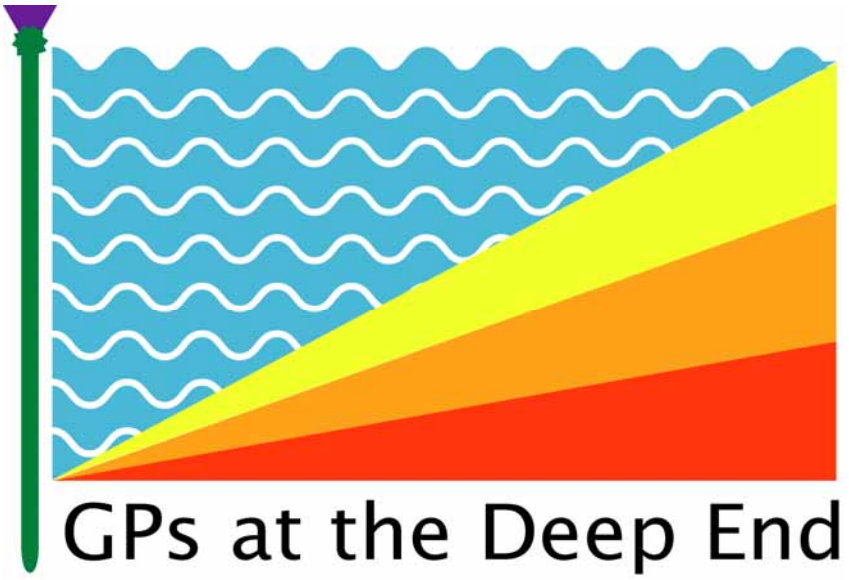


Deep End Report 14

Reviewing progress in 2010 and plans for 2011

The fourteenth meeting of "General Practitioners at the Deep End"

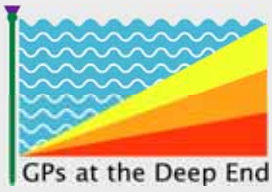
25 January 2011

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

SUMMARY

- 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.



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

Contacts for further information

Paul Alexander *RCGP Scotland* palexander@rcgp-scotland.org.uk
John Budd *Lothian Deprivation Interest Group* John.Budd@lothian.scot.nhs.uk
Petra Sambale *Keppoch Medical Practice, Glasgow* psambale@btinternet.com
Graham Watt *University of Glasgow* graham.watt@glasgow.ac.uk

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ATTENDING

Name	Location	List size	Deprivation ranking
Barry Adams-Strump	Midlock MC	8343	65
Wilma Best	Gorbals HC	6059	60
Claire Briggs	Crewe Rd, ED	8979	97
Ronnie Burns	Parkhead HC	3051	8
Peter Cawston	Drumchapel HC	5310	43
Margaret Craig	Possilpark	4167	12
Elizabeth Day	Springburn HC	2846	36
Mair Jamieson	Tollcross MC	6776	76
Susan Langridge	Possilpark HC	2165	18
Stephen MacPherson	Bridgeton HC	3953	42
Clare McCorkindale	Kelso Street	3382	57
Owen McHugh	Townhead HC	12990	159
Terry McIntyre	Springburn HC	7187	55
Catriona Morton	Craigmillar HC, ED	8353	20
Anne Mullin	Govan HC	8476	79
Jim O'Neill	Lightburn MC	3117	28
Euan Paterson	Govan HC	3983	32
Anna Pettigrew	Springburn HC	1359	44
Lindsey Pope	Port Glasgow	4143	84
Petra Sambale	Possilpark	3085	1
Nicola Smeaton	Dundee	9365	85

John Budd	Edinburgh Homeless Practice
Kerry Milligan	Glasgow Homeless Practice
Andrea Williamson	Glasgow Homeless Practice
Keith Buckingham	Practice Manager, Mill Practice, Dundee

Claire Knaggs	NES Health Inequality GP Fellow, Dundee
Yomi Olamosu	GP Trainee, Springburn HC
Stewart Mercer	Professor of General Practice, University of Glasgow
Alan McDevitt	GP, Clydebank (193)
Maureen Smith	Port Glasgow (127)
Andrew Lyon	International Futures Forum
Graham Watt	Professor of General Practice
Paul Alexander	RCGP Scotland
Lynn Malone	RCGP Scotland
Frank Strang	Scottish Government Health Department
Lorna Kelly	NHS Greater Glasgow and Clyde
Jim Egan	Glasgow Centre for Population Health

INTRODUCTION

Andrew Lyon opened the meeting and was followed by Alan McDevitt who commented on the impact that the Deep End Project had made in its first year.

