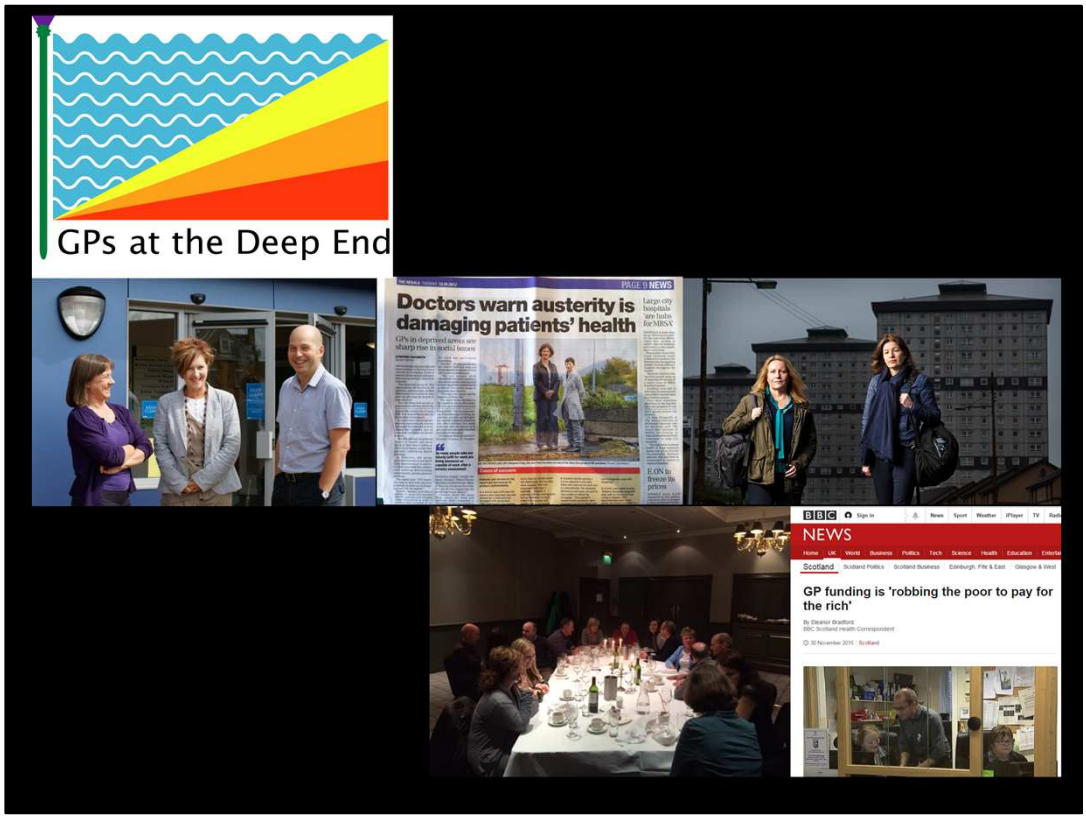
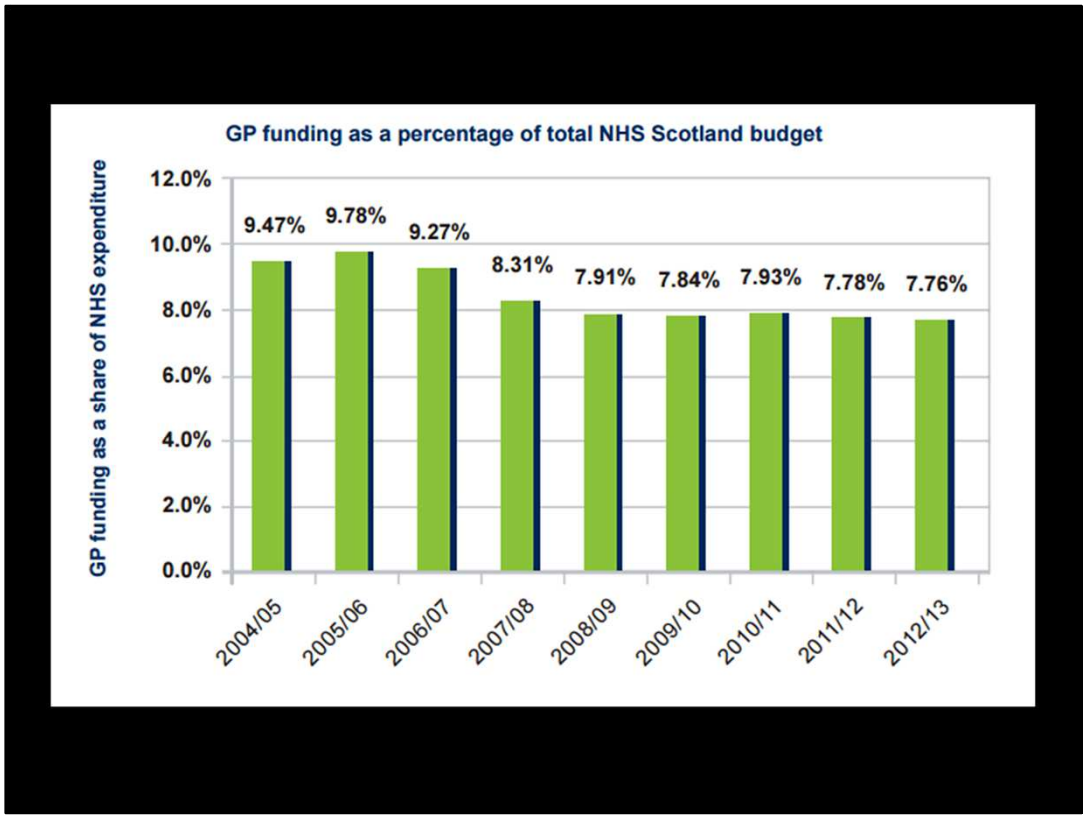


