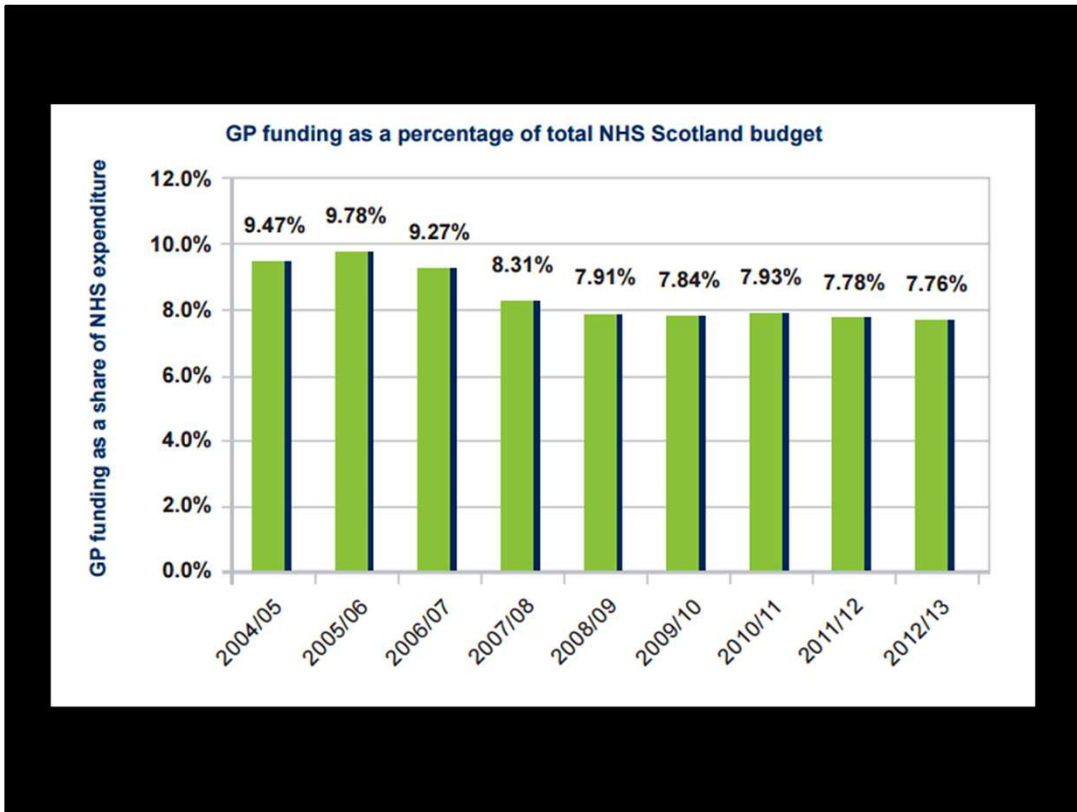


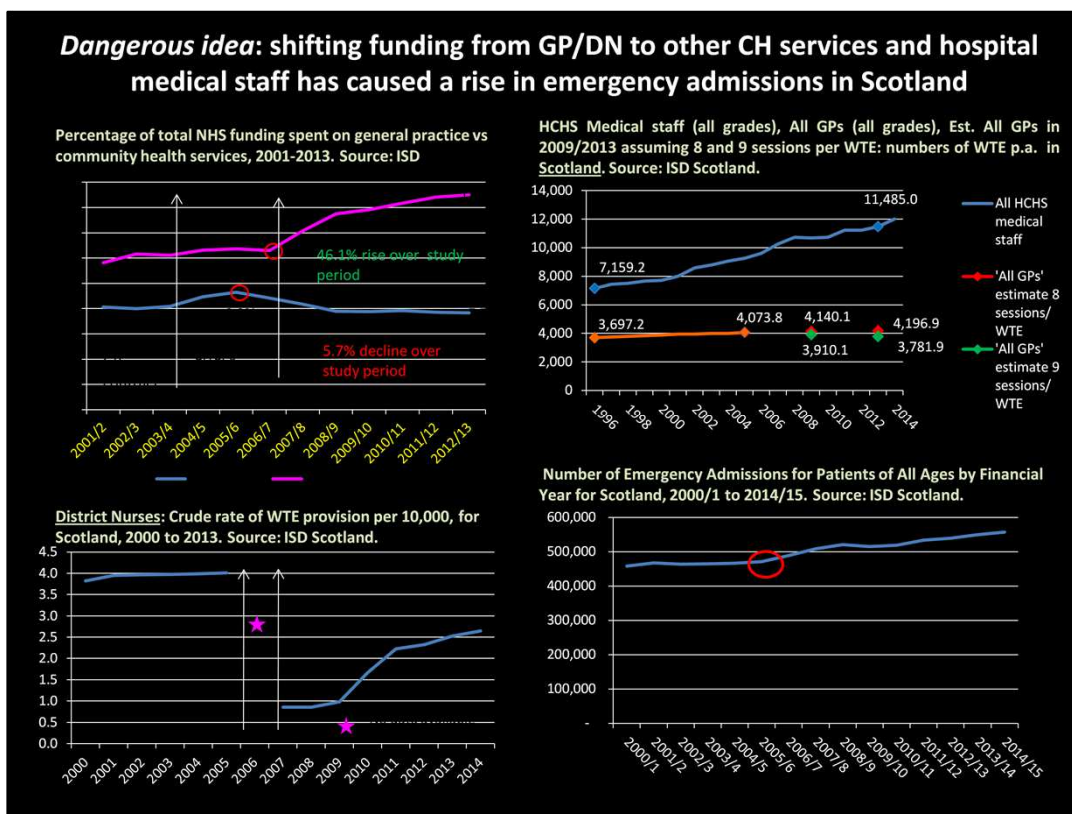
## SLIDE 1

Thank you very much for your invitation. My colleagues are Petra Sambale from Possilpark in Glasgow, Catriona Morton from Craigmillar in Edinburgh, Jim O'Neil from Lightburn, in Glasgow's East End and Alanna MacRae from Greenock. Of the 980 or so general practices in Scotland, they work in the 1<sup>st</sup>, 13<sup>th</sup>, 31<sup>st</sup> and 83<sup>rd</sup> most deprived. We call that the "Deep End", but we don't just want to talk about Deep End issues.



SLIDE 2

Primary care transformation is not new. General practice's share of NHS funding in Scotland has fallen a sixth. It's very important to understand that, and its consequences. General practice has been weakened. That puts the whole system under pressure.



### SLIDE 3

TOP LEFT, while the general practice share of NHS funding (in blue) fell by a sixth in ten years, funding for other community health services (in pink) increased 46%.

TOP RIGHT, while GP numbers (in orange) have largely flat-lined, medical staffing in hospital and community services (in blue) increased 60%.

BOTTOM LEFT, district nursing, our crucial ally, was slashed in the 20-zeroes, then rallied but is still 40% below its previous capacity.

