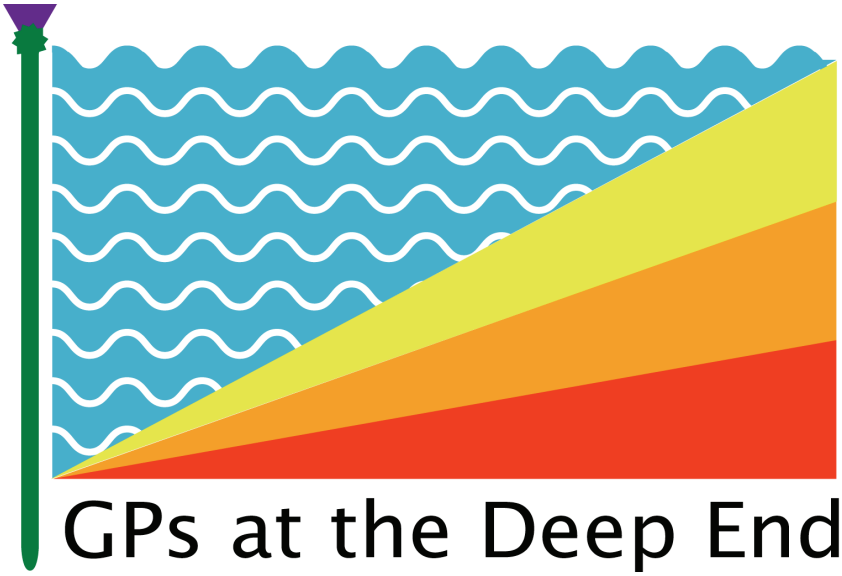


General Practitioners at the Deep End

This document comprises the summaries of 29 Deep End meetings held between January 2010 and December 2016.

Full reports available at http://www.gla.ac.uk/deepend

INTRODUCTION

For ease of reference this document collates the summaries of 29 Deep End reports, mostly capturing the experience and views of general practitioners working in very deprived areas on a wide range of issues.

Two Deep End Reports did not have brief summaries – the report of the first national Deep End conference in September 2009 (Deep End Report 1), and the Austerity Report in March 2012 (Deep End Report 16), whose full versions are available via the Deep End website.

Four reports on austerity and welfare benefit changes (Reports 16, 21, 25 and 27) informed the Deep End response to the Scottish Government's consultation on devolved social security arrangements. Two reports on mental health services (Reports 22 and 26) informed two Deep End responses to the Scottish Government's consultation on its Mental Health Strategy. These responses are available via the Deep End website

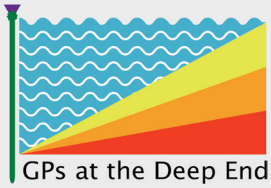
CONTENTS

DEEP END SUMMARY 2

Coping with needs, demands and resources

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

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



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

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

DEEP END SUMMARY 3

The GP role in working with vulnerable families

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

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

GPs at the Deep End

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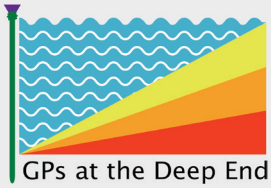
DEEP END SUMMARY 4

Experience and views of Keep Well and ASSIGN

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

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



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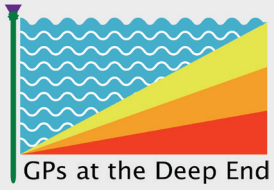
DEEP END SUMMARY 5
Single-handed general practice

Nine GPs from Glasgow, Dundee and Saltcoats met on Friday 07 May 2010 at the Section of General Practice & Primary Care, University of Glasgow, for a workshop on their experience and views of single-handed general practice in very deprived areas.

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



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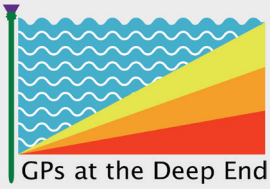
DEEP END SUMMARY 6

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

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

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

- Surgeries (serial consultations) can be made more efficient by good practice organisation, involving clear communication and the involvement of other members of the team including receptionists and practice nurses
- A frequent and important aspect of many consultations is referral to other professionals and services, requiring clear explanation. Referral is most likely to be effective when it is quick and to a familiar local setting.
- Practices provide a hub for referral to a huge range of other professions and services. Many of these pathways are dysfunctional, with poor communication and feedback
- Multiprofessional working across organizational boundaries works best via established relationships with named individuals, with regular, reliable contact and opportunities for professional exchange.
- Practitioners are keen to make use of the full range of possible services and sources of help for patients (e.g. via ALISS), but frequently lack accurate and up to date information about what is available locally.
- Patients also need ready access to health information and resources available within the local community.
- When a referral is made, some patients would benefit from additional help, support and reminders, to increase the probability of the referral being taken up.
- Evaluated experiments are needed in ways of providing access to consultations, of teamwork in addressing the needs of patients with complex problems, and in ways of providing and using additional time.
- There are few opportunities for practitioners working in severely deprived areas to share experience and views concerning the conduct of consultations and the organisation of practice.
- Additional education and training is required not only for young practitioners preparing to work in deprived areas, but also for established practitioners, to build on their substantial knowledge, experience and ideas.



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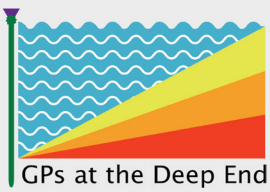
DEEP END SUMMARY 7

General practitioner training in very deprived areas

Eleven GP trainers met on Friday 04 June 2010 at the Section of General Practice & Primary Care, University of Glasgow for a workshop on GP training in very deprived areas, drawing on the experience and views of GP trainers and trainees.

