.*
- 2. This front line of the NHS lacks identity, existing across administrative boundaries and lacking dedicated support. Prior to the first meeting of the Deep End Project, the 100 most deprived practices had not been convened or consulted in the history of the NHS. There are no mechanisms whereby Deep End practices can meet, share experience and work collaboratively, nor are any of the main NHS support mechanisms (for information, evidence, training) provided in a way that recognises and supports this front line.*
- 3. The lack of alignment of general practice with many other primary care professionals and services, has led to fragmentation, duplication and inefficiency, failing to capitalise on general practice's structural strengths of contact, continuity, flexibility and co-ordination. Many areas of joint working are poorly developed.*
- 4. A plethora of initiatives to address "unmet need", health improvement and health inequalities have generally been small, short term, focused on peripheral rather than central issues and lacking sufficient evaluation. The realities of the inverse care law remain.*
- 5. There has been very little investment and support for the leadership role of general practices as hubs for primary care within local communities.*
- 6. The consequence of the lack of successful engagement with general practice is that NHS policy, and the large number of NHS staff employed to promote and implement NHS policy, has developed a jargon and language (e.g. anticipatory care, self help, health improvement,*

inequalities-sensitive practice) which means little to general practitioners or patients and which does not connect with the challenges of the work they do.

General considerations

“Addressing inequalities in health” is an abstract issue, which depends on retrospective comparison of advantaged and disadvantaged areas. A more direct policy objective is to increase the volume, quality and coverage of health care activity in deprived areas, not only in relation to interventions of proven effectiveness but also the general continuity and coordination of care required to reduce severity, delay or prevent complications and maintain healthy behaviours.

There is not only the political challenge to provide additional resources; it is also knowing how best to use additional resources in a culture in which both patients and professionals have become used to expecting less. A balance is needed between actions that can proceed immediately, and those requiring demonstration projects to establish best practice, or research and development to establish effectiveness and value for money. The widespread involvement of practices serving very deprived areas in the activities of the Scottish Primary Care Collaborative shows that widespread, co-ordinated initiatives are possible.

It is important to consider the many levels and ways in which actions can be taken. Community health partnerships, for example, are best placed to co-ordinate the provision of services within geographical areas, but they are less well placed to lead, coordinate or facilitate many other types of activity. A multifaceted approach is required, in which NHS support (information, evidence, education, training etc) is provided at all levels.

Actions to increase the volume, quality and equity of health care delivered by general practice in deprived areas may be taken:

- A. By practitioners when they meet with patients*
- B. By practices working as multi-professional teams*
- C. By practices organising their resources (i.e. time, space, staff) to best effect*
- D. By practices working with similar practices within networks or federations*
- E. By practices working with attached staff from other services (e.g. health visitors, community nurses, mental health workers etc)*
- F. By practices working with other local services (e.g. health improvement, community care, social work, child health, voluntary sector)*
- G. By practices working collectively within a geographical area*
- H. By practices working as part of integrated local and national systems*

The leadership required for actions A-D exists within general practices, depends on local knowledge and experience and is generally poorly supported by information, evidence, training, protected time etc. The leadership required for actions E-H is more widely distributed and is complicated by the number and variety of interfaces involved.

Specific proposals

- 1. Additional time for consultations with patients in very deprived circumstances, addressing directly the fundamental cause and operation of the inverse care law. Related questions include the purpose, content and targeting of extra time for consultations and the support and training needs of practitioners and patients.*

2. *Enhancement of multi-professional practice teams via the attachment of staff with specific skills/expertise. Related questions include the expectations and conditions required from all parties to ensure effective joint working.*
3. *Improved joint working between general practices and other local services e.g., child health, care of the elderly, mental health and addiction, health improvement. This will require a fundamental rethinking of the relationships between general practices and CH(C)Ps.*
4. *Demonstration projects - coordinating practices and other services working in geographical areas.*
5. *Recognition of the principle that additional activity should not be expected of Deep End practices without commensurate resources – for example, the roll out of Keep Well to the 63 practices in the top 100 which have not so far participated, and implementation of the ASSIGN score, with its implications for increased case-load.*
6. *Support and development of Deep End Practices as a multidisciplinary, learning organisation, committed and supported to share experience, information, evidence, activity and education.*
7. *Recognition, training, support and reward for the leadership required to co-ordinate integrated local services.*
8. *A project of further work with GPs and practice teams out-with the ‘deep end’ practices and in remote and rural areas to establish the impact of deprivation on patients and primary health care workers in these areas. Marmot’s concept of ‘proportionate universalism’ – to each according to their needs—is a useful principle to guide both further research and resource allocation.*
9. *Establish an intelligence function, using routine data to inform Deep End practices.*
10. *Establish a NHS research and development programme dedicated to the challenge of addressing the inverse care law.*

Audit Scotland. Health Inequalities in Scotland. December 2012

This report by the Auditor General for Scotland, the “watchdog” of the Scottish parliament, reviewed progress in addressing health inequalities in Scotland, and was unusual in being the first official Scottish report to highlight the inverse care law in general, and the under-resourcing of general practice in deprived areas in particular, as issues of concern.

GPs in the most deprived areas face significant challenges in tackling health inequalities

For most people, GPs are the initial point of contact with healthcare services. Primary care is the main focus of most efforts to reduce health inequalities, and Equally Well stated that: ‘NHS action to reduce health inequalities starts with primary care, where more than 90% of patient contacts take place.’