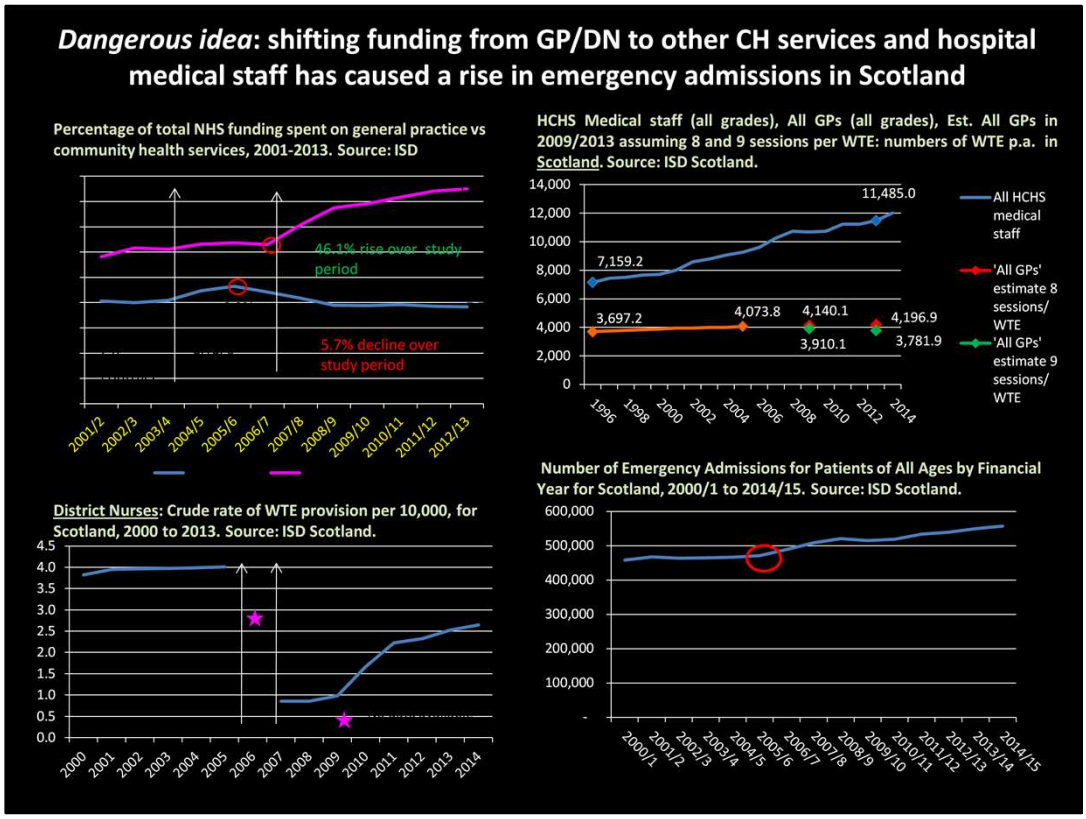
SLIDE 1

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 1st, 13th, 31st and 83rd 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.

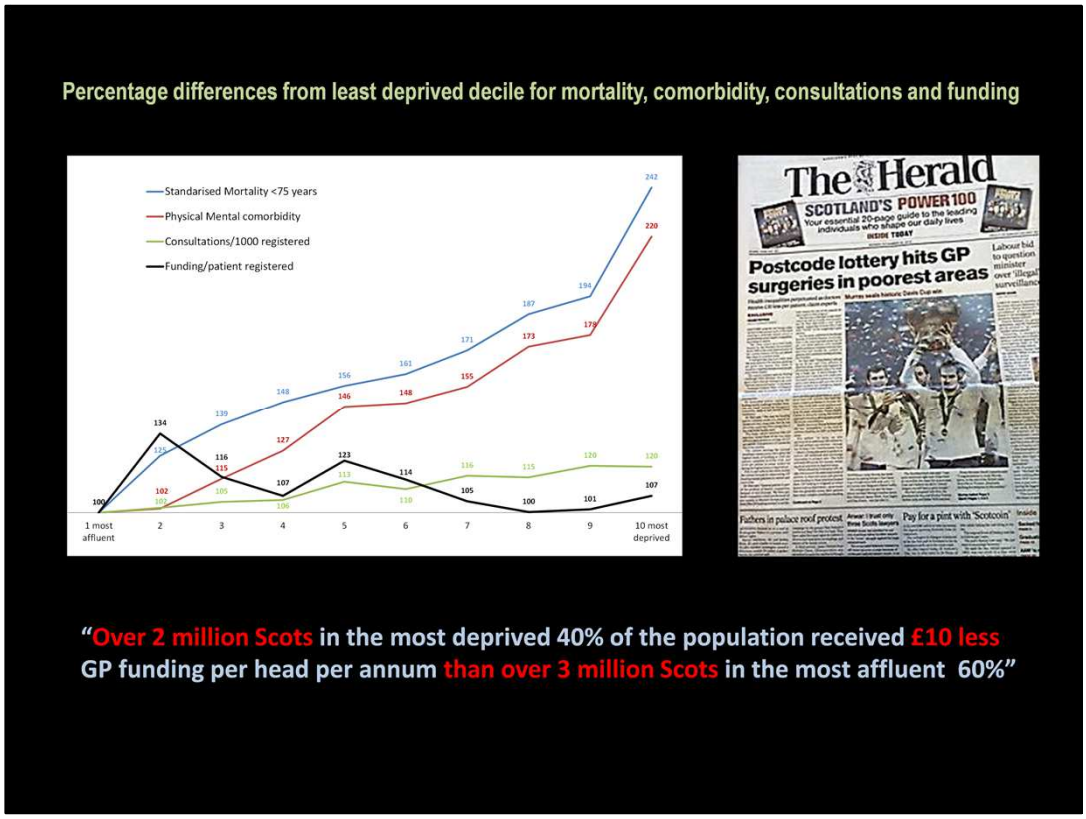
BOTTOM RIGHT, the consequences, since 20-05, an acceleration of emergency hospital admissions, which has not stopped, and is not fully explained by the ageing population.