BOTTOM RIGHT, the consequences, since 20-05, an acceleration of emergency hospital admissions, which has not stopped, and is not fully explained by the ageing population.

These slides are from work done by Dr Helene Irvine, Consultant in Public Health and Greater Glasgow and Clyde. There's a summary of her work in one of our handouts. We commend it to you.

The NHS underfunds primary care at its peril, but that it is what it has done.

## THE SECRET OF GATEKEEPING

**THERE IS NO GATE** (at least, to unscheduled care)

**ONLY A GATEWAY** (that patients can go through at any time)

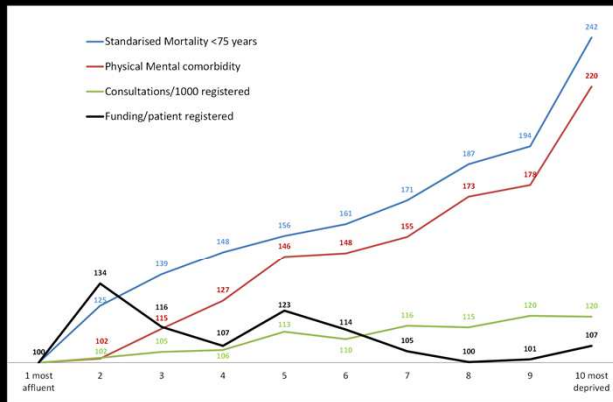


### SLIDE 4

To access unscheduled care - that's out of hours, A&E or an emergency hospital bed, there is no gate, or gatekeeper, only a gateway, that patients can go through at any time.

What stops them going through the gateway? Mainly, the capacity of primary care to address patients' problems, and patient's satisfaction with that care. Reduce that capacity and satisfaction and patients fast track to unscheduled care. Hospitals feel the pressure, but the answer is not to give even more resource to hospitals. That is fanning the flames. We need to reverse the trend, increasing the capacity of general practice and primary care to keep people for longer in the community.