The distribution of GPs across Scotland does not fully reflect levels of deprivation (Exhibit 13). The availability of GPs is more accurately measured by whole time equivalent (WTE) rather than headcount. The NHS has published information on the number of WTE GPs in Scotland but this did not include details of the distribution of WTE GPs across the various levels of deprivation and has not been updated since 2009.

Recent findings from the Deep End project indicate that GPs working in the most deprived areas of Scotland face significant challenges in tackling health inequalities. For example, GPs in these practices reported that:

- *they treat patients with higher levels of multiple health problems than GPs working in less deprived areas*
- *public sector budget reductions and changes to the benefits system were increasing patients' visits to GPs and having detrimental effects on patients' mental and physical health*
- *they are constrained by a shortage of consultation time with patients which limits the opportunity to provide appropriate treatment, advice and referral to suitable services.*

Key messages

Appropriate access to health services is an essential part of reducing health inequalities. GPs have a critical role to play in helping to reduce inequalities and in facilitating access to the whole range of NHS services including hospital care. But the distribution of primary care services across Scotland does not fully reflect the higher levels of ill health and wider needs found in deprived areas, or the need for more preventative health care. The distribution of other primary health care services, such as pharmacies, is more closely matched to need.

Action taken to improve health can have the unintended consequence of widening inequalities if uptake by those most at risk does not increase. Patterns of access to hospital services vary among different groups within the population and people from more deprived areas tend to have poorer access and outcomes. NHS boards need to ensure that all patients get the services they need, and provide better access to services for disadvantaged communities to help reduce health inequalities.

Key recommendations

The Scottish Government should:

- *introduce national indicators to specifically monitor progress in reducing health inequalities and report on progress.*

The Scottish Government and NHS boards should:

- *review the distribution of primary care services to ensure that needs associated with higher levels of deprivation are adequately resourced*
- *include measurable outcomes in the GP contract to monitor progress towards tackling health inequalities, and ensure that the Quality and Outcomes Framework is specifically designed to help reduce health inequalities.*

The Scottish Government and CPPs should:

- *ensure that cost effectiveness is built into evaluations of initiatives for reducing health inequalities from the start*
- *align and rationalise the various performance measures to provide a clear indication of progress in reducing health inequalities.*

CPPs should:

- *ensure that all partners are clear about their respective roles, responsibilities and resources in tackling health inequalities, and take shared ownership and responsibility for actions aimed at reducing health inequalities*
- *build robust evaluation, using all available data and including outcome measures and associated costs, into local initiatives aimed at reducing health inequalities*

- *include in SOAs clear outcome measures for reducing health inequalities which demonstrate impact, and improve the transparency of their performance reporting.*

NHS boards should:

- *monitor the use of primary care, preventative and early detection services by different groups, particularly those from more deprived areas. If this identifies systemic under-representation of particular groups, NHS boards should take a targeted approach to improve uptake*
- *monitor the use of hospital services by different groups and use this information to identify whether specific action is needed to help particular groups access services.*

NHS boards and councils should:

- *identify what they collectively spend on reducing health inequalities locally, and work together to ensure that resources are targeted at those with the greatest need.*

Public Audit Committee, 1st Report, 2013 (Session 4). Report on Health Inequalities, 10/4/13

http://www.scottish.parliament.uk/S4_PublicAuditCommittee/Reports/paur-13-01w.pdf

This report by the Public Audit Committee responded to the Audit Scotland Report on Health Inequalities while also drawing on evidence presented by Dr Jim O'Neil, Dr Susan Langridge and Professor Graham Watt to a subgroup of the Public Audit Committee, reviewing cardiology services in Scotland, at Glasgow City Chambers on 22nd June 2012 and on evidence presented to the full committee on 30th January 2013 by Dr Peter Cawston, Dr Susan Langridge and Professor Graham Watt.

The report's main recommendations were :-

16. The Health and Sport Committee may wish to pursue the possibility of the Scottish Government overcoming the practical barriers to collating WTE headcount figures for GPs, and providing this information broken down according to the level of deprivation.

25. In considering what constitutes an ideal distribution of GPs, the Health and Sport Committee may wish to acknowledge the increasing importance of the primary care team as a whole in tackling health inequalities in deprived areas.

26. Taking this into account, should the Health and Sport Committee consider that there is merit in increasing the proportion of GPs based in deprived areas, it may wish to explore the potential to:

increase the number of fellowships in deprived areas; and

incorporate incentivising measures into the GP contract or the Qualities and Outcomes Framework (QOF).

31. The Health and Sport Committee may wish to look further at how the NHS is shifting towards treating patients based on multimorbidity, and how the effectiveness of any such shift will be measured.

36. The Committee considers that progress needs to be made in the effective performance assessment of specific initiatives. The Health and Sport Committee may wish to give this further consideration, including considering the potential merits of a centrally funded research function.

39. *The Health and Sport Committee may wish to request evidence on the extent to which the success of the Keep Well programme is being capitalised on with resources targeted at follow-up care.*

After issuing its report, the Public Audit Committee concluded its interest in Health Inequalities. When pressed on how the Committee would follow up the recommendations in the Audit Scotland Report, the PAC chair referred the question to the Health and Sport Committee.