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.

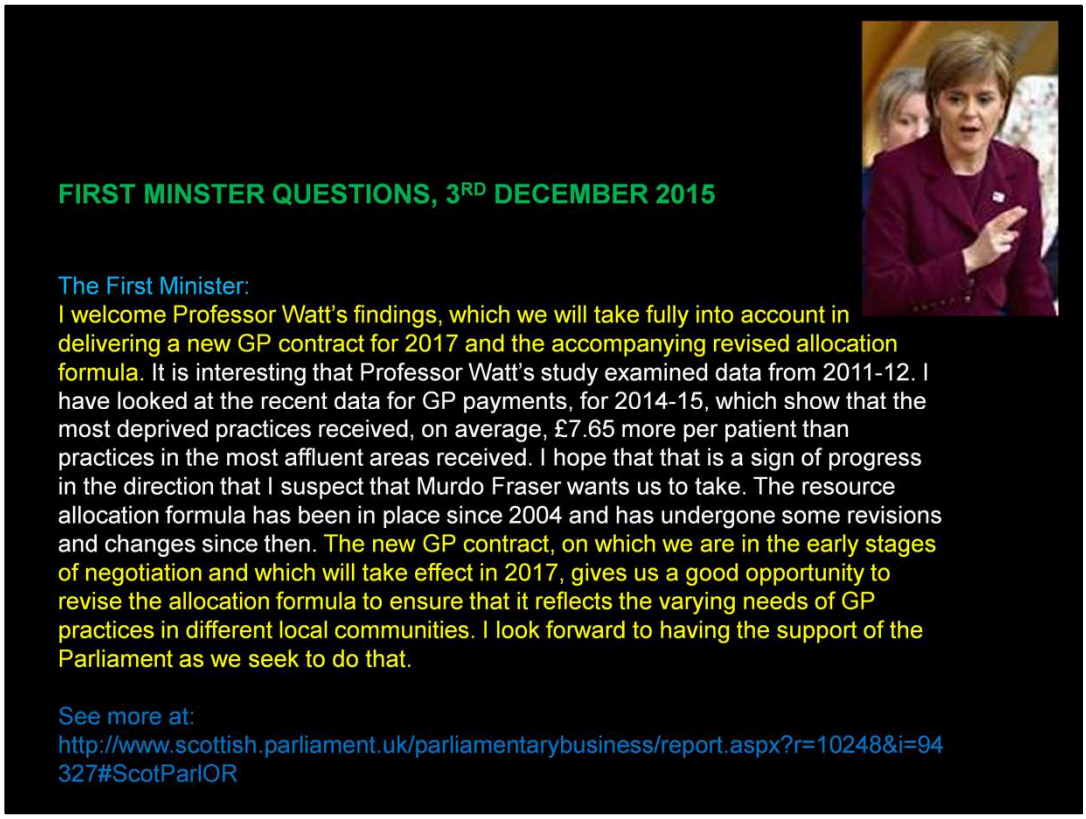
SLIDE 4

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.



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.



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 heath 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