Graham Watt then presented a short summary of the progress report which had been pre-circulated to everyone attending.

Andrew Lyon then invited comments from the audience.

A major achievement of the project had been to promote the identity of Deep End practices, which were described as “no longer the mushroom in the cupboard”. The project had been helpful to the morale of general practices working in severely deprived areas.

It was noted that 27 of the 100 most deprived practices had not taken part so far.

The project had done little to change the fundamental problems of Deep End practices, in terms of time constraints, but had clarified where the NHS could do better and had established links between practices which allowed experience and views to be shared. One practice had introduced multidisciplinary meetings to review vulnerable families, following the Deep End report on this issue. The “collegiate effect” of the project was strongly welcomed.

By formally setting out the problems of general practice in deprived areas, the project had attracted the interest of policy makers in the NHS and is keeping the Inverse Care Law “on the horizon”. The project had also helped to inform GPs working in non-deprived areas about the differences involved in working in severely deprived areas.

It was difficult to identify direct benefits to patients, but several indirect benefits were described, including the re-invigoration of practitioners, who “really turn up” for their work.

GPs had become more aware of the processes of change and how arguments have to be articulated and presented. The group had presented itself in terms of a shared and organised view, instead of a disparate collection of opinions.

Few of the meetings had focused on the business side of general practice. Rather the focus had been on meeting the needs of patients, whether covered specifically by the GP contract or not. An observer said that this broader focus was one the features of the project that made it attractive to others outside general practice..

The project had given status to the work of general practitioners in the Deep End, had helped to reduce discontent and had created the expectation that “things will be better”.

The joint letter to The Herald newspaper on alcohol pricing was considered a valuable precedent which might lead to other advocacy activities in the future. Several colleagues recalled the unusual situation at the Deep End meeting, which led to the letter, involving an encounter with a civil servant working on the progress of the Government’s Alcohol Bill through the Scottish Parliament.

The Learning Journeys were also recalled as an unusual experience for GPs in which they were challenged by several examples to consider how their work might be reconfigured and made more satisfying.

GROUP DISCUSSIONS

The meeting then split into six discussion groups with two groups addressing one of three topics:

- A Deep End manifesto for the forthcoming Scottish elections, highlighting issues to take forward with each of the main political parties
- Implications of a new Scottish GP contract, which seems likely (also in Wales) as a result of the increasing incompatibility of the NHS in England and elsewhere.
- Expectations of the Glasgow Deprivation Interest Group (DIG), which is being established in NHS Greater Glasgow and Clyde, partly in response to the successful example of the Lothian DIG.

Each discussion group identified key issues by attaching post-it notes to a wall poster. All six posters were displayed to members of the wider group, who prioritised specific issues by the attachment of adhesive dots. In the next session, the outcomes of these discussions are listed, in descending order of priority and mentioning only those issues attracting two or more votes.

467 votes were cast: 199 concerning the Deep End manifesto, 142 concerning the implications of a Scottish GP contract and 126 concerning the Glasgow DIG. The figures in brackets below show the number of votes cast for each item.

This exercise provided a quick snapshot of Deep End opinion on three issues based on GPs attending the meeting.

DEEP END MANIFESTO

- 15 minute appointments should be standard in Deep End practices (18)
- The impact of deprivation on needs and demands in Deep End practices should be recognised more effectively in financial arrangements (15)
- Mental health and addiction problems overlap to a huge degree, and require an integrated approach (15)
- Every Deep End general practice should have an attached mental heath care worker (11)
- Health visitors should be practice-attached (10)
- Community nursing should be linked more effectively to general practices (10)
- The primary care team should be recognised and developed as the essential unit of primary care delivery (10)
- Maintaining and using a Vulnerable Families Register should be included in the Quality and Outcomes Framework (8)
- There should be a national enhanced service for vulnerable children (8)

- Local flexibility is needed in allocating services according to need (7)
- All GP trainees should have experience of working in a practice serving a very deprived area (7)
- Health visitor case-loads should be capped at a reasonable level, and additional health visitors appointed to share excessive case-loads (7)
- The NHS should stop wasting money on providing extended opening hours (5)
- There should be more GP fellowships to support professional development addressing the needs of practices serving very deprived areas (4)
- Services for older people need to start at a younger age in very deprived areas (3)
- The NHS should provide more support for GPs, given their key role in deprived areas (3)
- Social workers should be attached to general practices (3)
- Hospital specialists should spend 6 months in general practice as part of their training (3)
- Contract incentives should be relevant to the particular problems and to what can be achieved by general practices serving very deprived areas (2)
- There should be an increase in the number of training general practices in deprived areas (2)