PARLIAMENTARY QUESTIONS AND ANSWERS CONCERNING THE INVERSE CARE LAW IN SCOTLAND

Professor Graham Watt gave evidence on health inequalities to the Health and Sport Committee on 5th February 2013 and 1st April 2014. Following the second session, the following 6 questions were asked by Duncan McNeil MSP, convener of the Health and Sport Committee, and answered by Alex Neil MSP, Cabinet Secretary for Health and Wellbeing in April 2014

Question S4W-20525: Duncan McNeil, Greenock and Inverclyde, Scottish Labour, Date Lodged: 02/04/2014 *To ask the Scottish Government whether it has introduced "national indicators to specifically monitor progress in reducing health inequalities" as recommended by Audit Scotland in its December 2012 report, Health inequalities in Scotland.*

Answered by Alex Neil (24/04/2014): *Health inequalities are complex, long-term and influenced by a wide range of societal and individual factors. The Scottish Government already uses a breadth of indicators to monitor progress in reducing health inequalities. Rather than introducing new indicators, we are further developing the existing range so they can be used more effectively and give the fullest perspective possible on the levels of health inequality experienced in Scotland.*

Question S4W-20526: Duncan McNeil, Greenock and Inverclyde, Scottish Labour, Date Lodged: 02/04/2014 *To ask the Scottish Government whether it has, along with NHS boards, "reviewed the distribution of primary care services to ensure that needs associated with higher deprivation are adequately resourced" as recommended by Audit Scotland in its December 2012 report, Health inequalities in Scotland.*

Answered by Alex Neil (30/04/2014): *The agreement the Scottish Government has reached with the Scottish General Practitioner's Committee for 2014-15, embeds into the contract support from each GP practice for health and social care integration, enabling every practice to make a contribution to local integration processes, locality planning and decision-making.*

In addition for the first time this year, health boards were also required to complete a 'strategic assessment of primary care' as part of the annual local delivery plan process. This is an important step forward and gives real opportunity to place much needed focus and emphasis on primary care. Within health boards these assessments will inform the measurable resource shift necessary to innovate and strengthen primary care. The assessments will also assist the development of approaches to enable the Scottish Government to provide support to health boards in expanding the role of primary care, recognising that across Scotland health boards have different priorities, reflecting their geographic situation, current infrastructure and health needs and enable the development of collaborative ways of working to achieve an expanded role for primary care.

Question S4W-20527: Duncan McNeil, Greenock and Inverclyde, Scottish Labour, Date Lodged: 02/04/2014 *To ask the Scottish Government whether the GP contract now includes measurable*

outcomes to monitor progress toward tackling health inequalities, as recommended by Audit Scotland in its December 2012 report, *Health inequalities in Scotland*, and, if so, what outcomes.

Answered by Alex Neil (30/04/2014): *The arrangements we agreed with the Scottish General Practitioner's Committee for 2013-14 introduced a number of measures important for deprived areas, including anticipatory care and poly-pharmacy for those most at risk of hospital admission; importantly, this also paved the way towards minimising the bureaucracy associated with the GP contract in Scotland whilst placing more freedom in the hands of GPs to exercise their clinical judgment in the provision of care for patients, rather than the constraints of a tick-box approach.*

The Scottish Government through recognising the challenges in the national contract in relation to practices whose patients face the greatest inequalities have significantly altered the 2014-15 contract to free those practitioners up to devote more time to the complex problems that their patients face.

Question S4W-20528:

Duncan McNeil, Greenock and Inverclyde, Scottish Labour, Date Lodged: 02/04/2014
*To ask the Scottish Government whether NHS boards now monitor the use of primary care, preventative and early detection services by people from more deprived areas, as recommended by Audit Scotland in its December 2012 report, *Health inequalities in Scotland*.*

Answered by Alex Neil (30/04/2014): *Designing and commissioning services to meet the needs of the local population is vital. To this extent understanding patterns of need across different population groups is crucial. Much of the data from primary care, prevention and early detections services will be held locally and we encourage health boards and other local delivery partners to make the best use of these data.*

It is for health boards to decide on how they monitor and make use of data on primary care, preventative and early detection services by people from deprived areas.

However there are national data sets which can help boards. These include inpatient and outpatient hospitalisation data (through, for instance, SMR00, SMR01 and SMR04), available at health board and local authority by deprivation category, gender and age. Data on uptake of the national screening programmes are available for bowel screening it is published by The Scottish Index of Multiple Deprivation at health board level. Health and wellbeing profiles are available to health boards via the Scottish Public Health Observatory site.

Report of the Health and Sport Committee on health inequalities, January 2015

Subsequently, in its report on Health Inequalities in January 2015, the Health and Sport Committee stated

99. *This is not to suggest that we think that health services do not have an important role to play in reducing health inequalities. As we have indicated in the report, the least well-off and most vulnerable individuals and communities often have the poorest access to primary health services and this remains an issue that the NHS will need to make efforts to improve, by whatever means. The health service also has a clear role in preventing ill-health through education and awareness-raising, notwithstanding what we have said in the report about the tendency for public health campaigns to widen health inequalities rather than narrow them. The health agencies are also where data are collected and analysed and progress is measured. Health service initiatives like the Early Years*

Collaborative and the Family Nurse Partnership (and the activities stemming from them) are also reported to be making a difference. More widely, we have seen developments like self-directed support, the integration agenda and moves towards preventative spending, all of which can play some role in helping to reduce health inequalities.

In summary, by January 2015, the impetus which had been established by the RCGP Report Time to Care and the Audit Scotland Report on Health Inequalities, and which had been endorsed by the Report of the Public Audit Committee, was diffused, first by a series of Ministerial replies to parliamentary questions and second, by the bland conclusion of the Health and Sport Committee that “this remains an issue that the NHS will need to make efforts to improve, by whatever means.”