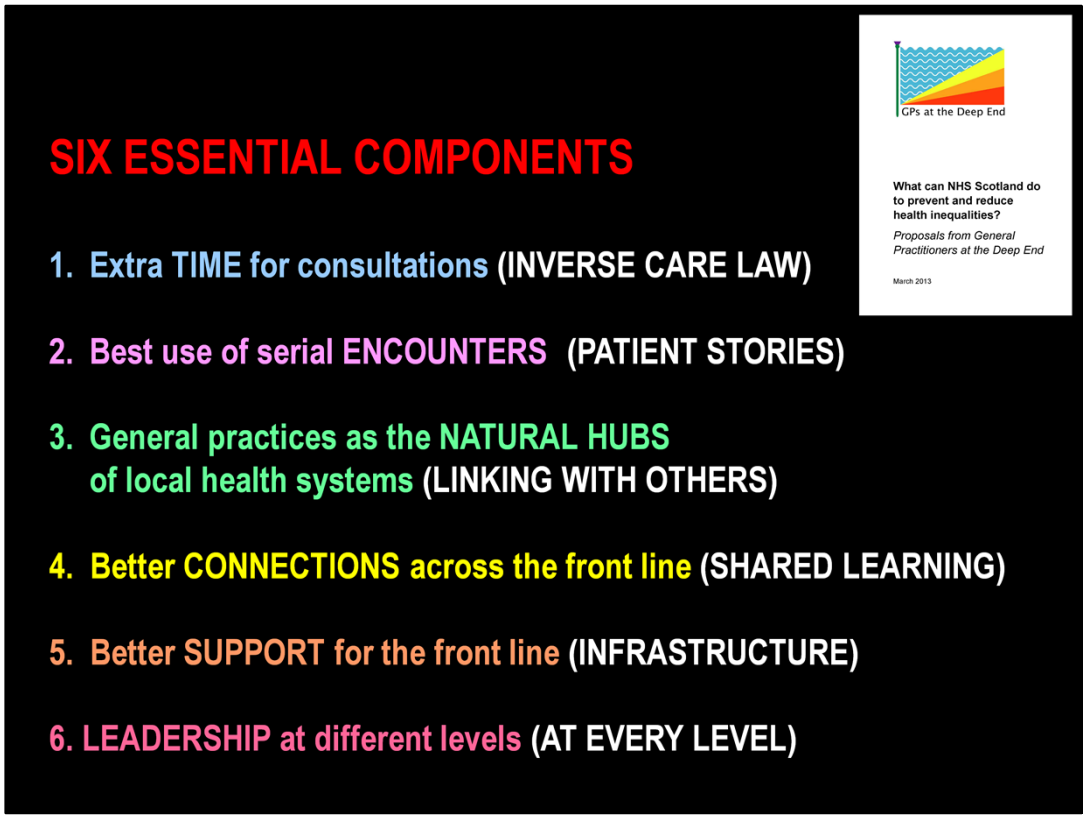
SLIDE 7

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.

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

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.

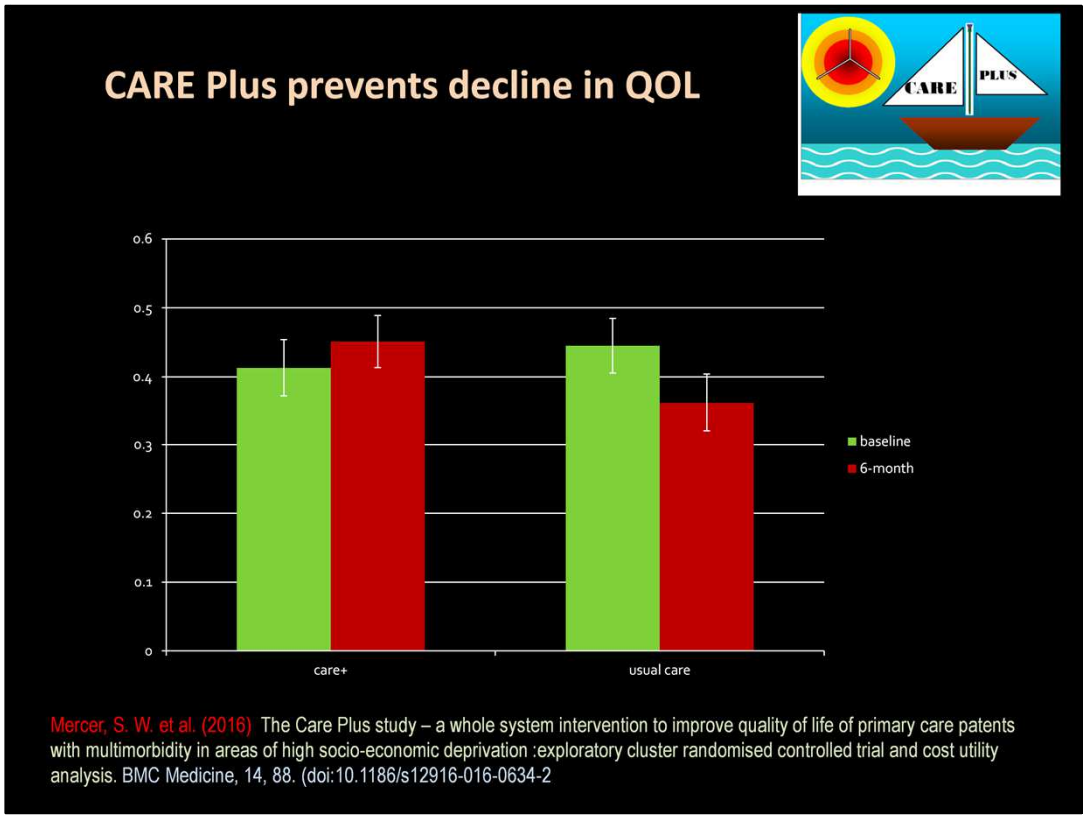


SLIDE 9

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.

