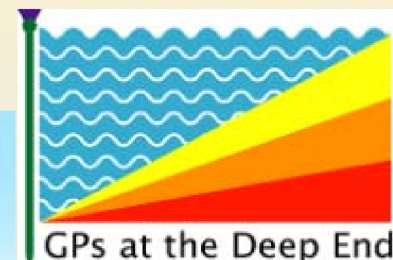
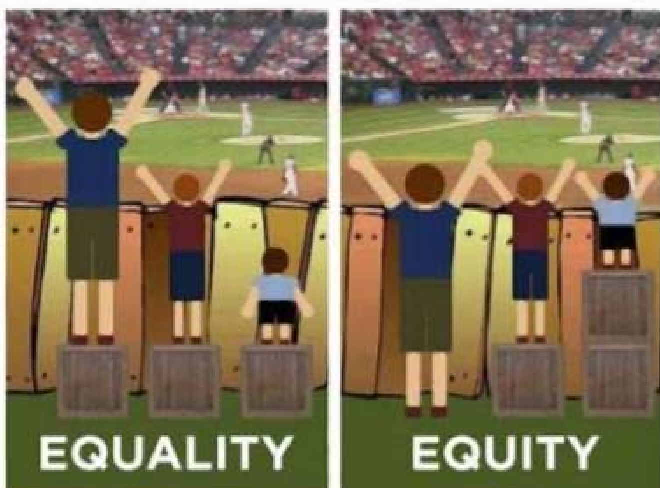
Making It a Priority-Levelling Up To Provide Equitable GP Healthcare



What are Health Inequities?



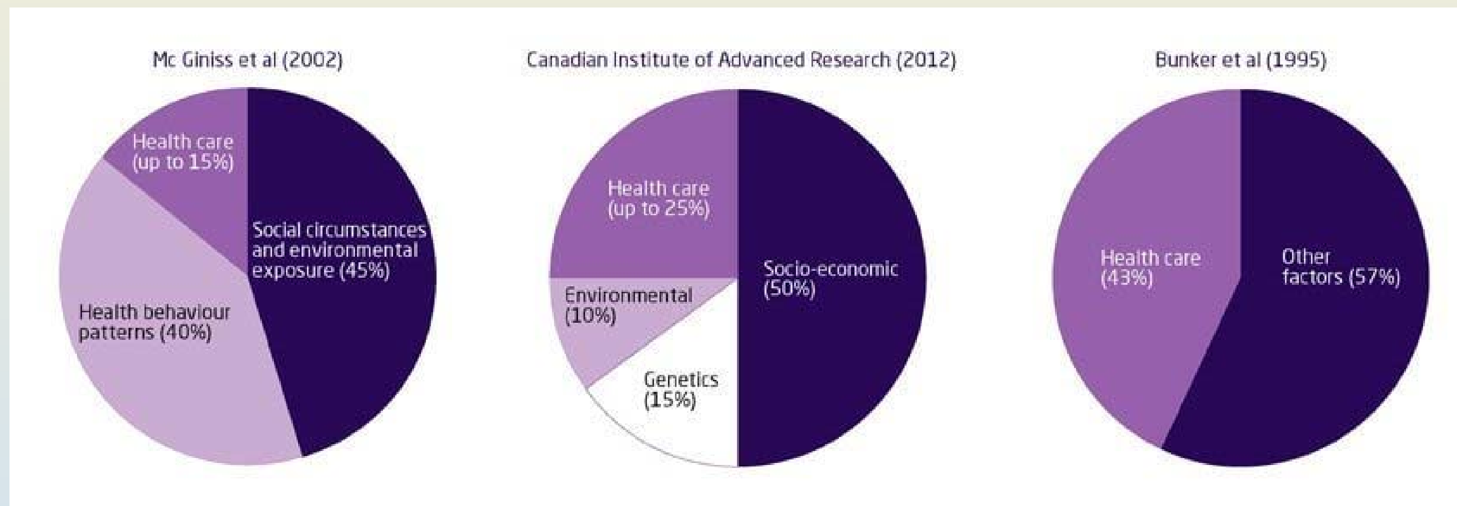
- **Equality = SAMENESS**
  - Only works if everyone starts from the SAME place
- **Equity = FAIRNESS**
  - Making sure people get access to the same opportunities

WHY INVEST IN GENERAL PRACTICE IN DEPRIVED AREAS

- DE patients have a higher prevalence of complex co-morbidity, mental health issues being most common- **this patterning of health and unmet need begins in childhood**
- They have only marginally higher GP consultation rates until age 75+ after which affluent patients have considerably higher rates. This suggests **DE patients' relative under-utilisation of GPs and unmet need throughout life.**
- **Mortality rates are higher** in DE patients suggesting they are experiencing a higher prevalence of morbidity. **A&E attendance rates and emergency inpatient rates are higher in DE patients** (X2) than the affluent throughout life
- **Investing in DE practices** aligns with many ScotGov policies and intiatives e.g ACEs, Healthy Aging, Health Literacy, Realistic Medicine, Anti Poverty Measures, Links- **IT'S THE ETHICAL THING TO DO !**