CREATING A FAIRER SCOTLAND (www.gla.ac.uk/deepend)

Subsequently, we took the opportunity to respond to the Scottish Government's consultation on Creating a Fairer Scotland

General Practitioners at the Deep End (www.gla.ac.uk/deepend) , serving the 100 most deprived communities in Scotland, which comprise 8% of the Scottish population, welcome the Scottish Government's commitment to reducing inequality and its initiative in seeking suggestions for creating a fairer Scotland.

*The Government's explanatory leaflet includes examples of social and gender differences in wealth, employment, income, educational achievement, emotional difficulties in pre-school children, life expectancy, crime and social connections. **There is no reference to NHS Scotland** or social variations in access to needs-based health care. GPs at the Deep End suggest that this should be a core element of the Government's plan to create a fairer Scotland.*

*The first step is to acknowledge that there is a problem within the NHS. If unfairness is not recognised, it cannot be addressed. Successive Scottish Governments have been reluctant to engage with this issue. **Their inaction continues to cost lives.***

*The NHS is often said to be seen at its best in dealing with emergencies, where patients receive whatever care they require, with no financial checks or other tests of eligibility. **Emergency care is only one aspect of health care**, however, and comes into play when problems occur unexpectedly, or when non-emergency care has fallen short.*

Modern health care is delivered via a combination of community and specialist services, with an expectation that more care will be delivered in the community by primary health care teams. Such care can reduce and delay the need for emergency care.

*The sterling record of the NHS in providing access to emergency care is not matched by its record in providing access to non-emergency care. The net effect is **earlier, more chaotic use of unscheduled care services**, such as out of hours, accident and emergency and hospital admissions.*

*General practitioners at the Deep End are in daily contact with large numbers of patients in Scotland's poorest communities and have **huge cumulative experience and knowledge** of the problems experienced in such communities and the difficulties experienced by patients in accessing the best care.*

We highlight two issues which the NHS must address if Government is to achieve its 2020 vision for improving the health of the Scottish population:-

1. **The flat distribution of general practice resources throughout Scotland**
2. **The dominance of demand over need**

Context

Men and women in the most deprived fifth of the Scottish population die 10.4 and 6.9 years earlier, respectively, than men and women in the least deprived fifth (See ISD data in table overleaf). The differences in health life expectancy (the estimate of how many years people are expected to live in a 'healthy state') are even more stark. HLE in men and women in the most deprived fifth of the population ends 20.8 and 20.4 years earlier than in the least deprived fifth. When HLE ends, **men and women in the most deprived fifth of the Scottish population spend twice as long in poor health before they die than men and women in the least deprived fifth of the population** (23.0 v 12.6 years in men; 25.7 v 12.1 years in women).

The flat distribution of general practice resources throughout Scotland

Although the prevalence of health problems increases 2-3 fold across the social spectrum, **the number of general practitioners and levels of general practice funding are broadly flat** across the same range. In 2012, the average spend per patient per annum in general practice (meeting expenditure on staff, premises and running costs, but not prescribing) was £118 in the most deprived fifth, compared with the Scottish average of £123, and £127 per patient per annum in the least deprived (most affluent) fifth.

This distribution of funding provides no basis for addressing the increased levels of health needs in deprived areas. Research shows that as a result consultations in general practices in deprived areas are characterised by **greater multimorbidity** (health and social problems) at younger ages, **less time, lower expectations, less patient enablement** (especially for mental health problems, which are the commonest co-morbidity in deprived areas) and **greater practitioner stress**.

While the majority of Scottish general practices have some patients who live in areas of deprivation (so called "pocket deprivation"), the issues described above most affect general practices with large numbers of such patients ("**blanket deprivation**"). In Deep End practices, 44-89% of patients live in Scotland's 15% most deprived data zones.

With no additional funding, general practitioners in deprived areas can only increase their consultation rates, by working longer days and/or having shorter consultation times. The situation is exhausting, unsustainable, threatens recruitment and **does not provide the conditions necessary to improve health and narrow health inequalities**.

All general practices "cope" at some level, but in deprived areas there is a substantial burden of **unmet need which cannot be addressed**. By definition, unmet need goes unrecorded in routine data and is excluded from NHS resource distribution formulae.

Simple estimates of the need for health care, based on use of services, not only ignore unmet need but also **fail to distinguish between need and demand**. Measuring how busy the NHS is provides little information on whether it is equitable in addressing patients' needs.

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**. It is not a law of nature, however, but a longstanding man-made policy which restricts access to care based on need.

In current circumstances, the Inverse Care Law is compounded by **factors which are putting all**

general practices under pressure, such as shortened hospital stays, the under-resourced transfer of clinical and paper work from secondary care and problems in GP recruitment and retention.

It is also compounded, however, by **factors particular to very deprived areas**, such as the higher prevalence of mental health problems, addictive behaviours (alcohol, cigarettes, drugs misuse), vulnerable families, the associated clinical and social complications and the volume of work generated by welfare benefit reform, including paper work to support appeals and the additional clinical time needed to address the distress caused

Current funding formulae take no account of the **additional time and support needed** by patients **lacking knowledge, agency and confidence**, (especially patients with multiple problems) when accessing an increasingly fragmented and complicated service.

1. The dominance of demand over need

Although centralised services are provided with the intention of open access, uptake data show that less deprived (i.e. more affluent) groups are better able to achieve their needs and demands than patients in deprived areas. To paraphrase the inverse care law “The use, rather than the availability, of specialised medical care tends to vary inversely with the need for it in the population served” (6).