IMPLICATIONS OF A SCOTTISH GP CONTRACT

- The contract should provide more clinical time in deprived areas (20)
- There is a need to develop a measurable proxy of high quality care for patients living in very deprived areas (11)
- The GP contract should recognise the length of time needed to achieve good outcomes in deprived areas (11)
- Any proposed new Scottish GP contract should be scrutinised to ensure it will not widen health inequalities (10)
- The higher prevalence of multiple morbidity at younger ages, in deprived areas, and the service implications, should be recognised (10)
- The contract should recognise the higher prevalence of mental health problems in deprived areas (10)
- General practitioners serving very deprived areas should be represented directly in contract negotiations (10)
- It is important to maintain the universality of health care provision (7)

- Lost QOF revenue due to exemption coding should be ring-fenced and fed back into deprived general practices to help address problems of access and use in deprived areas (7)
- The contract should reward empathic, patient-centred care in deprived areas, involving the whole health care team (6)
- The contract should incentivise the process of good care and not the outcome of care (5)
- Deprivation should be recognised and incorporated as a core issue (5)
- Social prescribing should be incentivised (5)

EXPECTATIONS OF THE GLASGOW DEPRIVATION INTEREST GROUP (DIG)

- An important function of the DIG should be to influence NHS policy (18)
- The DIG should have a strong advocacy role, highlighting the needs of patients in very deprived areas. (7)
- Following the positive experience of the Deep End meeting on Alcohol Problems, there should be further meetings, closing the communication gap between Deep End practitioners and policy makers (7)
- The DIG should provide opportunities to share best practice, including how best to organise local systems of care (7)
- The DIG should involve all members of the primary care team (6)
- The DIG should have an education and training role (6)
- The DIG should help to influence national resource allocation issues, as these have a huge effect on health in Glasgow (6)
- The DIG should help identify and support opportunities for practice-based research (5)
- Size matters – how will the Glasgow DIG relate to the large numbers of practices and practitioners serving very deprived areas? (4)
- GPs from Deep End practices need to be closer to positions of power (4)
- Meetings should address the wider determinants of poor health in deprived arewas and what can be done about them (4)
- The DIG should promote the sharing of information and the development of partnership working (4)
- The DIG may help to improve links between GPs and Community Health Partnerships (3)
- The DIG should provide a platform for airing the concerns of Deep End practices and expressing their collective voice (2)

- The DIG should help to consolidate the identity and special needs of Deep End practices (2)

SUMMARY AND NEXT STEPS

In the general discussion which followed, the following points were made:

- 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.
- The Deep End group should express its experience and view of the wider determinants of poor health in deprived areas, in addition to the aspects which can be addressed by general practice.
- The activities of the Glasgow Deprivation Interest Group should complement the work of the Deep End Project, but not attempt to replace it.
- There was concern about whether the Glasgow DIG would have sufficient resources to work with all practices and practitioners working in deprived areas.
- It is very 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.
- The DIG provides an opportunity to involve all members of the multiprofessional primary care team and also practices serving areas of pocket, as opposed to blanket deprivation. However, this wider inclusion should not be allowed to dilute the effectiveness of the Deep End Project in addressing the problems and needs of general practices serving the most deprived areas.
- The key manifesto issue is to obtain additional time for patient encounters in deprived areas, with a standard of 15 minutes per consultation, which is already the norm in many non-deprived areas.
- Attached workers are need to allow prompt referral to other professionals and services, without the long delays that often characterise referrals outside the practice.
- In view of the importance of early life determinants of poor adult health, and the predictable nature of poor health in many children, another key manifesto issue is to secure investment in the early care of vulnerable children and families.
- Effective care is delivered best in deprived areas by relatively small multiprofessional teams, who know their patients and communities well and who work cohesively together.
- It was agreed that secondary care as currently organised “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.

In closing the meeting, Professor Graham Watt summarised current and future Deep End activities:

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 multiprofessional 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. 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.

11. Lobby NES for additional GP training capacity in very deprived areas.

12. 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.

13. Hold a multi-professional Deep End meeting on the challenges of palliative care in very deprived areas.

14. Repeat the formula of the Beardmore meeting on Working with Vulnerable 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.