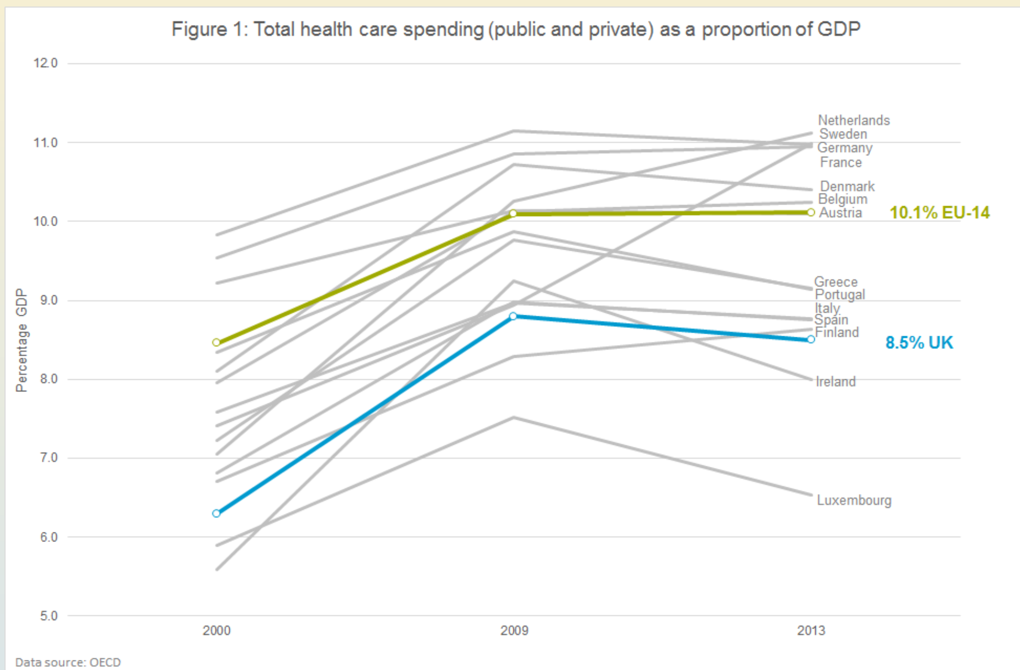
Health Matters

- Several studies attempt to estimate how the broader determinants of health impact on our health. **We should be radical in our thinking, in a Scottish context**, developing our own research base and support new ways of working.



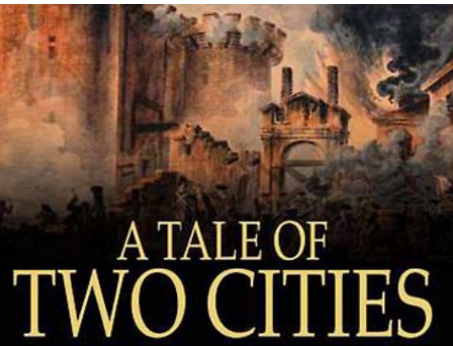
https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health

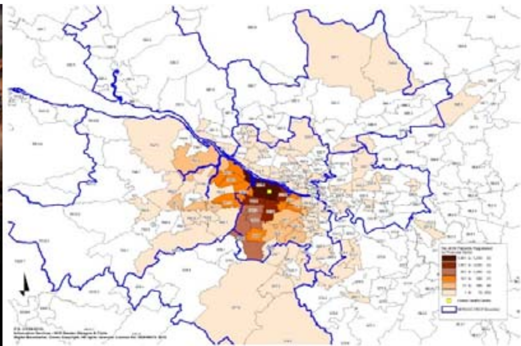
Can We Afford Not To?



In 2015-2016, male HLE at birth in the 10% most deprived areas in Scotland was 43.9 years, 26.0 years lower than in the least deprived areas (69.8 years).
Female HLE at birth was 49.9 years in the most deprived areas, 22.2 years lower than in the least deprived areas (72.0 years).
http://www.gov.scot/Publications/2017/12/4517/5

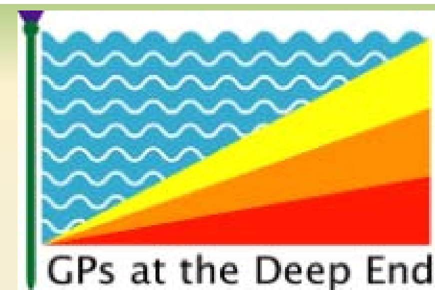
Whatever the flaws of international comparisons, **it's clear the UK is currently a relatively low spender on health care** – as the Barker Commission pointed out – with a prospect of sinking further down the international league tables. The question is increasingly not so much whether it is sustainable to spend more – after all, many countries already manage that and have done for decades. Rather, **it is whether it is sustainable for our spending to remain so comparatively low, given the improvements in the quality of care and outcomes we want and expect from our health services.**
https://www.kingsfund.org.uk/blog/2016/01/how-does-nhs-spending-compare-health-spending-internationally





Measure	Govan/ Linthouse	WhiteCraigs
Male Life Expectancy	67	85
Female Life Expectancy	73	94
Patients hospitalised with coronary heart disease	570	35
Early deaths from CHD (<75)	95	35
Patients hospitalised with asthma	94	44
Patients with emergency hospitalisations	11880	5621
Patients (65+) with multiple emergency hospitalisations	8913	3979
Patients with a psychiatric hospitalisation	630	95
Deaths from suicide	36	11
Teenage pregnancies	81	17
Mothers smoking during pregnancy	32%	3.4%
Immunisation uptake at 24 months - 5 in 1	97.6%	97.1%
Immunisation uptake at 24 months - MMR	97%	93%
Children Living in Poverty http://www.scotpho.org.uk	38%	3%