Multimorbidity occurs 10-15 years earlier in deprived areas, where the commonest co-morbidity is a mental health problem (in contrast to multimorbidity in elderly patients where the commonest co-morbidity is high blood pressure).

Increasingly it is recognised that multimorbidity involves substantial “work” for patients in coping with different conditions, treatments and services. **The “treatment burden” increases when the delivery of care is fragmented between different services** and patients lack the means or agency required to access such services.

The trend towards specialist services (which focus on a limited list of conditions, with referral criteria, waiting lists, evidence-based protocols etc, and including centralised services in primary care) **discriminates against patients in deprived areas** for whom patient-centred care needs to be timely, local and familiar. **The requirement for patients to deploy “self-help” and “self management”** also discriminates against patients who lack the resources, agency or mental health to cope with multiple conditions and complicated services.

The Link Worker programme, funded by the Scottish Government in 7 of the 100 Deep End practices, is not only improving the links between general practices and community resources for health (“**social prescribing**”), but is also highlighting **the important role of helping patients access fragmented, dysfunctional services**. Deep End practices need reliable, sustained support for both these functions.

Conclusion

The NHS is increasingly able to help patients live longer and better lives, partly as a result of **evidence-based medicine** but also via the delivery of **unconditional, personalised continuity of care**, for whatever combination of problems a patient may have. The corollary is that inequitable delivery has become an important new social determinant of health and a new explanation of **the failure to reduce health inequalities**.

Equitable access to emergency care has been a shining example of the NHS commitment to comprehensive health care, based on need and free at the point of use. A similar commitment is needed to reduce inequitable access to non-emergency care, especially general practice, and to

reduce social variations in access to specialised and centralised services.

RECENT PARLIAMENTARY QUESTIONS

Following circulation and publicity concerning a letter from the Balmore Practice to the Chief Executive of the Glasgow Health and Social Care Partnership, the following parliamentary exchanges took place.

Scottish Parliament, 23rd September 2015

Patricia Ferguson (Glasgow Maryhill and Springburn) (Lab): *To ask the Scottish Government what support it provides to so-called deep-end general practitioner practices in the most socioeconomically deprived populations. (S4O-04613)*

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): *There is recognition of the additional needs of patients in areas of deprivation in the calculation of Scottish Government funding to GPs for the provision of core services. That is shown in the weighting that is given to reflect deprivation, as a marker for increased morbidity for patients and increased workload for practices, covering the essential element of general medical services.*

Patricia Ferguson: *It has long been recognised that patients who attend such practices often suffer from a range of illnesses, as the cabinet secretary said, which often contribute to premature death. Is she aware that such patients are also likely to suffer some 20 years more of poor health than are those in more affluent areas? Is it not time that the funding formula for GP practices properly recognised that concern and the other challenges that face the deep-end practices and therefore supported the GPs whose patients suffer the most from health inequality, such as those in the Balmore surgery in Possilpark in my area?*

Shona Robison: *I am certainly very well aware of the issues that Patricia Ferguson has raised and I have a lot of sympathy for the points that she has made. There is an opportunity to discuss what the new contract from 2017 onwards—the first Scotland-only one—will look like and how it will facilitate new models of care. Within that, we must have a sharp focus on tackling health inequalities. I am happy to continue the dialogue on the issue with Patricia Ferguson, because what she said is very much in line with my thinking as we take the discussions forward.*

Bob Doris (Glasgow) (SNP): *I recently met GPs at the deep-end Balmore practice in Possilpark. They have a unique situation and they have made an evidence-led and powerful case for more resources from NHS Greater Glasgow and Clyde. I am in correspondence with the NHS board on the issue and I have written to the cabinet secretary about it.*

Will the cabinet secretary consider my suggestion to NHS Greater Glasgow and Clyde that the particular stresses that the Balmore surgery will experience over the winter period need to be mitigated and that the health board could use winter resilience moneys to get the surgery through that period to the spring? An additional resource allocation for the surgery could be considered then, given the unique and powerful case that it has made to NHS Greater Glasgow and Clyde.

Shona Robison: *I recognise Bob Doris's interest in the matter and I issued a written reply to him today about it. We all want to ensure that the Balmore practice is able to continue its important work in an area of deprivation. NHS Greater Glasgow and Clyde has been discussing with the practice how to provide support, and that has led to the board providing short-term support.*

As for what happens after that, it is important that the board continues to discuss with Balmore how to take the practice forward, because we need to put the practice on a sustainable footing. I certainly encourage Bob Doris to continue to liaise with NHS Greater Glasgow and Clyde on the issue, and I am happy to keep him informed of any discussions and to ensure that the board is aware of his and other members' representations.

ADDITIONAL SOURCES OF EVIDENCE

Two recent scientific papers provide further evidence on the nature, extent and importance of the inverse care law in Scotland, and will be the basis of renewed advocacy prior to the Scottish general election in May 2016.

Distribution of GPs in Scotland by age, gender and deprivation. Blane D McLean G Watt GCM

General practice in the UK is widely reported to be in crisis, with particular concerns about recruitment and retention of family doctors. This study assessed the distribution of GPs in Scotland by age, gender and deprivation, using routinely available data. We found that there are more GPs (and fewer patients per GP) in the least deprived deciles than there are in the most deprived deciles. Furthermore, there are a higher proportion of older GPs in the most deprived deciles. There are also important gender differences in the distribution of GPs. We discuss the implications of these findings for policymakers and practitioners.