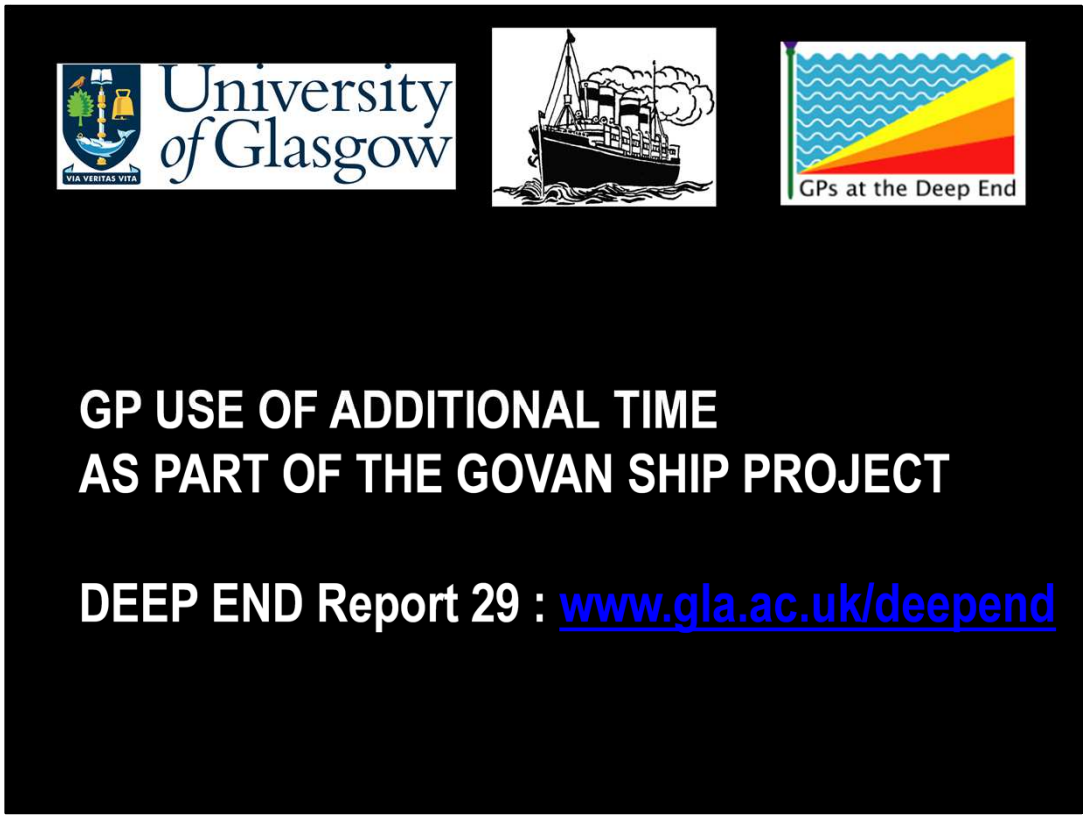
Extra time for consultations. Better consideration and use of serial encounters (i.e. continuity of care, not having to keep telling your story to a new person and building knowledge and confidence). Developing general practices as the natural hubs of local health systems. Better connections between 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.



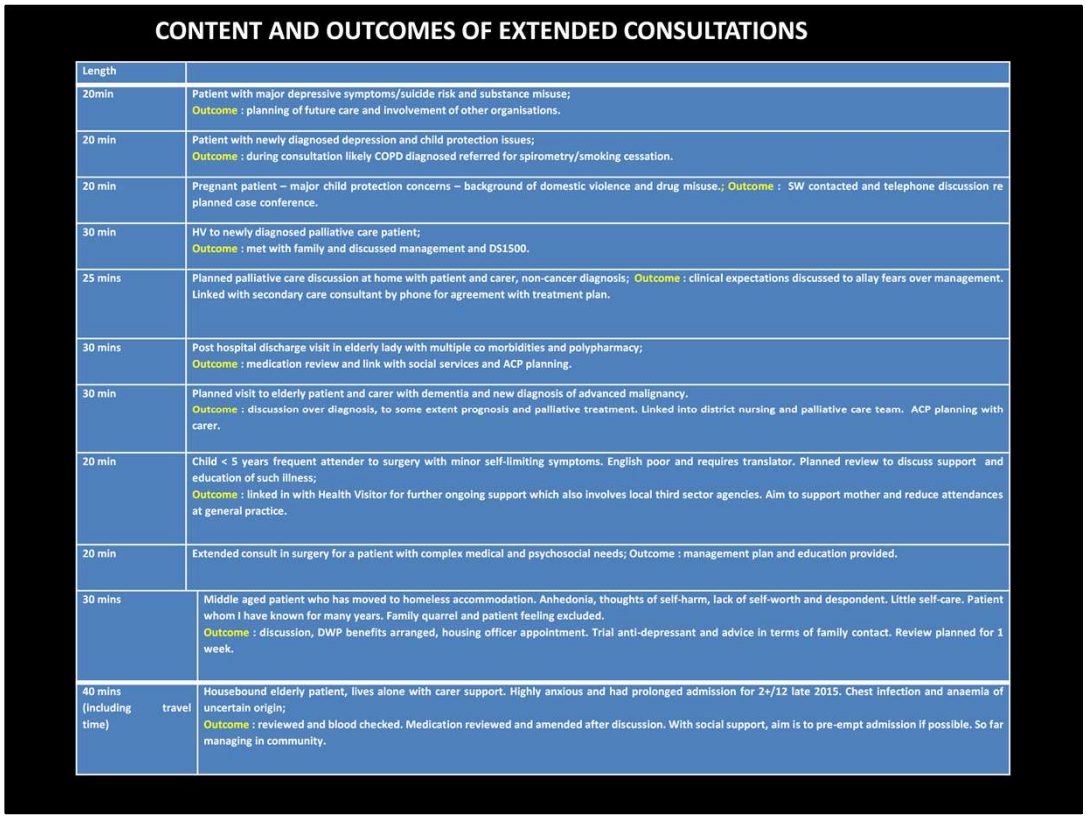
SLIDE 10

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.