Percentage differences from least deprived decile for mortality, comorbidity, consultations and funding



**“Over 2 million Scots** in the most deprived 40% of the population received **£10 less** GP funding per head per annum **than over 3 million Scots** in the most affluent 60%”

SLIDE 5

While that situation is new, the Inverse Care Law is not. The figure divides the Scottish population into tenths, richest on the left, poorest on the right. Premature mortality in blue and complex multimorbidity in red more than double in prevalence across the spectrum, while general practice funding per patient, in black, is broadly flat. In Scottish general practice we have horizontal equity in terms of access, but not vertical equity in terms of needs-based care. The consequences in the bottom right hand side of the slide include: GP consultations that involve more problems, but are shorter and achieve less. Unmet need accrues. Inequalities in health widen. Because general practice is less able to cope, patients are more likely to use emergency services. This isn't just a feature of the Deep End. On the right hand side of the slide, the 40% most deprived Scots, over 2 million people, received £10 less GP funding per head per annum in 2012 than the 60% most affluent, that's over 3 million people.



## FIRST MINISTER QUESTIONS, 3<sup>RD</sup> DECEMBER 2015



### The First Minister:

I welcome Professor Watt's findings, which we will take fully into account in delivering a new GP contract for 2017 and the accompanying revised allocation formula. It is interesting that Professor Watt's study examined data from 2011-12. I have looked at the recent data for GP payments, for 2014-15, which show that the most deprived practices received, on average, £7.65 more per patient than practices in the most affluent areas received. I hope that that is a sign of progress in the direction that I suspect that Murdo Fraser wants us to take. The resource allocation formula has been in place since 2004 and has undergone some revisions and changes since then. The new GP contract, on which we are in the early stages of negotiation and which will take effect in 2017, gives us a good opportunity to revise the allocation formula to ensure that it reflects the varying needs of GP practices in different local communities. I look forward to having the support of the Parliament as we seek to do that.

See more at:

<http://www.scottish.parliament.uk/parliamentarybusiness/report.aspx?r=10248&i=94327#ScotParlOR>

## SLIDE 6

No official Scottish report on health inequalities has ever mentioned this gross disparity – one of the reasons, perhaps, why we still have the widest health inequalities of any country in western Europe. But following publication of these data last November, both the First Minister and Cabinet Secretary for Health have said in the Scottish parliament that they expect this issue to be addressed via a revised Scottish Allocation Formula within the new 2017 Scottish GP contract. We'll believe it when it happens.

Your task, with respect, following the previous Health and Sport Committee's report on Health Inequalities in 2015, is to hold these Ministerial statements to account

## SCOTTISH PARLIAMENTARY CONSTITUENCIES 2016

1. East Kilbride
2. Moray
3. Aberdeen South/Kincardine North
4. Edinburgh Southern
5. Edinburgh Central
6. Eastwood
7. Angus North & Mearns
8. Aberdeenshire West
9. Western Isles
10. Orkney Islands
11. Shetland Islands
12. Fife North East
13. Skye, Lochaber & Badenoch
14. Midlothian South/Tweeddale/Lauderdale
15. Perthshire North
16. Midlothian & Musselburgh
17. Strathkelvin & Bearsden
18. Angus South
19. East Lothian
20. Dumfriesshire
21. Clydesdale
22. Aberdeenshire East
23. Perthshire & Kinross-shire
24. Edinburgh Western
25. Ettrick, Roxburgh & Berwickshire
26. Banffshire & Buchan Coast
27. Linlithgow
28. Cumbernauld & Kilsyth
29. Almond Valley
30. Inverness & Nairn
31. Falkirk East
32. Caithness, Sutherland & Ross
33. Stirling
34. Aberdeen Central
35. Argyll & Bute
36. Aberdeen Donside
37. Falkirk West
38. Galloway & Dumfries West
39. Fife Mid & Glenrothes
40. Dunfermline
41. Renfrewshire North & West
42. Glasgow Kelvin
43. Ayr
44. Cowdenbeath
45. Edinburgh Northern & Leith
46. Dumbarton
47. Carrick, Cumnock & Doon Valley
48. Clackmannanshire & Dunblane
49. Kilmarnock & Irvine Valley
50. Edinburgh Pentlands
51. Cunninghame North
52. Clydebank & Milngavie
53. Uddingston & Bellshill
54. Renfrewshire South
55. Edinburgh Eastern
56. Hamilton, Larkhall & Stonehouse
57. Kirkcaldy
58. Glasgow Cathcart
59. Airdrie & Shotts
60. Rutherglen
61. Dundee City East
62. Coatbridge & Chryston
63. Dundee City West
64. Paisley
65. Glasgow Southside
66. Motherwell & Wishaw
67. Cunninghame South
68. Glasgow Anniesland
69. Greenock & Inverclyde
70. Glasgow Pollok
71. Glasgow Shettleston
72. Glasgow Maryhill & Springburn
73. Glasgow Provan