General practice funding underpins the persistence of the inverse care law. McLean G Guthrie B Mercer SW Watt GCM. BJGP In Press

Levels of multimorbidity rose with practice deprivation. Practices in the most deprived decile had 38% more patients with multimorbidity compared to the least (most deprived 222.7 per 1000 patient's v least deprived 161.1; $p < 0.001$) and over 120% more patients with combined mental-physical multimorbidity (114 per 1000 patient's v 51; $p < 0.001$). Practices in the most deprived decile had 20% more consultations per annum compared with the least deprived (4616 v. 3845, $p < 0.001$). There was no association between total practice funding and deprivation (spearman rho -0.09; $p = 0.03$). Although consultation rates increased with deprivation, the social gradients in multimorbidity were much steeper. There was no association between consultation rates and levels of funding.

This study found no evidence that general practice funding matches clinical need, as estimated by different definitions of multimorbidity. Consultation rates provide only a partial estimate of the work involved in addressing clinical needs and are poorly related to the prevalence of multimorbidity. In these circumstances, general practice is unlikely to mitigate health inequalities and may increase them.

ADVOCACY AND ACTIVITY IN PRIMARY CARE DEVELOPMENT

While little progress has been achieved in developing support for measures to address the inverse care law in Scotland, more has been achieved in response to proposals by General Practitioners at the Deep End for service re-design in primary care to meet the challenges of providing integrated care for people with multimorbidity

The 2022 GP. A Vision for General Practice in the future NHS. RCGP, 2012

In 2012 RCGP UK included the recommendations of Deep End Report 18 on Integrated Care in the Compendium of Evidence which accompanied its report on Patients, Doctors and the NHS in 2022

- 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.

A Route Map to the 2020 Vision for Health and Social Care, NHS Scotland 2012

The Scottish Government Health Department, in its Route Map to the 2020 Vision of Health and Social Care, also endorsed the "Deep End approach", without specifying what this was.

Reducing health inequalities

We will refocus our efforts on health inequalities particularly in the context of benefits cuts which will impact those most at risk of ill-health. We will do this by targeting improvement resources into primary care in the most deprived areas of Scotland including staff and equipment such as tele-health facilities, learning from and rolling out successful initiatives such as the 'Deep-end' GP practices in Glasgow.

Key deliverables for 2013/14:

There will be a new focus on targeting resources to the most deprived areas. The successful approach developed in the 'Deep-end' GP practices will be rolled out more widely across relevant areas of Scotland reducing the risk of admission to hospital and improving outcomes for people in Scotland's most deprived communities

RCGP Report on Health Inequalities, July 2015

In a 2014 survey of members of the RCGP in the UK, health inequalities were ranked third in the list of issues where members wished the College to be more active. The subsequent RCGP Report on Health Inequalities, published in July 2015, makes little direct reference to General Practitioners at the Deep End, but is the first RCGP document at UK level to highlight the inverse care law as an important barrier to general practice addressing health inequalities

Despite many years of commitments from successive governments in the four nations of the UK to tackle health inequalities, there has been little improvement in the differences in health outcomes. Radical action is now needed to urgently address this vital public health issue. This paper sets out the RCGP's thinking on how general practice can best be supported to help mitigate and ultimately tackle health inequalities. Although general practice is of course only part of the solution, a central theme of this paper is that without measures to end the current resource and workforce pressures facing GP services across the UK, health inequalities will continue to get worse. In particular, we believe that action is needed in the following six areas:

- 1. As part of measures to increase the overall size of the GP workforce, put in place incentives to attract more GPs to currently under-doctored areas, ensuring that there is sufficient GP workforce capacity in areas where patient need is highest.*
- 2. As part of a wider rebalancing of resources towards general practice, direct more NHS funding into GP and wider primary care services in those areas where health inequalities are currently worst.*
- 3. Ensure that the process of piloting and delivering new models of care integrated around patients in each of the four nations of the UK serves to tackle, rather than exacerbate, health inequalities.*
- 4. Create a supportive environment for GPs and their teams to take a more proactive population based approach to preventing ill health in their communities, working with other professionals to tackle the underlying causes of health inequalities. However, this cannot be taken forward without an increase in workforce capacity and resources, and must be led by GPs and other professionals from the bottom-up, rather than through imposing top-down interventions.*
- 5. Focus on incentivising ways of working that promote continuity of care in areas where patients would benefit most from a continuous therapeutic relationship with their GP — particularly areas where a high number of patients are living with multiple morbidities.*
- 6. Fund outreach programmes to help often excluded groups such as those with mental health problems, learning disabilities and the homeless to access general practice.*

The future of primary care. Creating teams for tomorrow. Report by the Primary Care Workforce Commission, commissioned by Health Education England, July 2015

Perhaps more important, the influential report of the Primary Care Workforce Commission, commissioned by Health Education England and published in July 2015 makes explicit reference to General Practitioners at the Deep End, their proposals and examples of activity

2.5 Population groups with particular needs

2.5.1 Care in areas of severe socio-economic deprivation

People in areas of major socio-economic deprivation often suffer the dual disadvantage of poor health and poor health services. 'GPs at the Deep End' is a group of GPs working with general practices

servicing Scotland's 100 most socio-economically deprived populations, and comparable support groups are also being set up in English areas of socio-economic deprivation.

