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.

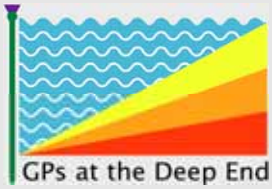
- Key points for the imminent Greater Glasgow Deprivation Interest Group (DIG) include the need for advocacy to influence NHS policy at national and local levels, the need for activities and infrastructure to support the sharing of best practice across the front line of practices service the most deprived 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.

"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 Academic Unit of General Practice & Primary Care at the University of Glasgow.*



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