Anne Mullin 170118



Seeing the Future

Health Inequalities widening in Scotland with Poorest Nine Times More likely To Die from Alcohol Harm

DEEP END SUMMARY 21

GP experience of welfare reform in very deprived areas

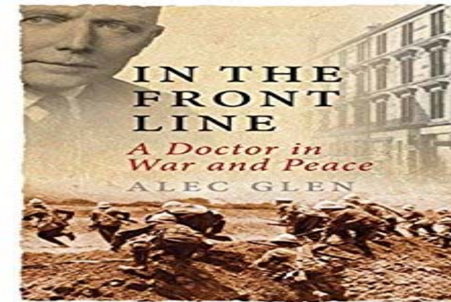
In March 2013, GPs at the Deep End produced a report on "GP experience of the impact of austerity on patients and general practices in very deprived areas". Eighteen months on, Deep End practices are seeing increasing problems associated with the welfare reforms.

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.

https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/

Much of this ill health and mortality can be **traced back to stubborn lifestyle factors such as persistently higher rates of smoking, obesity, and alcohol consumption in poorer areas,** although the Scottish Government's new policies on minimum alcohol-pricing and a proposed crackdown on cheap junk food deals are aimed at reversing this http://www.gov.scot/Resource/0052/00529436.pdf

At The Far End and Deep End in History



- The Dewar Report 1912- the Publication of the Highlands and Islands Medical Committee.
- A Blueprint for the NHS in Scotland ‘Doctors… lived in inadequate housing with inadequate income… did not have access to appropriate transport and the telephone system was poorly developed…were unable to afford the cost of a locum so went without holidays and had no opportunity to undertake any continued professional development’
- A response to the difficulties of providing medical care to crofting communities with little income to pay for medical care

In Govan ;

‘Post-war recession -1/3 of men unemployed…the dole 15 shillings for 5 weeks and stopped every alternate 5 weeks ‘What the men and their families were supposed to live on during the second five weeks I never quite understood, but any savings which they had were soon used up, and furniture in the houses became very scarce’

‘Conditions of unemployment and semi-starvation…150 inhabitants to 1 WC…poorer patients could not pay accounts…For many years it is true that I did a great deal of work for nothing’ Dr Alec Glen

‘I was back on the frontline again but in a different kind of warfare’

Anne Mullin 170118

THE TSUNAMI HEADING OUR WAY

- **Heavier workloads coupled with a relative reduction in resources**
- **Increased demands – ageing & increasingly multimorbid population, and transfer of work from hospitals (and elsewhere) to general practices**
- **Resources not matched demand. In Scotland, the share of NHS funding spent on general practice from 9.8% in 2005/6 to a record low of 7.8% in 2012/13**
- **GPs face later retirement & smaller pension - Recent BMA survey suggested that 1 in 3 Scottish GPs were hoping to retire within the next 5 years**
- **19% of GP trainees and 16% of those qualified in the last 10 years said they intended to leave the UK to work overseas in the next 5 years**
- **Across the UK, applications for GP training fell for a second successive year, with many training posts unfilled**
- **Unsustainable impact of the GP workforce on health inequalities, and the inverse care law in particular**
- **Feminisation of the workforce**

- Blane, D. N., McLean, G., and Watt, G. Distribution of GPs in Scotland by age, gender and deprivation. Scot.Med.J. 23-9-2015

The Direction of Travel –Realism not Fatalism

- **People are supported to live well at home or in the community for as much time as they can**
- **Planning for populations, not delivery structures**
- **Pooling resources – money and people**
- **Embedding GPs, other clinicians and care professionals in the processes of service planning, investment and provision**
- **Very strong local leadership**

To retain the same number of beds as 2009/10 we need to achieve a 12% reduction in the bed-day rate by 2014/15. By 2020/21 to retain the same number of beds we have to have achieved a 24% reduction in the bed-day rate. Source; Cosla

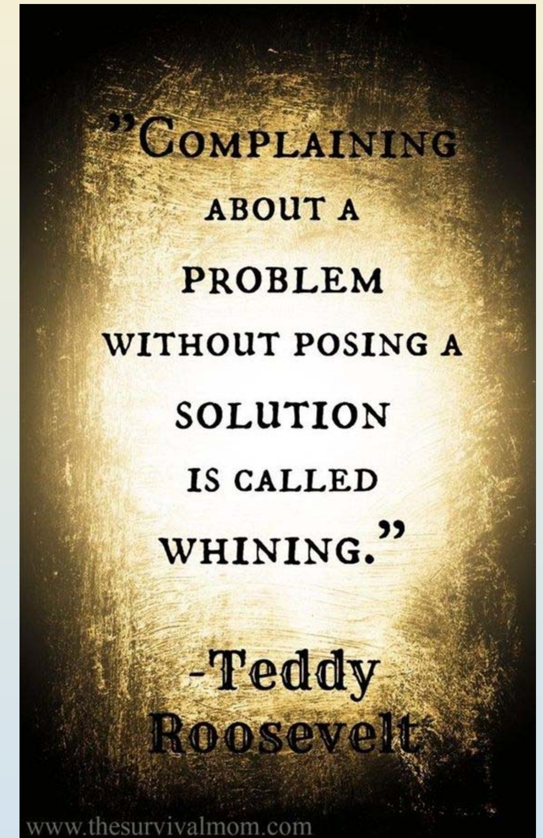
'It is impossible to achieve Realistic Medicine without a truly multidisciplinary approach, appreciating the varied skills and experience of the health and social care workforce in Scotland' Chief Medical Officer for Scotland Annual Report 2015/16 Realising Realistic Medicine