SLIDE 11

The Government-funded Govan SHIP Project (SHIP standing for Social and Heath 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.

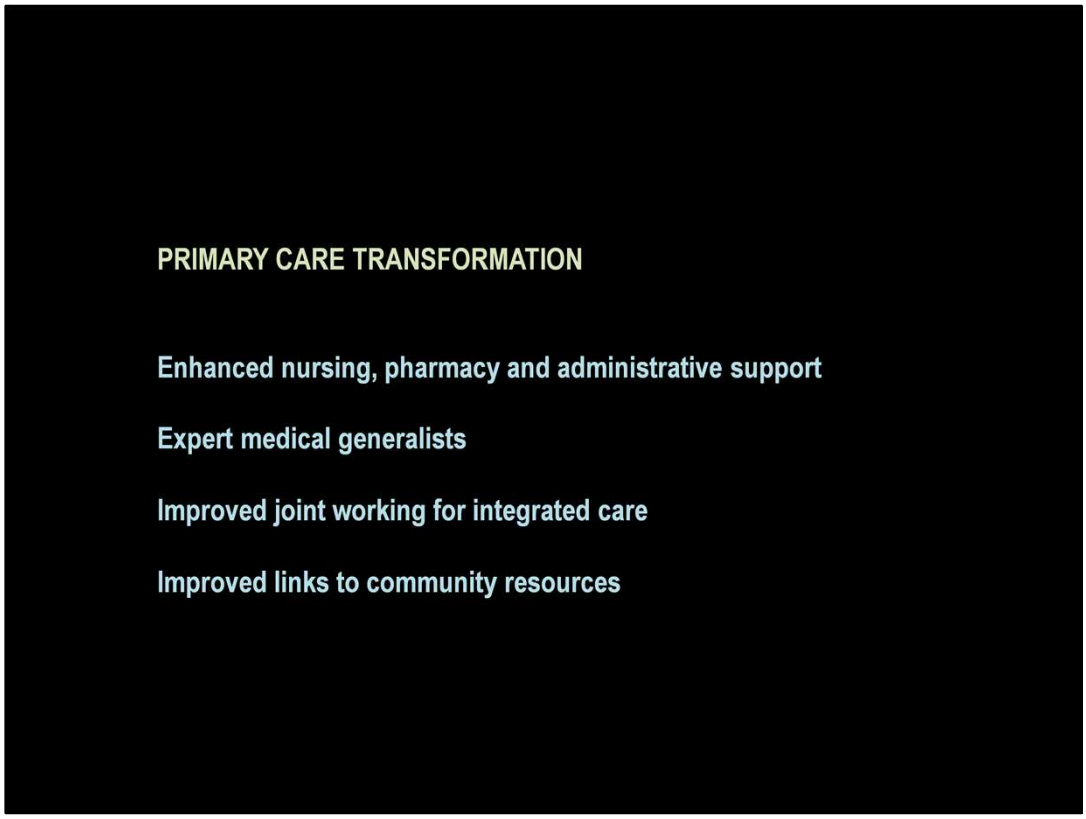


SLIDE 12

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.

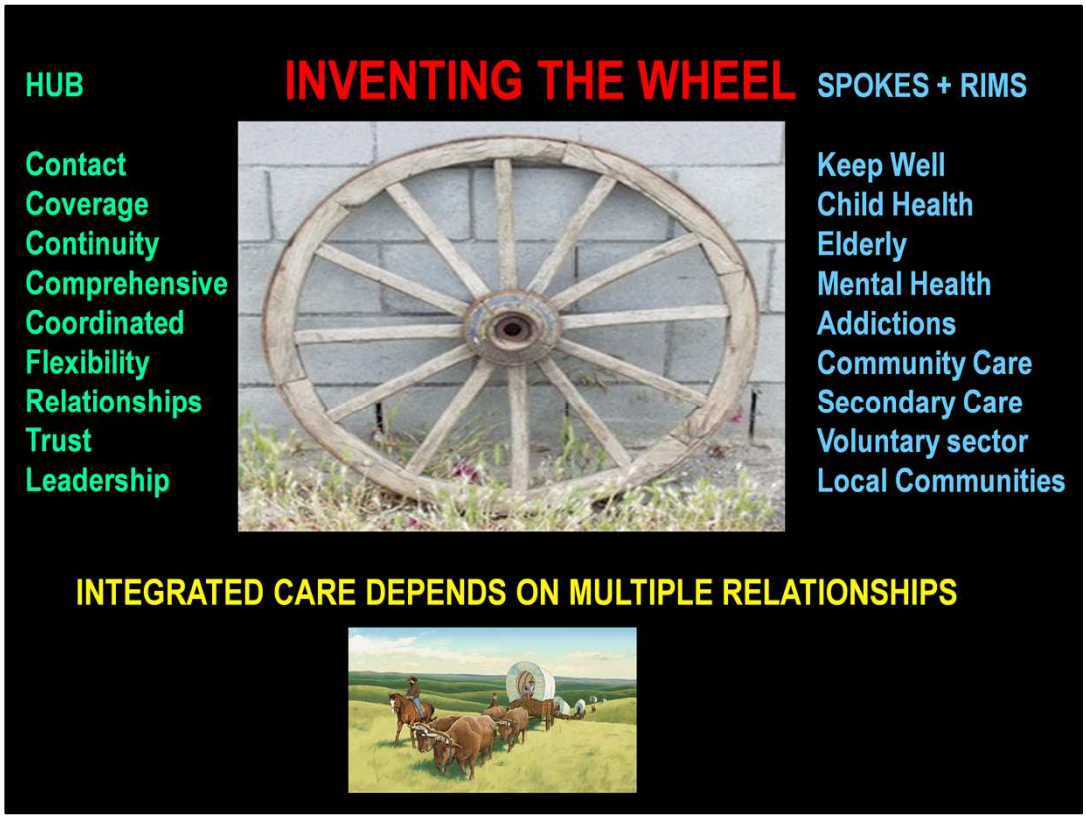
A 10% increase in GP capacity allows this to happen. It also enables practices to re-focus and to engage wholeheartedly in other developments, such as multidisciplinary team discussions, attending child protection case conferences, working jointly with consultants in A&E.