### SLIDE 7

Here are the 73 first past the post constituencies in the Scottish parliament, colour coded by party, from most affluent No 1 to most deprived 73.

	<b>MOST AFFLUENT</b>	<b>MIDDLE GROUP</b>	<b>MOST DEPRIVED</b>
<b>Constituencies</b>	<b>24</b>	<b>25</b>	<b>24</b>
<b>Population</b>	<b>1,301,820</b>	<b>1,476,026</b>	<b>1,363,080</b>
<b>Data zones in Most deprived 15%</b>	<b>1.9%</b>	<b>10.5%</b>	<b>32.1%</b>
<b>Male life expectancy</b>	<b>79.0 y</b>	<b>77.2 y</b>	<b>75.1 y</b>
<b>Female life expectancy</b>	<b>82.6 y</b>	<b>81.0 y</b>	<b>79.9 y</b>
<b>Lacking very good or good general health</b>	<b>14.8%</b>	<b>17.5%</b>	<b>21.0%</b>
<b>Limited a lot by long term health condition or disability</b>	<b>7.6%</b>	<b>9.2%</b>	<b>11.9%</b>

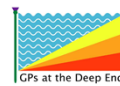
## SLIDE 8

Deprivation is 2% in the most affluent third, 10% in the middle group and 32% in the most deprived; the trend is associated with significant differences in life expectancy, affecting millions of people. They need better general practice, and better representation to obtain it.



## SIX ESSENTIAL COMPONENTS

1. Extra TIME for consultations (INVERSE CARE LAW)
2. Best use of serial ENCOUNTERS (PATIENT STORIES)
3. General practices as the NATURAL HUBS of local health systems (LINKING WITH OTHERS)
4. Better CONNECTIONS across the front line (SHARED LEARNING)
5. Better SUPPORT for the front line (INFRASTRUCTURE)
6. LEADERSHIP at different levels (AT EVERY LEVEL)



What can NHS Scotland do to prevent and reduce health inequalities?  
Proposals from General Practitioners at the Deep End  
March 2013

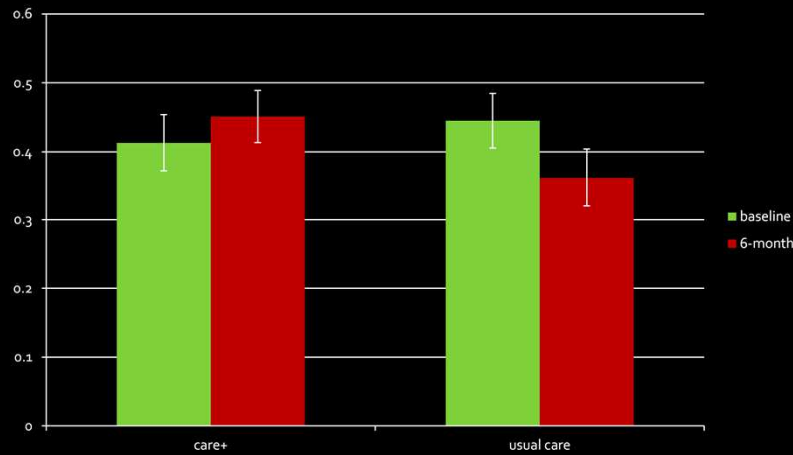
### SLIDE 9

Although most social determinants of health operate outside the health service, the health service is itself a social determinant, according to its success or failure in reducing the severity and slowing the progress of established conditions. In 2013 we produced a six point Deep End Manifesto to do just that.

Extra time for consultations. Better consideration and use of serial encounters (i.e. continuity of care, not having to keep telling your story to a new person and building knowledge and confidence). Developing general practices as the natural hubs of local health systems. Better connections between practices, to share experience, learning, resources and activity in supporting patients. Better support for the front line, from all the various NHS support agencies. Better leadership at every level.