- While 39% of practices in the most affluent 20% of Scotland are involved in GP training, this drops to 24% of practices in the most deprived 20%.
- A major explanation has been the small size of most practices in deprived areas, making it difficult to accommodate training requirements.
- The practical requirements of a training practice, in terms of organisation, record keeping and IT, are considered less of a barrier, now that all practices have addressed such issues, as part of the Quality and Outcome Framework (QOF).
- It was felt that training practices have to be particularly well organized to include training activities within the generally intense nature of general practice in very deprived areas.
- Training status is highly valued by trainers, allowing expression of professional values, and providing a constant stimulus for improvement, regular contact with colleagues and protection against burn out.
- Special features of the clinical environment in deprived areas include problems of alcohol and drugs misuse, multiple morbidity, psychological distress as a major co-morbidity, polypharmacy with risk of side effects and drug interactions, child protection issues and a high prevalence of social problems.
- An increasing aspect of practice is the large number of immigrants to Scotland, speaking foreign languages, with distinct customs and beliefs and who are often concentrated on arrival in very deprived areas.
- Patients are often less articulate than patients in affluent areas and have different views and priorities, for example, concerning anticipatory care and self management. As experienced clinicians, trainers can help trainees acquire the consultation skills to work with such patients.
- Understanding the benefits system is often a steep learning curve for trainees, which is made more challenging by the expert knowledge of patients on this subject and the importance of benefits for economic survival.
- Nothing compares with home visits for trainees to acquire an understanding of the realities of patients' lives in deprived areas.
- Although it is desirable that all GP trainees acquire some experience of general practice in deprived areas, it is not clear how this could be accommodated.
- GPs with substantial experience of practice in deprived areas also have educational and development needs, requiring new arrangements for protected time and professional support.



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DEEP END SUMMARY 8
Social prescribing

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

KEY FINDINGS

- GPs in Deep End practices routinely encourage their patients to make use of non-medical community resources to address their health and social needs
- Helping patients to become more self reliant and able to control and improve their own health is a core value for GPs in Deep End practices
- Current processes to distinguish between deserving and undeserving poor on the basis of medical assessments are perceived to produce disability and dependence and to undermine the doctor-patient relationship
- Key interventions that would support more effective social prescribing by GPs are:
  - Benefits reform that reflects the realities of life in Scotland's poorest communities.
  - An internet directory of community resources: if user friendly, locally relevant and kept up to date.
  - More medical and nursing time in consultations to respond to very challenging needs by clear explanation and guidance.
  - Clear guidance for patients and organisations approaching GP practices for reports or advocacy support.
  - Increased funding to voluntary and local agencies in deprived communities.
- GPs with substantial experience of practice in deprived areas also have educational and development needs, requiring new arrangements for protected time and professional support.

GPs at the Deep End

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DEEP END SUMMARY 9
Learning journeys

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

KEY LEARNING

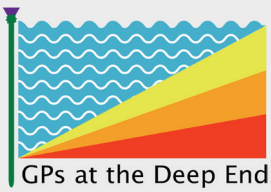
- Enormous talent and resources exist in communities of all kinds if one knows where to look and how to behave.
- People work effectively when their motivation comes from inside themselves rather than only outside.
- It is never too late to make a difference.
- Changing context is an effective way of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

KEY ACTION POINTS

GPs at the Deep End

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

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



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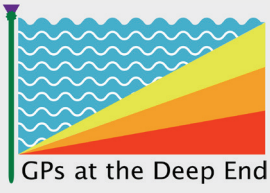
DEEP END SUMMARY 10
Care of elderly patients

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

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



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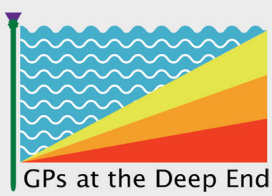
DEEP END SUMMARY 11

Alcohol problems in adults under 40

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

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



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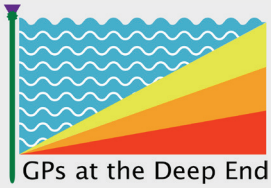
DEEP END SUMMARY 12

Working together for vulnerable children and families

81 practitioners and managers from Greater Glasgow and Edinburgh, including 19 Deep End GPs, met on Thursday 09 September 2010 at the Beardmore Conference Centre, Clydebank, for a discussion about policies and practices for children and families.

- Practitioners and managers agree that there are not enough resources to respond to need, resulting in a focus on fire fighting, raised thresholds for engagement and missed opportunities for early intervention.
- Local teams are often aware of vulnerable children and families before serious problems develop, but lack the resources to intervene and to make a difference. Investments are needed in home support, free nursery places and other ways of supporting families.
- The many suggestions made in this report can result in greater efficiency, especially via better joint working, but do not address the fundamental problem of resources.
- Hundreds of professional teams are involved in providing care for vulnerable children and families, and all need to work well, both individually and as components of an integrated system.
- The system needs accurate information on the numbers and distribution of vulnerable children and families, including but not restricted to children on child protection registers, as a basis for resource distribution, audit and review.
- Effective joint working depends on colleagues being well informed concerning each others' roles, how they may be contacted locally and the constraints under which they work.
- Information about the progress of particular cases needs to be shared between professions and services, so that each is aware of what is happening. There is an urgent need for bespoke IT which links systems and professionals.
- Pregnancy is an important opportunity to demonstrate the integration of professionals and services working to identify and help vulnerable mothers and their families.
- Professionals and services should be accountable not only for their own contribution but also how this connects with the contributions of others. The "connectedness" of care should be a major policy, management and practitioner objective, concerned not only with joint working around crises, but also continuity of care as required throughout childhood.
- Professionals acquire local knowledge and develop trusted relationships with families that are crucial for long term preventive care. There is a need to support and retain such staff, to value the relationships they have developed and to use the information they acquire, via regular multidisciplinary meetings.
- The hallmarks of a caring system are not only the quality of encounters between practitioners and families, but also the extent to which the system measures itself in providing needs-based support to all who need it, matches rhetoric about joint working by measures to support and review joint working, provides continuity of care and assesses itself against a range of outcomes, including the views of parents and children.
- A caring system should also care for its staff, ensuring reasonable caseloads, sharing the burden and finding practical ways of encouraging and rewarding commitment and continuity.
- An important determinant of service integration is the commitment of senior managers in encouraging, supporting and rewarding joint working by staff within their service.

- The GP contract and/or enhanced service agreements should explicitly support practices in working with vulnerable families in ways that are commensurate with the numbers of vulnerable families within practices.
- Clarity is needed about specific interventions for specific needs at specific points, and whose responsibilities these are.
- The system needs to learn and share examples of how existing resources can best be used, based on experience, audit and evidence.
- The meeting provided an example of how practitioners and managers from different services can learn from each other, share experience, correct misperceptions and discuss how services can be improved.
- The extraordinary nature of the meeting needs to be made ordinary, as part of a learning organization, dedicated to supporting professionals and services working with vulnerable children and families.