Deep End projects have identified a range of measures to improve the care of, and outreach to, the most vulnerable and marginalised groups within local communities. These include targeted appointments for people with the most complex needs, combined with additional consultation time, practice-attached community link workers to help people navigate the health and social care systems, connecting practices and individuals to community resources for health, and attached alcohol and mental health workers.

There are marked regional variations in the numbers of healthcare professionals across England; for example, the number of GPs per 100,000 ranges from 63.4 in the North West to 81.5 in the Thames Valley. Furthermore, the poorest regions, where health is also worst, have fewest GPs and the greatest difficulty recruiting, with many posts remaining unfilled. In addition to addressing deficiencies in staffing, reducing inequalities in distribution of staff may be as important as the absolute increase in numbers. We note international experience that providing training places in underserved areas increases the likelihood that doctors will stay in those areas, and that non-financial incentives (such as ongoing training and support) are just as important as financial incentives in encouraging health professionals to work in these areas.

The NHS Five Year Forward View suggests new ways of working, with GP practice staff working more closely and empowering communities. This may be of particular importance to encourage in areas of socioeconomic deprivation, where poor lifestyles make a major contribution to ill health.

Recommendation

Measures are needed to address inequalities in the distribution of healthcare professionals in order to improve the major deficits seen in areas of socioeconomic deprivation and poor health. New workforce initiatives should be prioritised in these areas.

ACTIVITIES AND TRAJECTORIES

Several Deep End reports have led to consistent activity within themes as illustrated by the following trajectories, some of which have led to specific projects.

Report 3 on the GP role in working with vulnerable families led to :-

- Report 12 on Working together for vulnerable children and families
- Input to Health and Sport Committee investigation of child health and health inequalities (Dr Anne Mullin)
- Report 23 : The contribution of general practice to improving the health of vulnerable children and families (Dr Anne Mullin)
- A focus on vulnerable children and families via monthly multidisciplinary team meetings in 4 general practices taking part in the Govan Integrated Care Project (SHIP)

Report 8 on Social prescribing in very deprived areas led to :-

- The Links Project (Dr Peter Cawston)
- The Bridge Project (Professor Graham Watt)

- The Link Worker Programme (Dr Peter Cawston)

Report 11 on Alcohol problems in Adults under 40 led to :-

- Input to Cross Party Group on Alcohol at Holyrood (Dr Jim O'Neil)
- Attached Alcohol Nurse scheme in North West Glasgow, funded by the Alcohol and Drugs Programme (Dr Margaret Craig, Dr Andrea Williamson)

Report 16 on GP experience of the impact of austerity on patients and general practices in very deprived areas led to :-

- Widespread media coverage and political attention
- Meetings with Dr Margaret Curran, Shadow Secretary of State for Scotland, and then Jackie Baillie MSP with other Scottish Labour MSPs and Councillors.
- Report 21 on GP experience of welfare reform in very deprived areas (Dr Raymond Orr)
- Engagement with Dr Bill Gunnyeon, Chief Medical Officer at the UK Department of Work and Pensions, including a meeting with 30 Deep End GPs in January 2013
- Collaboration with the Glasgow Centre for Population Health, the Glasgow Poverty Leadership Panel and the Glasgow Financial Inclusion Network in multidisciplinary meetings to strengthen joint working (Professor Graham Watt, Dr Maria Duffy)
- Report 25 on Strengthening primary care partnership responses to the Welfare Reforms
- A programme of small projects co-ordinated by the GCPH, including a special study at the Keppoch Practice at Possilpark Health Centre (Dr Maria Duffy, Dr Petra Sambale, Professor Graham Watt)

Report 18 on Integrated Care led to :-

- Inclusion of the summary in the UK RCGP Compendium of Evidence, collated as part of its 2020 Vision for General Practice
- Development of a proposal for integrated care based on the four practices at Govan Health Centre (Dr John Montgomery, Dr Anne Mullin, Dr Euan Paterson, Dr Niall Cameron)
- Scottish Government Funding for the Govan Integrated Care Project (SHIP)

Report 22 on Mental Health issues in the Deep End led to:-

- Report 26 on Generalist and Specialist views of mental health issues in very deprived areas
- Collaboration with specialist mental health colleagues in taking forward the CPD needs of Deep End GPs
- Joint meeting between Deep End GPs and the Scottish Association of Mental Health (SAMH) (Dr Andrea Williamson, Professor Graham Watt)
- Development of a funding application to Scottish Government for a project linking Deep End practices with local SAMH resources (decision pending)

Report 24 on What are the CPD needs of GPs working in Deep End practices? Led to :-

- Development of three strands of practice-based small group learning (PBSGL) based on identified priorities (Dr Lisa McIntyre)

DEEP END PROJECTS

Deep End projects include :-

The SGHD-funded **Care Plus Study** involved :-

- 8 Deep End general practices (4 intervention, 4 control)
- 152 complex patients randomised to intervention or control
- Additional consultation time (about one hour per patient per year)
- Additional support for patients and practitioners
- Improved quality of life and less negative wellbeing after 12 months
- The intervention was cost-effective, within NICE criteria

The **Links Project** involved :-

- Short term SGHD funding
- 6 Deep End practices
- A Deep End clinical lead
- Exploration of links to community resources
- Evaluation based on practice audits, including follow-up

The **BRIDGE project** involved :-

- Short-term funding from MRC Public Health Research Programme
- 3 Deep End practices
- Scoping work involving SNOOK
- Capitalising on practice knowledge of elderly patients to facilitate links to community resources for physical and social activity
- Evaluation by a team at the University of Glasgow