Realistic professionalism;

Practice teams should look after their own health and well-being to be helpful to patients 'put on your own oxygen mask first'

'Your problem is our problem'. Seldom, if ever, 'That is not my job'

Thinking Collaboratively & Enabling Legislation- Children and Young People (Scotland) Act 2014 The Public Bodies (Joint Working) Act 2014



GOVAN SHIP Getting Us From H1-H3

Navigating Horizon 2

HORIZON 1 SINKING IN THE DEEP END

- Pre-established team working but no strategic support
- Collective memory of working with attached social worker- A POSITIVE EXPERIENCE
- Clunky communication systems - an ongoing frustration
- Fragmented data systems
- GP contract no specific role for GPs in care of vulnerable children & families despite being the 'hub' - MINIMISES MATERNITY, PAEDIATRIC AND FAMILY HEALTH CARE
- Vulnerable adults often don't reach thresholds of service provision.Boundaries to service provision are barriers to access to service
- Very little research to argue our case. GPS DON'T WRITE THINGS DOWN, DIFFICULT TO QUANTIFY 'NON EVENTS'
- Experience doesn't seem to count

HORIZON 3 SAILING ON CALM WATERS

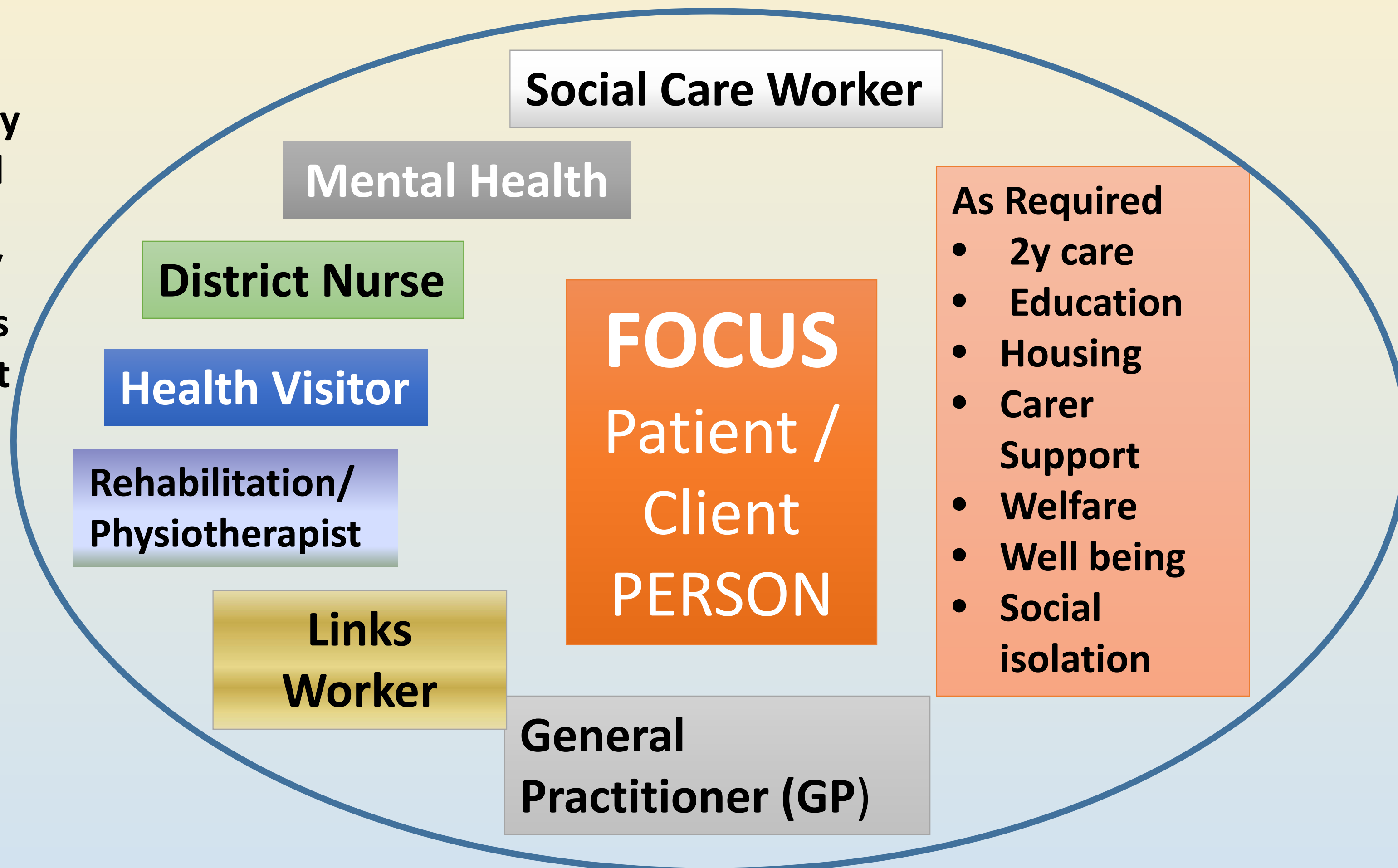
- Protected time - CASE PLANNING
- Professional relationships - face-to face discussions- blurring the boundaries – ALL WORKING AS GENERALISTS,
- Infrastructure- e.g. MDT meetings, whole systems approach, 1y & 2y care interface, steering group
- Multimorbidity database
- Documentation - minuted meetings, diaries ADMIN SUPPORT
- Patient engagement
- RESEARCH THAT FITS WORKING PRACTICES (e.g. Evaluation Report)
- Bigger picture - Links Workers, Mental Health, Education, Management (understanding budgetary constraints and planning networks)
- Normalising the project work through connectivity, embedded knowledge, knowledge exchange – AN ECOLOGY OF LEARNING