These challenges pervade NHS Scotland, but the Deep End context is different. “Realistic medicine” encourages the worried well to be satisfied with less. Our task is to help the unworried unwell to seek more.

## CARE Plus prevents decline in QOL



**Mercer, S. W. et al. (2016)** The Care Plus study – a whole system intervention to improve quality of life of primary care patients with multimorbidity in areas of high socio-economic deprivation :exploratory cluster randomised controlled trial and cost utility analysis. *BMC Medicine*, 14, 88. (doi:10.1186/s12916-016-0634-2)

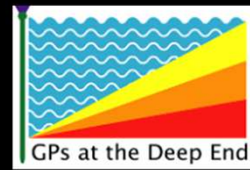
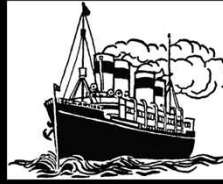
### SLIDE 10

We know from the recently published CARE Plus study, that longer consultations for patients with complex problems in deprived areas are associated with better outcomes after 12 months; the intervention is also cost-effective, not only because patient's health gets better, from green to red on the left, but because patients who didn't get the extra time got worse, on the right.

The right hand side is what's happening now as a result of the Inverse Care Law. The left hand side shows the way ahead.



University  
of Glasgow



## **GP USE OF ADDITIONAL TIME AS PART OF THE GOVAN SHIP PROJECT**

**DEEP END Report 29 : [www.gla.ac.uk/deepend](http://www.gla.ac.uk/deepend)**

### SLIDE 11

The Government-funded Govan SHIP Project (SHIP standing for Social and Health Integration Partnership) is the only primary care transformation project which, among several other things, includes added GP capacity, allowing longer consultations. Deep End Report 29, which we've provided as a handout, describes what the 15 GPs at Govan did with the extra time the project has given them.

## CONTENT AND OUTCOMES OF EXTENDED CONSULTATIONS

Length	
20min	Patient with major depressive symptoms/suicide risk and substance misuse; <b>Outcome</b> : planning of future care and involvement of other organisations.
20 min	Patient with newly diagnosed depression and child protection issues; <b>Outcome</b> : during consultation likely COPD diagnosed referred for spirometry/smoking cessation.
20 min	Pregnant patient – major child protection concerns – background of domestic violence and drug misuse; <b>Outcome</b> : SW contacted and telephone discussion re planned case conference.
30 min	HV to newly diagnosed palliative care patient; <b>Outcome</b> : met with family and discussed management and DS1500.
25 mins	Planned palliative care discussion at home with patient and carer, non-cancer diagnosis; <b>Outcome</b> : clinical expectations discussed to allay fears over management. Linked with secondary care consultant by phone for agreement with treatment plan.
30 mins	Post hospital discharge visit in elderly lady with multiple co morbidities and polypharmacy; <b>Outcome</b> : medication review and link with social services and ACP planning.
30 min	Planned visit to elderly patient and carer with dementia and new diagnosis of advanced malignancy. <b>Outcome</b> : discussion over diagnosis, to some extent prognosis and palliative treatment. Linked into district nursing and palliative care team. ACP planning with carer.
20 min	Child < 5 years frequent attender to surgery with minor self-limiting symptoms. English poor and requires translator. Planned review to discuss support and education of such illness; <b>Outcome</b> : linked in with Health Visitor for further ongoing support which also involves local third sector agencies. Aim to support mother and reduce attendances at general practice.
20 min	Extended consult in surgery for a patient with complex medical and psychosocial needs; <b>Outcome</b> : management plan and education provided.
30 mins	Middle aged patient who has moved to homeless accommodation. Anhedonia, thoughts of self-harm, lack of self-worth and despondent. Little self-care. Patient whom I have known for many years. Family quarrel and patient feeling excluded. <b>Outcome</b> : discussion, DWP benefits arranged, housing officer appointment. Trial anti-depressant and advice in terms of family contact. Review planned for 1 week.
40 mins (including travel time)	Housebound elderly patient, lives alone with carer support. Highly anxious and had prolonged admission for 2+1/2 late 2015. Chest infection and anaemia of uncertain origin; <b>Outcome</b> : reviewed and blood checked. Medication reviewed and amended after discussion. With social support, aim is to pre-empt admission if possible. So far managing in community.

## SLIDE 12

Annex A, shown here in a snapshot, lists the extra cases they saw, their complexity, severity and variety - work requiring clinical generalists to help sort it out. Each long consultation resulted in a new plan, often bringing other colleagues into play, driving integrated care from the bottom up, based on patient's needs.