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

DEEP END SUMMARY 13

The Access Toolkit: views of Deep End GPs

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

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

GPs at the Deep End

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See also http://www.rcgp.org.uk/treating_access_scotland

DEEP END SUMMARY 14

Reviewing progress in 2010 and plans for 2011

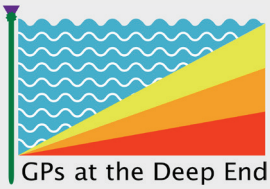
32 general practitioners and three observers met on Tuesday 25 January 2011 at the Beardmore Centre, Clydebank for a meeting to review Deep End activity in 2010 and to discuss activity in 2011.

- The Deep End Project has been successful in raising the profile of general practices serving areas of blanket deprivation, boosting the identity and morale of Deep End practitioners and stimulating interest and support from NHS organisations.
- 73 of the 100 most deprived practices have taken part in at least one meeting, and there is work to do in engaging with other practices, including those outside the central belt.
- The project has captured the experience and views of Deep End practitioners, as a basis for developing a shared view, for engagement with others and as a basis for joint advocacy e.g. the letter to the Herald on minimal alcohol pricing.
- Deep End practices are witness on a daily basis to the "slow motion car crash" of poor starts in life resulting in poor health and social outcomes in early adulthood. The knowledge and experience of practice teams needs to be included more effectively in policies to support vulnerable families who are most at risk.
- A feature of the project has been its focus on improving services for patients, which is part of its attraction to colleagues in NHS policy and management.
- Little progress has been made in addressing the fundamental problem of the inverse care law, as experienced on a daily basis, via shortage of time for consultations.
- It was felt that the current GP contract "works against" general practice in deprived areas and needs to be brought into line with the needs and demands of patients and services in the Deep End.
- It was also agreed that secondary care "does not work" for deprived areas. There is a need to engage with specialists so that they contribute more effectively to meeting the needs of patients in very deprived areas.
- Key points for the Deep End manifesto, addressed to political parties addressing the May Scottish elections, are the need for 15 minute appointments, better recognition of deprivation in NHS resource allocation formulae, the need for help (e.g. attached mental health workers) in developing an integrated approach to mental heath and addiction problems and investment in the primary care team as the hub of local systems of care.
- Key Points for a Scottish GP contract, which most feel is now inevitable, include more clinical time in deprived areas, measurable proxies of high quality care for patients living in very deprived areas, recognition of the length of time and engagement needed to achieve good outcomes in very deprived areas, and recognition of the higher prevalence of multiple morbidity, including mental health problems at younger ages in very deprived areas.
- Key points for the imminent Greater Glasgow Deprivation Interest Group (DIG) include the need for advocacy to influence NHS policy at national and local levels, the need for activities and infrastructure to support the sharing of best practice across the front line of practices service the most deprived areas, and the involvement of all members of the primary care team.
- There was concern that the task of the Glasgow DIG is much bigger than that of the successful Lothian DIG, and that the resources available to the Glasgow DIG may be insufficient.
- It was considered important that the Deep End Project retains a national profile, given the national importance of deprivation-related health and the fact that many important issues can only be addressed at a national level.

Next steps

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

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



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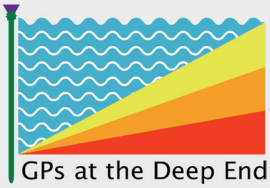
DEEP END SUMMARY 15

Palliative care in the deep end

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

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

- Social work was not represented at the meeting, despite invitations. It was noted that social work has no sub-speciality expertise in palliative care.
- It was said that community carers and their managers “don’t understand what district nurses do” in assessing clinical aspects of care, and tend to withdraw as the end of life draws near. It was felt that community carers could be a very important part of the caring team, but that district nurses are best placed to lead the team.
- Current GP contractual arrangements supporting palliative care include “essential services”, a Designated Enhanced Service (DES) and part of the Quality and Outcomes Framework.
- Minimum elements of care are inclusion on a register (so that care can be planned and reviewed), minuted regular multi-professional meetings and the availability and passage of relevant information for use out of hours.
- The DES is considered “too much a data collection exercise” and sometimes out of touch with the needs of the service at ground level, where flexibility and discretion are part of the art of tailoring care to individual needs.
- GPs described how it was sometimes “better not to put some patients on the palliative care list”, because of the bureaucratic implications.
- The previous Gold Standard Framework had involved 80% of practices, without reward or incentives, but had been “torpedoed” by the DES.



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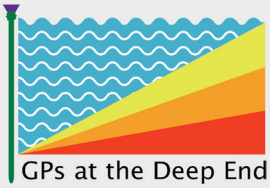
DEEP END SUMMARY 17
Detecting cancer early

Eleven Deep End GPs met on Friday 20 April 2012 at the University of Glasgow for a workshop on detecting cancer early in deprived areas with colleagues from the Scottish Government Cancer Team.

- Early cancer detection is more difficult in deprived areas because of the vague nature of many early symptoms and the high prevalence of other medical, psychological and social problems.
- Deep End GPs felt disengaged from the national bowel cancer screening programme.
- Communications with patients were considered to have “too much writing” for the particular target group, given issues of health literacy.
- Mass media campaigns provide a starting point, but engagement with patients in deprived areas needs a more personal approach.
- The “hard to reach” are often in regular contact with practices, but these contacts are used for pressing needs, which are currently more social than medical.
- Postal approaches do not work well in deprived areas and are often no more effective than junk mail. Many Deep End practices have abandoned this method of contacting patients. Timely phone contact by a person known to the patients is more effective.
- Centrally determined targets are generally more effective in secondary care than they are in general practice, where HEAT targets have relatively little penetration and profile.
- A general finding from the Deep End Project is that referral pathways have to be short, familiar and local if patients are to attend. The generic role of lay link worker may help to establish and use such links.
- General practices are more likely to be effective in contributing to a series of well coordinated and supported short term campaigns on specific issues. Exhortation on “everything, all of the time” quickly loses any effect.
- “Bolt-on initiatives” with externally determined priorities are difficult to assimilate under the conditions of the inverse care law, where practices have insufficient time to address the multimorbidity and social complexity of many patients.
- The lack of GPs relative to patient need, and the consequent shortage of time within consultations, are major constraints in addressing the range and depth of patients' problems.