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.



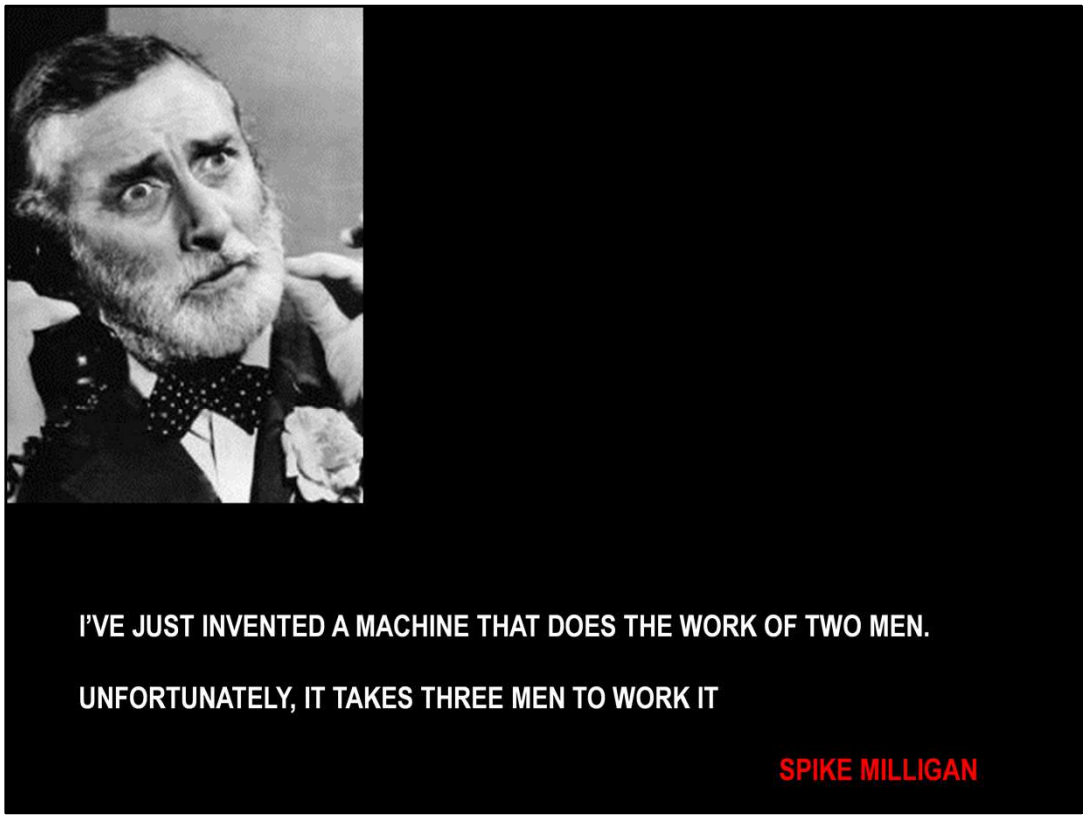
SLIDE 13

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.



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.