Key Components of Govan SHIP (people,communication, time)

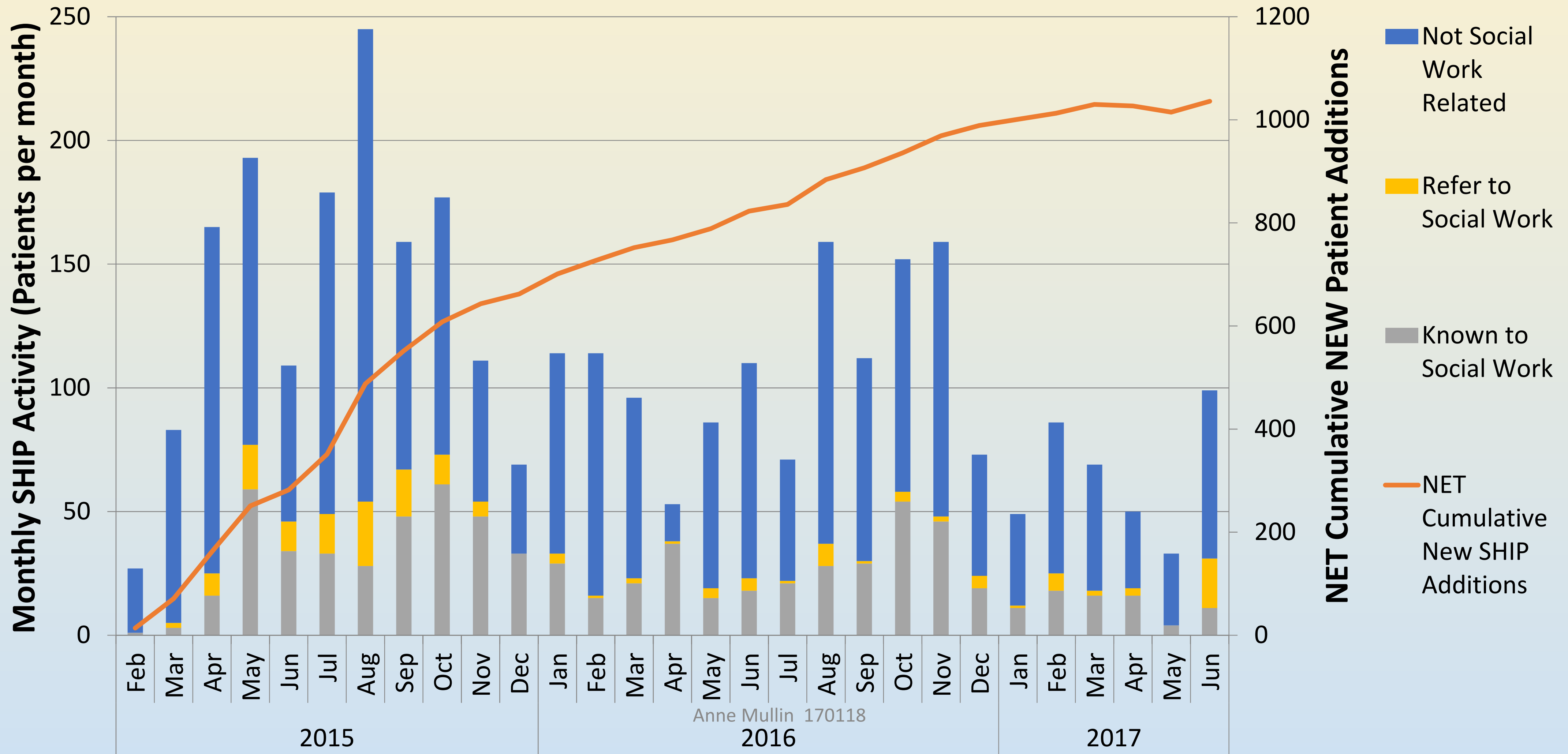
1. **Aligned Social Care Workers**
2. **Structured Multi-Disciplinary Team Meetings** (Vulnerable Adults, Vulnerable Children and Families)
3. **Additional time for GPs**
   - Extended consultations
   - Polypharmacy reviews
   - Case Review
   - Outward facing / planning
   - Leadership and Development
   - Academic support