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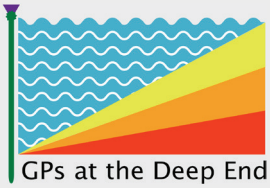
DEEP END SUMMARY 18
Integrated care

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

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



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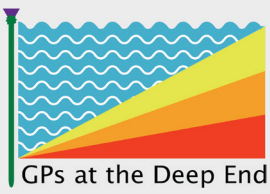
DEEP END SUMMARY 19
Access to specialists

Seven Glasgow GPs met on Friday 15 February 2013 in the Department of General Practice and Primary Care at the University of Glasgow for a discussion about the problems patients in very deprived areas have in accessing specialist care in the NHS, and how these problems might be overcome.

- In contrast to the marked social gradient in emergency admissions and out-of-hours service use, the ***social gradient for outpatient referrals is generally flat***.
- This pattern could be due to over-referral in affluent areas or under-referral in deprived areas. It may also reflect the relatively ***flat distribution of GPs*** and, therefore, their capacity to deal with patients' problems.
- It is possible to identify a ***number of factors*** – at patient, GP/practice, and secondary care levels – that may act as ***barriers to accessing specialist care*** in areas of severe socio-economic deprivation.
- ***Patient factors*** include: late presentations, competing demands, lack of confidence, literacy or language problems, and financial/travel difficulties.
- ***GP/practice factors*** include: lack of time, the burden of advocacy (e.g. re-referrals for those who miss appointments), volume of workload, and assessment of who is unlikely to attend an outpatient appointment, and for whom emergency admission may be the safer option.
- ***Secondary care factors*** include: referral processes (e.g. opt-in systems) being harder to navigate for the most vulnerable patients, communication problems (both with individual patients and with the primary care team), difficulty accessing specialist advice, inconsistency of service provision from specialist nurses, and under-resourcing of mental health services.
- ***Potential solutions*** to these challenges include:
    1. Better data collection to describe and explain variations in referral
    2. More targeted approaches, addressing the needs of patients in deprived areas
    3. Attached link workers to support the uptake of referral services
    4. Improved joint working relationships between health professionals
    5. Smarter use of information technology
    6. Clearer accountability of colleagues providing shared care
    7. Valuing and supporting the "specialist generalist" role for patients under 65
    8. Additional, targeted resources for mental health services in deprived areas



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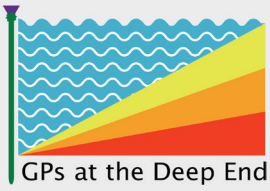
DEEP END SUMMARY 20

What can NHS Scotland do to prevent and reduce health inequalities?

The views expressed in this paper are based on a series of 18 meetings and reports, and have been collated by the steering group, meeting 27 times between 2009 and 2013. With the exception of one daytime meeting, the steering group has always met in the evenings, after long days in practice.

- General Practitioners at the Deep End are NHS Scotland's front line in areas of severe socio-economic deprivation.
- They have patient contact, population coverage, continuity, flexibility, long term relationships, substantial knowledge and experience and the trust of patients.
- These characteristics make general practices the natural hubs around which local health systems should develop.
- But Deep End practices lack the time, links to other services, NHS support and leadership roles needed to maximise what NHS Scotland can do to prevent and reduce inequalities in health.
- The Deep End Project has been unusually successful, with Scottish Government support, in engaging with general practices, in capturing and communicating their experience and views, and in harnessing their commitment to the Links, CarePlus and Bridge Projects.
- It is time to move beyond advocacy, and small projects, however, and to make a real difference to inequalities in health.
- By recognising the causes and consequences of the inverse care law, NHS Scotland can help to prevent poor health and life chances in young families, improve the health and life expectancy of patients with established conditions and prevent the further widening of health inequalities in adults.
- Additional clinical capacity is required, on a pro rata basis, providing one extra GP session per week per 1000 patients living in very deprived areas.
- The principles of co-production, including mutuality and respect, should be applied to serial encounters in general practice and primary care, enabling patients to become more knowledgeable and confident in living with their conditions and in making good use of available resources.
- The principles of co-production should also be applied to the joint work of general practices and area-based services, including attached workers (from social work, mental health, addictions and child health services), on a named basis.
- The lay link worker role should be developed to link practices and patients with community-based services and resources.
- Building on the Deep End Project, practices serving very deprived populations need regular opportunities to share experience, views and activities.
- NHS Scotland should re-deploy its substantial support systems (including information, research and development, training, continuing professional and leadership development) to provide more effective, integrated support for practices in the front line.
- These proposals should be applied together, as a demonstration of integrated care for patients with multimorbidity, an antidote to health service fragmentation and a model for NHS Scotland in the future.
- NHS Scotland should be seen at its best in areas of greatest need, or inequalities in health will widen. A new partnership with General Practitioners at the Deep End can show the way.



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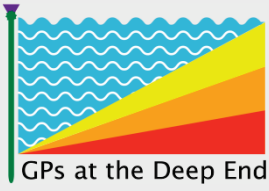
DEEP END SUMMARY 21

An update on welfare reform

In March 2012, GPs at the Deep End produced a report on "GP experience of the impact of austerity on patients and general practices in very deprived areas". Eighteen months on, Deep End practices are seeing increasing problems associated with the welfare reforms. This short report provides a follow-up to last year's report, and comes at a time when GPs across the UK are receiving criticism for their role in the welfare process.

- Changes to welfare have both **intended and unintended consequences**, which need to be measured and reflected upon, otherwise they may result in great damage.
- **We remain concerned that**, in its entirety, the welfare reform programme will be detrimental to the lives and well-being of the poorest in society.
- The **Welfare Reform Act (2007)** removed Incapacity Benefit (IB) and the Personal Capability Assessment (PCA) and replaced them with Employment Support Allowance (ESA) and the Work Capability Assessment (WCA).
- **The entire ESA application process is too long and complicated**. Many people, but particularly those with mental health problems, addictions, and cognitive impairment, find the process of form-filling, assessment, rejection, then the appeals process, punctuated by meetings with welfare officers, lawyers and the need for further medical evidence, to be confusing and demanding to navigate and, ultimately, damaging to their health.
- **Requests for medical information and support** fall most heavily on general practices serving very deprived areas, in which the numbers of such requests are concentrated. This places **additional demands on an already overloaded system** and compromises the time available for other aspects of medical care.
- **We all recognise the health benefits of appropriate work**. ESA should be part of a process which enables people to maximise their potential in achieving that benefit. Therefore, the underlying ethos of this process should be that of **support, understanding and enablement**. ESA, as it stands, fails in that endeavour.
- The **Welfare Reform Act (2012)** has introduced a number of additional changes, including Universal Credit, the Personal Independence Payment (PIP) to replace DLA, and changes to housing benefit, widely referred to as the "Bedroom Tax".
- **The real costs of the "Bedroom Tax" are unknown**, but there are early indications that, since its introduction in April 2013, there have already been damaging effects on communities, families and support networks for society's most vulnerable.
- **This report sets out a number of recommendations** to make the welfare system fairer, simpler, and easier to navigate. Central to this is the need for a radical overhaul of the Work Capability Assessment, which is not fit for purpose.