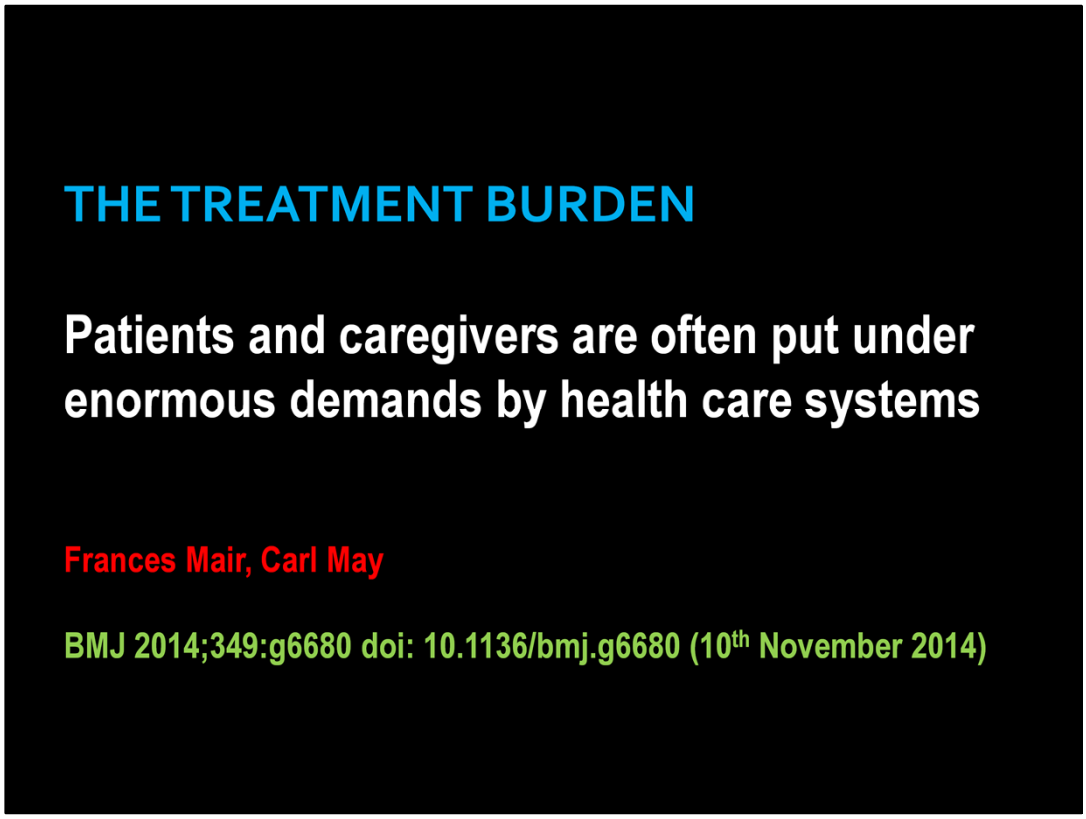
SLIDE 15

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.

SLIDE 16

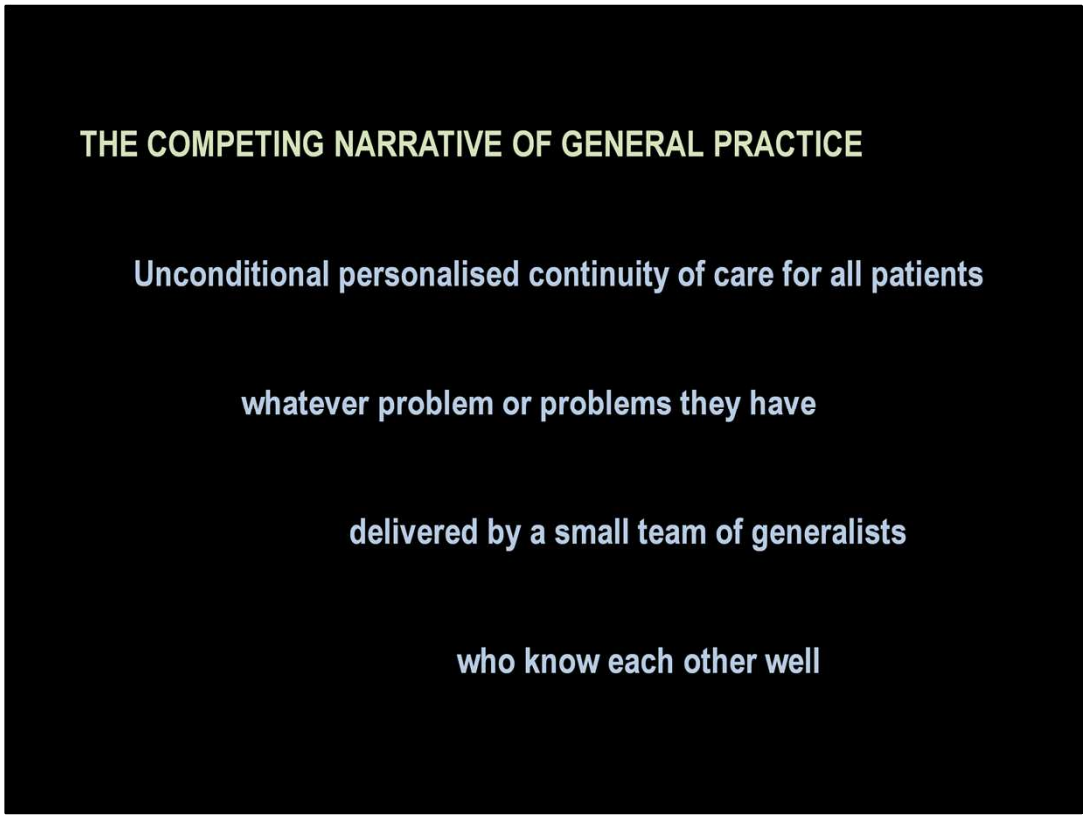
There are too many parts of the NHS that only do a particular thing. They have referral criteria, waiting lists to control access, protocols to deliver care, discharge when they are done. All this may be done well, but leaves lots for general practice to do, with patients who don't fit the criteria,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



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.



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.