Putting It All Together – SHIP MDT

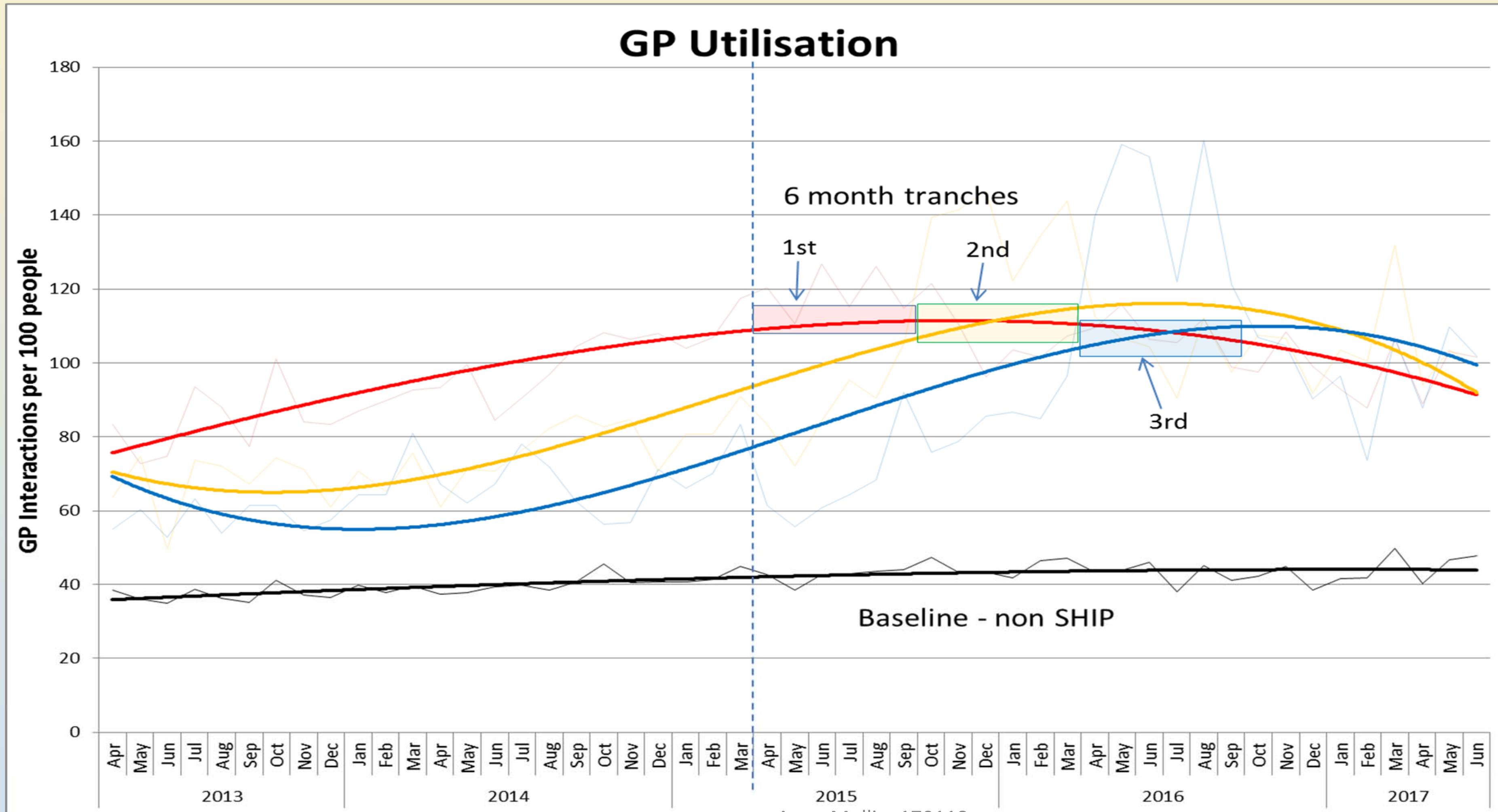
- **Workstreams**
- **Children & Families**
- **Frail & Elderly**
- **Unscheduled Care**
- **Information/ Data Systems**
- **Management**