The **Link Worker Programme** involves :-

- SGHD funding for 5 years via the Health and Social Care ALLIANCE and General Practitioners at the Deep End
- Full-time community links practitioners based in 7 Deep End general practices
- A Deep End clinical lead
- Improved links to community resources for health
- Support for patients in accessing services
- Improved team working within practices
- External evaluation by Profs Stewart Mercer and Sally Wyke at Glasgow University

The **Govan Integrated Care Project** (SHIP) involves :-

- SGHD funding

- 4 Deep End general practices
- Additional clinical time, with two salaried GPs shared between 4 practices
- Two attached social workers
- Community links practitioners attached to 2 practices
- Support for monthly practice multidisciplinary team meetings to review vulnerable families and frail elderly patients
- Protected time for GP leadership

The **Attached Alcohol Nurse** scheme involves :-

- Collaboration with NHS Glasgow and Clyde Addiction Services
- Funding from the Alcohol and Drug Partnership
- 6 Deep End practices in north west Glasgow
- Embedding of alcohol nurse in practices for ease of referral and engagement

Discussions are underway with the Scottish Association for Mental Health (SAMH) concerning a programme to link Deep End practices with local SAMH resources.

Following three Deep End reports (16, 22 and 25) concerning the effects of austerity and welfare benefit reform on patients and practices, and two multidisciplinary meetings with members of the Glasgow Financial Inclusion Network, a programme of activities is being coordinated via the Glasgow Centre for Population Health to improve joint working to support people having problems with welfare benefits.

PRACTICE PARTICIPATION IN DEEP END PROJECTS

Links Project	6 practices
Bridge Project	3 practices
Care Plus Study	4 intervention and 4 control practices
Link Worker Programme	7 practices
Govan SHIP Project	4 practices

Some practices took part in more than one project, so the total number of participating practices was 16, all in Glasgow.

Only two projects have involved additional resources for practices – the Link Worker Programme and the Govan SHIP Project, involving 9 Glasgow practices in total.

ANNEX A

About Deep End practices

Deep End general practices comprise the 100 Scottish general practices with the highest proportion of patients on their registered lists who live on the 15% most deprived Scottish data ones, based on the Scottish Index of Multiple Deprivation (SIMD).

As the SIMD classification is based on numerous routine data sets which are updated on an annual basis, the ranking of practice populations based on SIMD changes from year to year. Since 2009, 123 practices have featured in the “top 100” during at least one year.

Practices may also disappear from the list when they close or are merged.

ANNEX B

Resources for the Deep End Project

Funding for the first national meeting in September 2009 was provided on a 50/50 basis by RCGP Scotland and the Scottish Government Health Department.

Locum funding for the first series of roundtable meetings was provided via the unspent part of the Primary Care Observatory Project grant from the Glasgow Centre for Population Health to the General Practice and Primary Care at the University of Glasgow.

Activities featured in Deep End Reports 11-12, and the 2nd national meeting in May 2012 were funded by the Scottish Government Health Department.

Other roundtable meetings were funded by NHS Health Scotland, RCGP Scotland, the Scottish Association for Mental Health (SAMH), Chest Heart and Stroke Scotland (CHSS), the SGHD Detect Cancer Early programme, the Greater Glasgow and Clyde Health Board Mental Health Division and the Glasgow Centre for Population Health.

RCGP Scotland has administered Deep End funding provided by the Scottish Government Health Department.

Coordination has been provided by Professor Graham Watt of the University of Glasgow , principally via 3 sessions per week of “indirect NHS activity”.

The Department of General Practice and Primary Care has provided a venue for roundtable meetings and expertise in setting up and maintaining the Deep End website (www.gla.ac.uk/deepeend).

The Glasgow BMA Local Medical Committee has provided a venue for steering group meetings, usually from 7-9pm on a weekday.

ANNEX C

The Deep End Steering group is open to all, but has generally involved a core of regular attenders, meeting 45 times, usually from 7-9pm on a weekday evening. There have been two all day, locum-funded, away days in 2012 and 2015.

Steering group members with ≥ 4 attendances are :-

David Blane	GP academic fellow, University of Glasgow and Maryhill Health Centre
Georgina Brown	Springburn Health Centre
John Budd	Edinburgh Homeless Practice
Peter Cawston	Drumchapel Health Centre
Margaret Craig	Allander Street Practice, Possilpark
Maria Duffy	Pollok Health Centre
Susan Langridge	Possilpark Health Centre
Andrew Lyon	International Futures Forum (Chair)
Lisa McIntyre	Gorbals Health Centre
Catriona Morton	Craigmillar Health Centre
Anne Mullin	Govan Health Centre
Cathy Norton	Gorbals Health Centre
Jim O'Neil	Lightburn Medical Centre, Carntyne
Raymond Orr	Glenmill Medical Centre, Royston
Euan Paterson	Govan Health Centre
Petra Sambale	Keppoch Practice, Possilpark
Graham Watt	University of Glasgow (Coordinator)
Andrea Williamson	University of Glasgow and Hunter Street Clinic, Glasgow

19 other Deep End GPs have attended on less than 4 occasions. In addition, there have been many attendances by GP academic fellows and registrars, medical students, researchers, public health doctors, civil servants and international visitors.

Specific guests have included Sir Harry Burns, Dr Alan McDevitt, Dr Miles Mack and Ms Catriona Renfrew.