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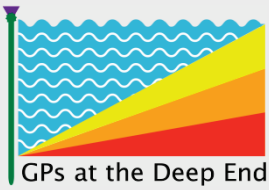
DEEP END SUMMARY 22

Mental health issues in the Deep End

Ten general practitioners and a psychiatrist met on 25 October 2013 to discuss mental health issues in severely deprived areas. A draft report, collating the evidence and experience which were discussed on the day, was considered by the participants, by members of the Deep End Steering Group and by the Lothian Deprivation Interest Group.

- Mental health problems, and GP consultations involving mental health problems, are more than twice as prevalent in deprived areas as in affluent areas, and are the commonest co-morbidity in deprived areas, and rise in prevalence in direct proportion to the number of patients' other problems.
- Depression (i.e. being on regular antidepressant treatment) is recorded in about a sixth of patients with most chronic medical conditions.
- In consultations for psychosocial problems, patients in deprived areas have poorer health and a greater number of other health problems; consultations are shorter than in affluent areas and patient enablement is lower; GPs report higher levels of personal stress after such consultations.
- In a study of 3000 consultations, the patients who were least likely to report being enabled after seeing their GP were patients in deprived areas with a psychosocial problem.
- The causes of the high prevalence of mental health problems include the burden of other conditions, the long term consequences of difficult experiences in early life and the combination of these factors.
- Theories of childhood attachment, the consequences of complex trauma and "allostatic load" may lead to better understanding and management of mental health problems and multimorbidity.
- Some patients have difficulty in forming and maintaining relationships, with substantial implications for their use of professional help and health care.
- Medication provides only a partial solution to these problems.
- When care is shared between services, it is essential that the links are quick and effective.
- Although an audit of referrals for first level support of mental health problems in Glasgow showed referrals rates to be 50% higher from very deprived areas than from affluent areas, epidemiological data suggest that rates should be double in very deprived areas.
- The HEAT target on waiting times for psychological services has had little impact on mental health issues in the Deep End.
- In practices with large numbers of patients with mental health problems, attached mental health workers could help to provide more integrated care.
- Counselling and third sector support services are seen as vital and more permeable than statutory services, but are under increasing threat as a result of current austerity policies.
- Services for homeless people have pioneered highly integrated and personalised support arrangements for people with long term problems and complex mental health needs, providing a model which mainstream services should follow.
- There is a need for increased professional dialogue, sharing experience, evidence and views as to how such care is best delivered.
- **A major continuing constraint is the inverse care law in Scotland, which results in less consultation time being available in general practices in deprived areas for patients with mental health problems.**



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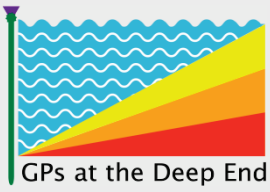
Full report available at http://www.gla.ac.uk/departments/generalpracticeprimarycare/deepend

DEEP END SUMMARY 23

The contribution of general practice to improving the health of vulnerable children and families

This report summarises the views of General Practitioners at the Deep End in addressing the needs of vulnerable children and families, as part of efforts to invest in the early years, improve health and prevent inequalities. It draws on previous Deep End reports, the research literature, the Deep End Response to the Health and Sport Committee's consultation on health inequalities and the early years and proposals for integrated care for the population served by Govan Health Centre.

- Inequality and poverty in early childhood have long term consequences that affect the entire life course.
- Interventions in early childhood provide the foundations of good health and reduce the scale of disease and premature death in later life.
- GPs at the Deep End recognise the magnitude of the challenges in addressing inequalities in early years and have outlined the intrinsic strengths of general practice in contributing to this challenge.
- General practices' contacts with the wider family, in good times and bad, allied to continuity, flexibility, cumulative knowledge and trust, provides an important resource and basis for sustained preventive efforts, linking with other services and community resources.
- Current policies such as GIRFEC (Getting It Right For Every Child) make virtually no reference to this important role of general practice teams.
- The key professional relationship between health visitors and GPs is undermined by the disproportionate numbers of vulnerable children on health visitor caseloads in very deprived areas, and the gaps that arise as a result of difficulties in health visitor recruitment.
- General practices can lead in developing strong local systems, based on multiple relationships between services, to contain and prevent problems without recourse to emergency services.
- This requires a fundamental policy shift that recognises the "Inverse Care Law" which continues to limit what practitioners in the front line are able to offer, in terms of a proportionate response to the needs of vulnerable families.
- The high political priority given to policies supporting the health of families with young children should be evaluated in terms of their impact on health inequalities in the early years and beyond.
- The Govan Integrated Care Project is a pragmatic approach to develop and evaluate a robust intervention to support vulnerable children and families at an early stage.



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DEEP END SUMMARY 24

What are the CPD needs of GPs working in Deep End practices?

Eleven general practitioners met in a round table meeting on 14 March 2014 to discuss the Continuing Professional Development (CPD) needs of GPs working in very deprived areas. The participants considered these questions: How could GPs working in deprived settings better serve their population? What learning needs do they have to meet to achieve this? What is the gap between current practice and better practice that education could address?