Monthly SHIP Activity



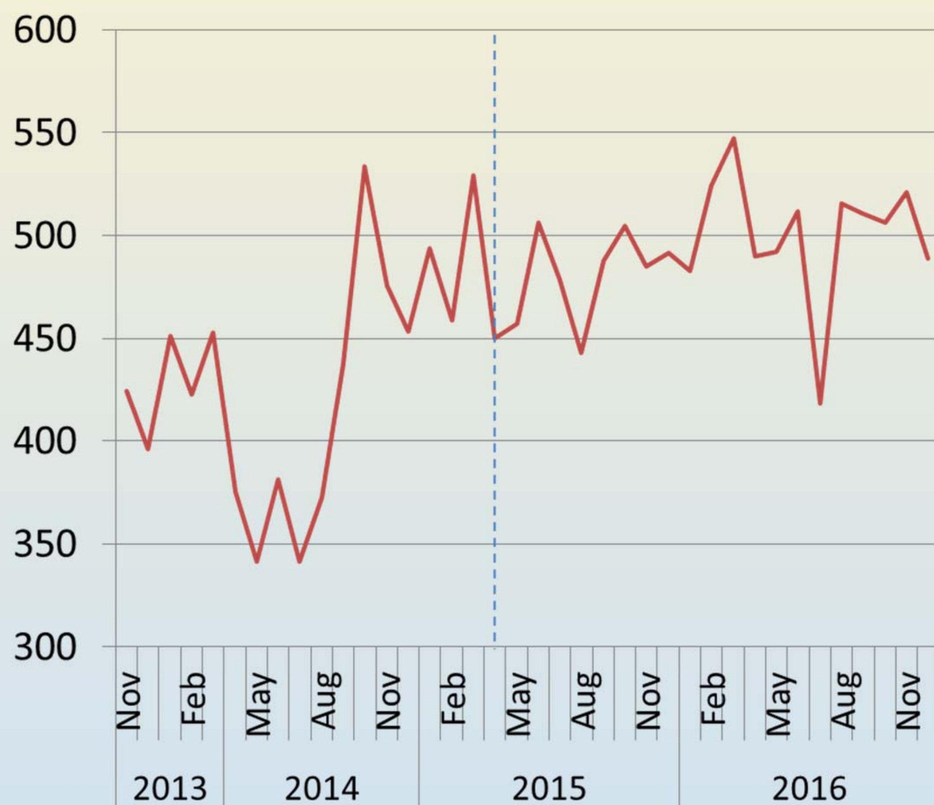
GP Demand – Registered – SHIP



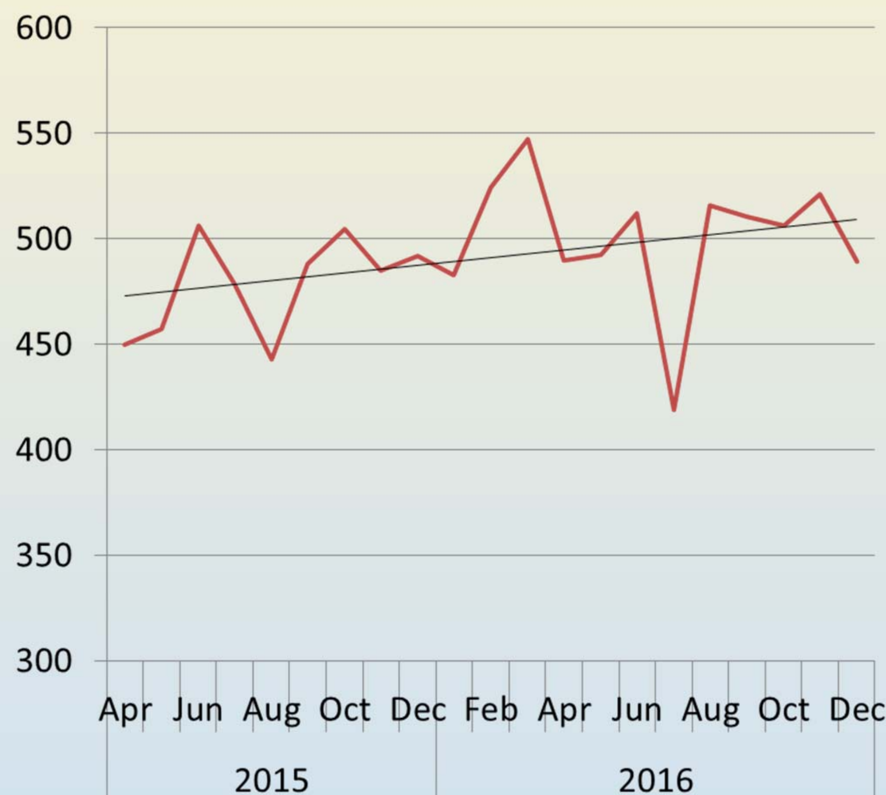
GP Demand - Comparator

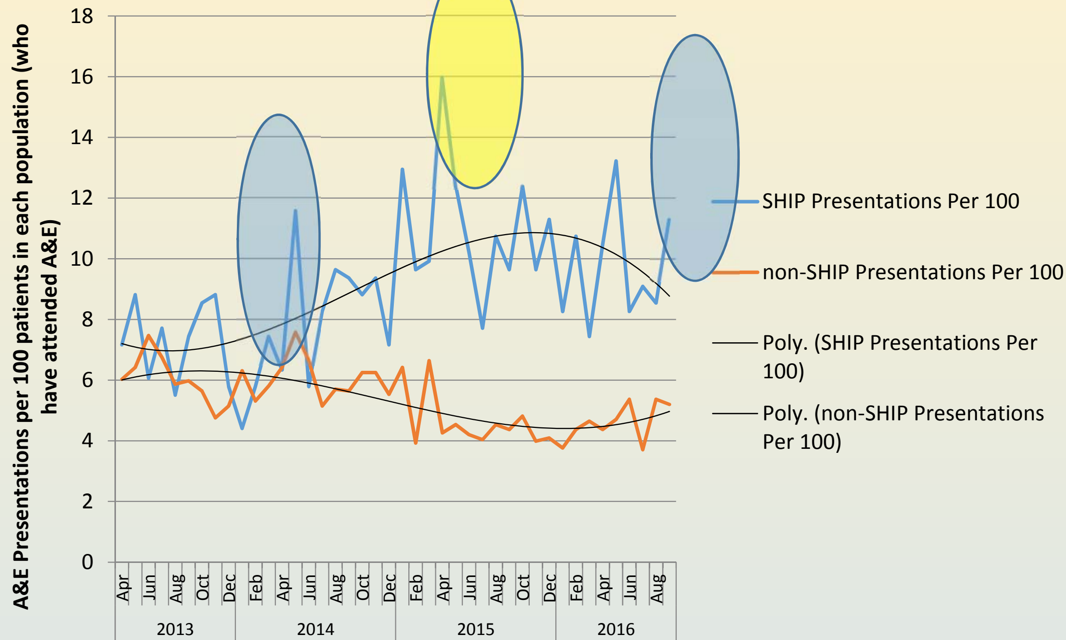
DRUMCHAPEL Comparator Practices - GP Interactions per 1000 patients

Nov 2013 – Dec 2016



Apr 2015 – Dec 2016





69 patients in total attended A&E from the Blue practice over April and May 2015 on 98 occasions with a cohort of patients attending on multiple occasions. 5 of those patients attended 3 or more times in 1 month.