A 10% increase in GP capacity allows this to happen. It also enables practices to re-focus and to engage wholeheartedly in other developments, such as multidisciplinary team discussions, attending child protection case conferences, working jointly with consultants in A&E.

Govan SHIP is a very positive development. There are other promising Deep End projects, such as the Link Worker programme, but so far they involve only 16 of the 100 Deep End practices. That's transforming only a small part of primary care.

## PRIMARY CARE TRANSFORMATION

Enhanced nursing, pharmacy and administrative support

Expert medical generalists

Improved joint working for integrated care

Improved links to community resources


### SLIDE 13

Primary care transformation is certainly needed : increasing the roles of nurses and pharmacists (not on their own but part of the team); greater administrative support; enhancing the GPs role as expert medical generalist; improving the links between services within communities.

**HUB**

- Contact
- Coverage
- Continuity
- Comprehensive
- Coordinated
- Flexibility
- Relationships
- Trust
- Leadership


**INVENTING THE WHEEL**



**SPOKES + RIMS**

- Keep Well
- Child Health
- Elderly
- Mental Health
- Addictions
- Community Care
- Secondary Care
- Voluntary sector
- Local Communities

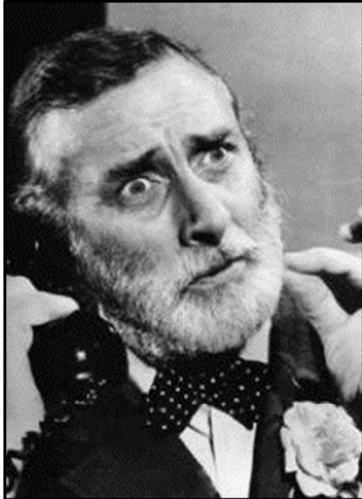
**INTEGRATED CARE DEPENDS ON MULTIPLE RELATIONSHIPS**



SLIDE 14

There is also a need for better connections between the essential features of general practice (that's contact, coverage, continuity, flexibility, long term relationships and trust) and other services which need to be near at hand. Hubs don't work unless connected by spokes to the rest of the wheel. In primary care, the wheels that will transport us into the future depend on multiple relationships.





I'VE JUST INVENTED A MACHINE THAT DOES THE WORK OF TWO MEN.

UNFORTUNATELY, IT TAKES THREE MEN TO WORK IT

**SPIKE MILLIGAN**

## SLIDE 15

Spike Milligan described the invention of a machine that does the work of two men. Unfortunately, it took three men to work it. The NHS in a nutshell.



**TOO MANY HUBS  
INCREASES THE TREATMENT BURDEN**

## SLIDE 16

There are too many parts of the NHS that only do a particular thing. They have referral criteria, waiting lists to control access, protocols to deliver care, discharge when they are done. All this may be done well, but leaves lots for general practice to do, with patients who don't fit the criteria, aren't good at accessing services, who are not made better and who are discharged back to primary care.

Mental health is an example. The commonest co-morbidity in deprived areas is a mental health problem. Mental health professionals and the new Mental Health Strategy have a role to play, but this shouldn't be exaggerated. When mental health problems co-exist with other problems, the majority of patients need generalist rather than specialist care.

## THE TREATMENT BURDEN

**Patients and caregivers are often put under enormous demands by health care systems**

**Frances Mair, Carl May**

**BMJ 2014;349:g6680 doi: 10.1136/bmj.g6680 (10<sup>th</sup> November 2014)**

### SLIDE 17

The proliferation of such services can make life difficult for patients, especially patients with multiple conditions, which is becoming the norm. Too often the NHS increases the treatment burden - that is the work that patients have to do to live with a condition, or several conditions.

## **THE COMPETING NARRATIVE OF GENERAL PRACTICE**

**Unconditional personalised continuity of care for all patients**

**whatever problem or problems they have**

**delivered by a small team of generalists**

**who know each other well**

### SLIDE 18

This proliferation of services, as described by Helene Irvine, is unaffordable and unsustainable. We need to imagine machines that do the work of two men but require only one person to work them. That means small local teams of generalist doctors and nurses, who know each other and their patients well, providing unconditional, personalised, continuity of care for all patients, whatever condition or conditions they may have. That is the competing narrative of general practice, in Scotland as a whole, but especially in its most deprived third.