Following a discussion of the issues Deep End GPs encounter in their daily work, eleven learning needs were identified as being of high importance to Deep End GPs:

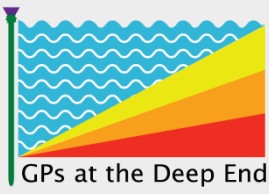
1. Engaging with patients (autonomy/health literacy/screening)
2. Promoting GP tenacity/realistic optimism
3. Drugs and alcohol
4. Safeguarding children
5. Asylum seekers/migrant health
6. Multimorbidity
7. Poverty
8. Vulnerable adults
9. Evidence-Based Medicine (EBM) and unhealthy populations
10. Previous sexual abuse
11. Homelessness

The topics that the group wished to take forward were prioritised by focusing on identified learning resource gaps:

1. How to address low patient engagement in health care and increase health literacy.
2. How to promote and maintain therapeutic optimism when working in areas of high deprivation.
3. How to use EBM effectively when working with patients with high levels of multi-morbidity and social complexity.
4. How to meet the health needs of migrants including people seeking asylum and refugees.

The first three are being taken forward as PBSGL modules.

This report will be of use to those who are interested and involved in supporting primary care learning in the UK especially those working in deprived communities.



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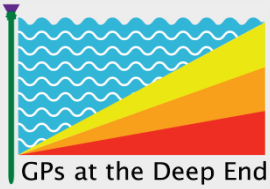
DEEP END SUMMARY 25

Strengthening primary care partnership responses to the welfare reforms

A meeting was held on 22 May 2014 involving general practitioners and other organisations, services, advice centres and groups in Glasgow, providing information, advice and support for people receiving or applying for welfare benefits. The main focus of this report is on how improved joint working with general practice could help welfare benefit applicants, recipients and appellants in Glasgow. It is not the purpose of the report to review other financial inclusion activities.

- The Glasgow population is set to lose £259 million per annum as a result of ongoing changes to the welfare benefit system, the largest of any Scottish city and second only to Birmingham in the UK.
- The changes have caused much hardship, uncertainty and anxiety. More changes are in the pipeline.
- The Financial Inclusion Contract is a partnership between Glasgow City Council, NHS Greater Glasgow and Clyde and the Glasgow Housing Association, with combined annual funding of £4.3 million for the support of core advice agencies in the city.
- Services are contracted at three levels, providing information (Type 1 workers), general advice (Type 2 workers) and specialist advice (Type 3 workers), via a range of community-based and central locations.
- The Glasgow Advice and Information Network (GAIN) is a network of over 200 third sector and public sector organisations involved in financial inclusion. Less than 10% of referrals to GAIN advice services come from the NHS sources.
- General practices have regular contact with most patients. Routine and urgent contacts with GPs, practice nurses and receptionists can be used to signpost patients to advice centres. Many patients, especially those with mental health problems, including addictions, require additional help and support.
- General practitioners are often asked to provide supporting medical information for benefit applications and appeals, but are not necessarily well informed about changes to the benefits system or the availability of support services.
- Welfare Rights Officers need help from GPs in representing their clients, but GPs are busy, especially in very deprived areas, as a result of the inverse care law (which provides a flat distribution of the GP workforce in Scotland, irrespective of deprivation).
- Although benefit problems are concentrated in practices serving very deprived areas, no additional resources are provided to address the additional workload.
- There is very little slack in general practices serving very deprived areas. Initiatives need to be “time-neutral”, or work saving. Work-generating initiatives are unlikely to be taken up.
- The role of general practice teams includes recognising patients with financial problems, signposting patients to advice centres, referring patients to advice centres and (via link workers) providing support for patients to access advice centres.
- Current referral data show that there is huge potential for general practices to increase their referrals to GAIN services.
- Many local systems for benefits advice and support (including general practices) consist of poorly connected parts, with little sense of joint ownership or shared learning.

- Different advice agencies have had varying success in trying to work more closely with general practices and health centres. “What works” needs to be understood and applied more widely.
- General practices would welcome reliable information on local advice services and authoritative briefings on changes to the benefit system e.g. the new PIP arrangements, ESA appeals, the roll out of Universal Credit and welfare sanctions which can precipitate families into crisis.
- Audit of referrals to GAIN services can identify areas where the provision and uptake of information could be increased.
- Much can be done centrally in terms of standardised information, referral forms, letter templates and IT development.
- Local health fairs could help introduce potential local colleagues to each other.
- Practices could be briefed on imminent appeal hearings involving their patients, to improve the content, timing and focus of the information they provide.
- NHS badging of local systems could help to establish that financial advice and support is a legitimate health care activity.
- There is a need to learn from experience (positive and negative significant events), including the experience of professionals and of services users, both to improve local systems and to inform lobbying at a higher level (e.g. via the Glasgow Poverty Leadership Panel).
- Educational activities, based on practical knowledge and experience of the welfare benefits system should be developed for GP training and protected learning activities for practice teams.
- A programme of initiatives in these areas could lead to more effective joint working between general practices and other agencies concerned with the experiences and outcomes of Glaswegians engaging with the welfare benefit system.



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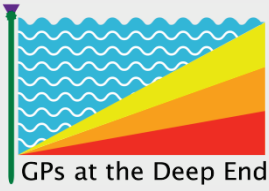
DEEP END SUMMARY 26

Generalist and specialist views of mental health issues in very deprived areas

Seven general practitioners from Glasgow, Edinburgh and Dundee, six specialists from psychiatry and psychotherapy and three observers met for a half day meeting on 26 September 2014 to share and compare views and experience of mental health problems in very deprived areas.

- Generalists and specialists working in mental health care have different purposes, vantage points, perspectives, resource constraints, experience and language, but common cause in understanding the nature of mental health problems in deprived areas and how they are best addressed.
- Mental health services provide excellent care for patients with psychoses or severe depressive illnesses, but everyone struggles to work effectively with patients with relational difficulties, including the consequences of complex trauma and personality disorder.
- Many adult patients in this context face the "double whammy" of ongoing adversity combined with the lack of social and relationship skills to deal with it.
- Patients who do not "fit" established categories and services for dealing with problems can end up "ping ponging" round and out of services in a chaotic way. Many patients have had experience of multiple exclusion and the challenge is to break this cycle.
- Although all services can provide long term care, specialist services try to focus on where they can make a difference, before referring patients back to general practice.
- In Greater Glasgow and Clyde Health Board, there is an interface group to address problems which occur when patients are referred, in either direction, between general practice and mental health services.
- Multidisciplinary working within homelessness services was described as a positive model of service provision for patients with complex, challenging problems.
- The knowledge and expertise of colleagues working in specialist services could be shared more widely with general practitioners, for example "mentalising" approaches and supervision/peer support for complex cases.
- Deep End practitioners need more consultation time and are keen to assess the role of attached workers in helping patients with mental health problems.
- Almost everyone who is significantly "distressed" will meet diagnostic criteria for depression, but not all will be helped by antidepressant medication. The Scottish Government is reviewing the NHS response to distress, a move which was welcomed by GPs but has significant implications for mental health services.
- There is collaborative work to do, in determining what is meant by "complex, challenging needs", developing an ideal treatment plan, and comparing current experience against this ideal
- Separate discussion is needed, between GPs and specialists in child and adolescent psychiatry, to consider the contribution of general practice to the prevention of mental health problems across the life course. A key focus is on effective support for children and families.