23 Case Patient Records examined in detail

Age Group	No Patients
0-4	7
5-14	2
15-24	1
25-44	5
45-64	2
65-74	2
75-84	4

- **19 patients of the sample in total had been discussed at an MDT meeting either around the time of the A&E attendance in April or May or after the A&E attendance .**
- **18 patients contacted the practice on 20 occasions in 2015. 4 of those patients are extreme users of GP services (50 or more contacts).**
- **13 patients contacted the practice on 20 occasions in 2016. 3 of those patients are extreme users of GP services (50 or more contacts). An outlier was identified – patient who had 139 health contacts in 2015.**

Of the 5 patients who attended A&E more than 3 times in one month;
1 patient was in the age group 25-44, 2 patients were in the age group 45-64, 2 patients were in the age group 65-74.

Govan SHIP – Frail / Elderly Case Study- The System Is Working

- **73 year old patient**
- **Current problems-** Unexplained weight loss, escalating pain issues, psychological distress, non-compliance with current meds
- **Relevant PMHx-** Depressive Disorder (Psychiatry input) Chronic pain, IBS, COPD
- **Relevant Social Hx-** Lives with husband and son (who has severe LD). Husband is main carer but has been admitted to hospital with a terminal illness.
- Patient increasingly distressed and not coping. Found wandering outside and multiple OOH contacts.
- **Family has been discussed at several MDT** to anticipate care arrangements for son in lieu of elderly parent's declining function. **Delay in SW planning response across Adult and LD teams** which culminated in an emergency placement for son in suitable care accommodation
- **Current crisis** precipitated by husband's admission to hospital.
- **Patient referred urgently to DME** and seen within 2 days with urgent investigations, dietician review and follow up appointment organised (also referred by GP to psych geriatricians for assessment of capacity)
- Exemplary coordinated approach between 1y and 2y care. **Avoidance of admission** because of urgent assessment at DME.
- **GPs, Secondary Care, Statutory services all involved**

Becoming SHIP- Shape

- **SHIP delivered**
  - **Decrease in patient GP Demand**
  - **Right people seen at right time by right person (integration)**
  - **Decreased patient repeat attendance**
  - **Improved GP recruitment and retention**
  - **Alignment management and clinical**
  - **Representative, localised data**
- **Mechanisms of Change**
  - **Change to way in which system works – GP behaviour, relational change .**
  - **Extended consultations**
  - **Knowledge exchange between academia and frontline working -disseminated**
  - **Pharmacy reviews**
  - **Multi-Disciplinary Team (MDT) working**
  - **Embedded non- GP staff. On site physios, Links workers, pharmacy. By proxy via the MDTs- Mental health, Housing, 3rd Sector Family Support**

Next Steps

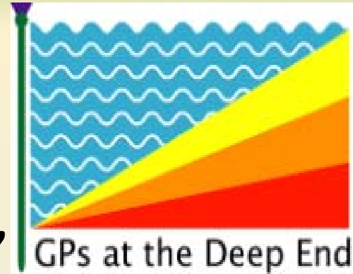
- **Continuation**
- **Short term** (to end March 2018)
  - Physiotherapy (now funded)
  - Pharmacy (now funded)
  - Link with Education, 3rd sector, Housing
  - Continued teamwork with 2y care
- **Medium term** (April 18 – March 19)
  - Time to prove more
  - Rollout of key principles (cost / no cost)
- **Long term** (April 2019 and beyond)
  - Wider rollout
  - New GP contract

An Ecology Of Learning-Scaling Up

- Three inter-related aspirations- **sustaining core general practice , delivering extended services, leading a population health system**
- Larger scale has the potential to sustain general practice through operational efficiency and standardised processes, maximising income, strengthening the workforce and deploying technology.
- Scaling up will take a lot of hard work ... **All GPs will need to play a part in making these new organisations successful**
- The evidence that these organisations can improve quality is mixed. Patients had differing views about the benefits of large-scale organisations. Some appreciated increased access, while **others were concerned about losing the close relationship with their trusted GP**
- Policy-makers and practitioners should be **realistic in their expectations of the pace** at which large-scale organisations can contribute to service transformation

https://www.nuffieldtrust.org.uk/research/is-bigger-better-lessons-for-large-scale-general-practice

How Can We Continue To Achieve That? Economic Return on Investment



- Coordinated continuity of health care for patients with multiple health problems.
- Arrangements and resources reflect the epidemiology of multimorbidity, including earlier onset in deprived areas.
- Approach focusing on respect, relationships and trust.
- Neediest/most complex patients have sufficient time for consultations.
- Effective team working with a range of critical services (social work, mental health, addictions, child health).
- Practices and patients are connected with community resources for health.
- Services and arrangements address the needs of vulnerable families.
- Effective serial encounters and productive use of long term relationships are supported.
- Training and leadership development within and between practices.
- Protected time for practices to share experience, information, learning and activity
- Links, Govan SHIP, Deep End Pioneer

(Deep End Manifesto 2017, https://www.gla.ac.uk/media/media_557256_en.pdf)