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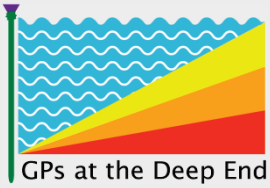
DEEP END SUMMARY 27

Improving partnership working between general practices and financial advice services in Glasgow: one year on

A half day symposium was held at the Lighthouse in Glasgow on 30 June 2015 to review progress in joint working between general practices in Glasgow, the Glasgow City Financial Inclusion Partnership, NHS Greater Glasgow and Clyde, the Wheatley Housing Group, Third Sector organisations and the Glasgow Centre for Population Health. A previous meeting took place in May 2014.

- The Glasgow Financial Inclusion Partnership (involving Glasgow City Council, NHS Greater Glasgow and Clyde, the Wheatley Housing Group, Citizen's Advice Bureau and other Third Sector organisations) has secure funding for three years and a strategic programme of activity to support citizens in their engagement with the welfare benefits system.
- This period will be increasingly challenging because of changes and cuts to the benefits system and resource constraints within public services generally.
- Substantial added value could and should be added to the programme by more effective joint working with general practices in the city, making use of their population coverage, cumulative knowledge of patients, clinical records and continuity of contact with patients at various stages of engagement with the benefits systems, including referral for advice, applications, appeals and sanctions.
- Mental health problems are very prevalent in very deprived areas, both as a cause and a consequence of problems with benefits
- General practitioners in the Deep End, serving the most deprived populations, are already under severe pressure dealing with the large numbers of patients with complicated medical, psychological and social problems.
- In a gross example of the Inverse Care Law, the largest concentrations of patients who need most help in engaging with the benefits system are found in general practices which are least able to take on this extra work.
- Improved links between clinical practice, welfare advice, employability schemes and housing could provide more holistic, personalised support for many individuals, families and households.
- A "coalition of learning" is required, following the adage that "the best anywhere should become the standard everywhere" and involving improved communications and protected time for sharing information, evidence, experience and views.
- General practices need to be briefed with general and practical information about the benefits system (especially ESA, PIP and sanctions).
- They also need bespoke local information (a "toolkit") on referral pathways, forms and contacts, for use in referring patients for financial advice, supporting applications and appeals, and dealing with financial emergencies.
- The new Scottish GP contract, which is being developed for introduction in 2017, should include a mechanism to provide targeted resources for this work.

- The preparation of medical evidence from review of clinical records does not need to be carried out by general practitioners, but practitioners should review, edit and sign off such work.With patient consent, colleagues from outside the practice team (with honorary NHS contracts where necessary) could access clinical records within practice premises. Such arrangements are only feasible, however, on the basis of local relationships, involving mutual understanding, confidence and trust.
- Centralisation of welfare advice services allows efficient use of resources, but may not suit all people in need of such advice. Several examples demonstrate the value of advice workers who are embedded within health centres or groups of practices, improving referrals by the practice team and uptake by vulnerable groups.
- The substantial variation between general practices and between health professions in their rates of referral to advice services needs to be addressed, on the basis of audit and feedback.
- The most useful feedback for general practice teams may be timely information on what has been achieved financially for the patients they have referred.
- A continuing challenge is how to provide general practices with timely, bespoke advice on the type of information most likely to help patients submitting appeals.
- An immediate proving ground for joint working will be the coverage and effectiveness of the programme in helping Glaswegians with Disability Living Allowance (DLA) engage with the new arrangements and criteria for Personal Independence Payments (PIP).



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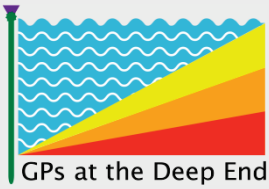
DEEP END SUMMARY 28

GP recruitment and retention in deprived areas

Three focus groups were held with 60 GP trainees and early career (First5) GPs to get their views on issues related to recruitment and retention of General Practitioners in severely deprived areas. These took place in October and November 2015.

- Recruitment and retention of general practitioners are becoming crisis issues, as a result of pressures on and within practices, the perceived unattractiveness of GP careers, the age and gender profile of general practitioners and increasing numbers taking early retirement.
- GP trainee exposure to practice in very deprived areas is highly variable, depending on the location of their training practice. At present, there are proportionately more training practices in more affluent areas compared with practices in more deprived areas.
- Very few trainees are considering partnership straight after their training, with most planning to locum to gain experience in different practices. The additional workload, stress and responsibility of partnership are off-putting.
- General practice in very deprived areas is not in itself off-putting for younger GPs. More important issues in determining whether a practice is attractive or not are whether it is well organised, with strong nurse support and a good working atmosphere. Relationships are key.
- Trainees identified particular features of general practice in deprived areas that might generate stress and lead to burnout, but offered a number of strategies that could reduce the likelihood of burnout.
- The next generation of GPs is “up for the challenge” of general practice in the Deep End, but needs to be adequately resourced and supported in the leadership roles they will be taking on.



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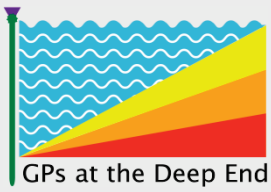
DEEP END SUMMARY 29

General practitioner use of additional time at Govan Health Centre as part of the SHIP project

- The Govan SHIP Project is funded by the Scottish Government to improve integrated care for patients living in a very deprived area.
- It is based on a general practice cluster comprising the four general practices at Govan Health Centre and serving the 16th, 28th, 30th and 32nd most deprived practice populations in Scotland, with a combined list size of 18,139 patients.
- The project involves additional GP and social work capacity, plus support for monthly multidisciplinary team (MDT) meetings to review vulnerable families and frail elderly patients.
- Two of the practices also have an embedded community links practitioners (CLP).
- The additional GP capacity comprises a 0.5 WTE salaried GP (SHIP locum) for each of the four practices and is used to provide one session of protected time per week for each of the 15 GP partners.
- During February 2015, 82% of all patient contact in the practices involved general practitioners (64% by GP partners, 19% by GP registrars, 6% by GP retainees and 11% by SHIP locums).
- In 25 protected GP sessions during two weeks in February 2015, 13 GP partners reported 136 activities, including 76 extended consultations with the patient present and 14 sessions viewing 25 case records with the patient absent (an average of about four cases reviewed per GP per week).
- Other activities included correspondence, reports, contacts with professional colleagues and attendance at a range of meetings, including child protection case conferences.
- The content of extended consultations displays the nature, severity and complexity of physical, psychological and social problems within families and households, which is typical of patients in very deprived areas.
- Annex A of the full report (available at http://www.gla.ac.uk/deepend) describes the content and outcomes of the extended consultations and should be read by all who are unfamiliar with the nature of general practice in very deprived areas..
- Extended consultations, case record reviews and contact with professional colleagues provided opportunities to take stock, plan and coordinate care, and were hugely valued by the GPs.
- The range and complexity of cases required generalist clinical care. Only two cases were referred to a Community Links Practitioner.
- Ten months into the SHIP Project, the study shows that addressing unmet need remains the dominant use of additional GP time. Other uses of GP time are developing.
- The extended consultations not only provide better planning and coordination of individual patient care; they also provide a basis for driving change through local arrangements for integrated care, based on the needs of patients.
- The long term outcomes of extended consultations in the SHIP Project are not known, but are likely to be similar to the outcomes and cost-effectiveness of the Care Plus Study.
- It is not known whether, or how often, extended consultations need to be repeated.
- This small study provides a snapshot of the use of additional GP time as part of the Govan SHIP Project. Follow up and further evaluation are needed.



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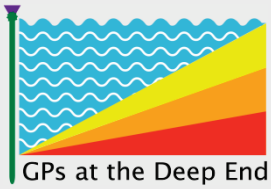
DEEP END SUMMARY 30
November 2016
A role for Members of the Scottish Parliament in addressing inequalities in healthcare in Scotland

- At least a third of Members of the Scottish Parliament represent constituents who receive less time with their GP, despite higher levels of psychological problems, more multimorbidity and more chronic health problems.
- This situation arises as a result of the Inverse Care Law, whereby steep social gradients in premature mortality and multimorbidity are associated with a flat distribution of GP funding.
- The Inverse Care Law applies not only to socio-economically very deprived areas at the edge of Scottish society, but also to over 2 million Scots living in the 40% most deprived areas.
- Underfunding of general practice in deprived areas results in unmet need, GP stress and complications of patients' conditions occurring sooner, with increased pressure on out of hours, accident and emergency and acute hospital services.
- In 2015, Scottish Government Ministers pledged to address the issue via revision of the Scottish Allocation Formula (SAF) which allocates funding to general practices via the national GP contract.
- The Ministerial commitments replace years of denial, vague commitment and weak resolve concerning the Inverse Care Law.
- It is not clear whether a suitably revised SAF is achievable with a formula based on data which take no account of unmet need.
- If a suitably revised SAF is not possible, another solution must be found.
- Additional clinical capacity for general practices serving deprived areas is essential, in order to address the needs of patients with varying combinations of physical, psychological and social problems.
- The Care Plus Study shows that additional consultation time for patients with complex problems in deprived areas is a cost-effective use of NHS resources.
- Additional help from nurses, pharmacists and link workers can complement but not substitute for the medical generalist role.
- Policies for primary care transformation must not leave the Inverse Care Law intact.
- Redistribution of resources within general practice has not been feasible when general practice funding was reduced as a proportion of the NHS budget, putting all general practices under pressure and leaving many GP vacancies unfilled.
- The Scottish Government's recently announced commitment to increase primary care funding introduces the possibility of addressing the Inverse Care Law via a policy of differential growth, in which no practice loses funding.
- Patients in deprived areas in Scotland have lost out in the competition for NHS resources, as a result of the poor understanding, representation and advocacy of their needs.
- If the NHS is not at its best where needs are greatest, inequalities in health will widen.
- Very deprived areas are the main testing and proving ground for the equitable intentions and policies of NHS Scotland.
- With new funding for Scottish general practice, there is a historic opportunity to address and abolish the Inverse Care Law.
- MSPs must not let their constituents down.



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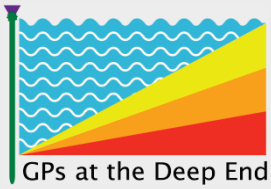
DEEP END SUMMARY 31

Attached Alcohol Nurse Deep End Pilot

- The Attached Alcohol Nurse Deep End Pilot (July 2015-2016) tested a service model of partnership working by bringing specialist community services into Deep End general practice settings.
- Its aim was to address the needs of people with problem alcohol use who are in contact with their general practices but who have not previously engaged well with addiction services.
- Two FTE specialist Band 6 addiction nurses were attached to six Deep End practices in NW Glasgow working in partnership with the general practice team.
- 132 patients were referred, 71% of those agreed to be seen, and 82 patients had specialist alcohol assessment and treatment in the pilot.
- The profile of the patients in the pilot bore a striking to resemblance to the profile of people described in a recent in-depth study of alcohol related deaths in Glasgow.
- Associations of improved outcomes beyond engagement in alcohol care were not feasible due to the short time scale and size of the pilot.
- All professionals involved in the pilot were unanimous – it was welcomed and successful.
- The theory of change was:
    - The team relationship and function that built up between the GP practices and attached alcohol nurses. Vital to this was informal discussion and recording in GP notes.
    - The engagement strategies the nurses used with patients – described as responsiveness, 'stickability' and flexibility.
- Recommendations for the future are:
    - The pilot should be repeated at scale in Deep End practices for a period of three years with a programme evaluation resourced and embedded in service delivery which will include feedback from patients.
    - This should be delivered by specialist senior alcohol nurses embedded in general practices providing the full range of alcohol treatment services using GP recording systems and with a team working approach.
    - Delivery of care should be characterised by these key ingredients for patient engagement – responsiveness, 'stickability' and flexibility.



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