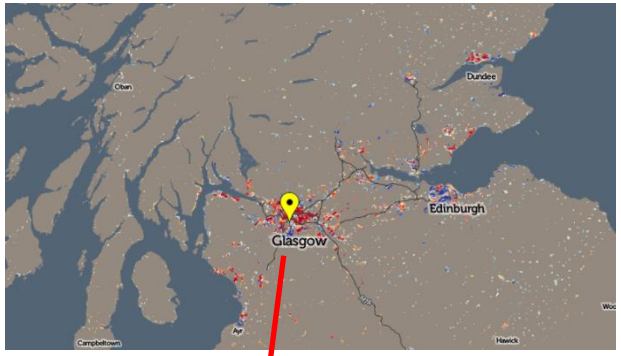
GPs at the Deep End: beyond the inverse care law

Dr David Blane,
Academic GP, University of Glasgow
Member of Deep End GP group and Academic Co-ordinator for Deep End GP Pioneer Scheme
@dnblane

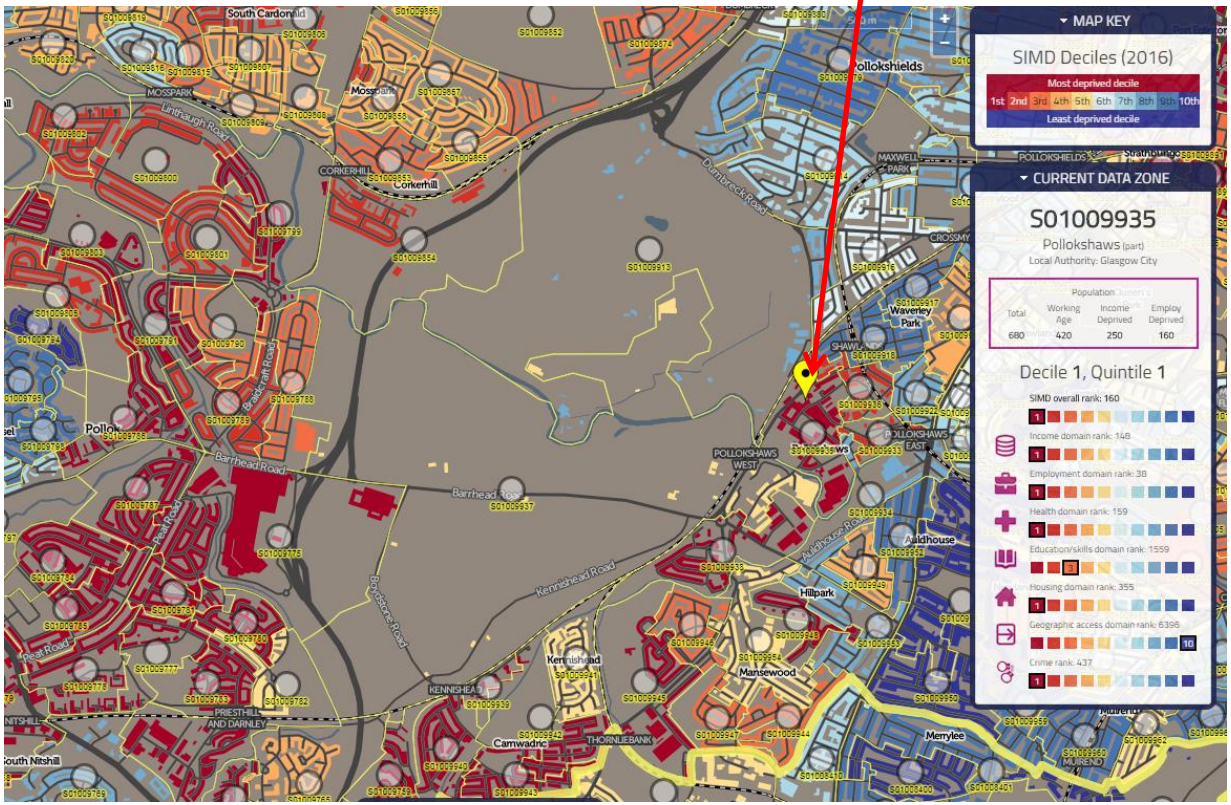
Declaration of interest



- Not a sociologist
- White Scottish, male
- ‘Deep End’ GP

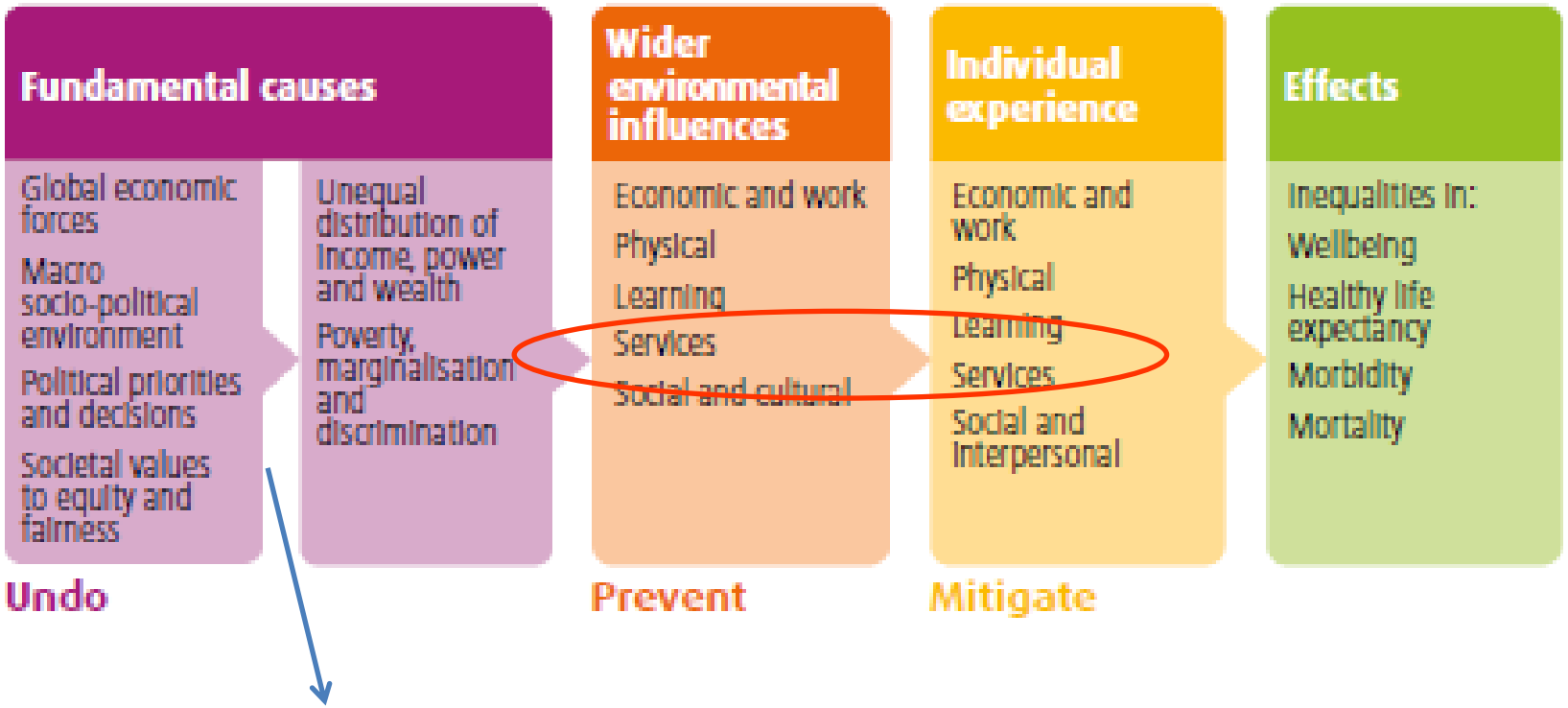
and…

sleep deprived!



Overview

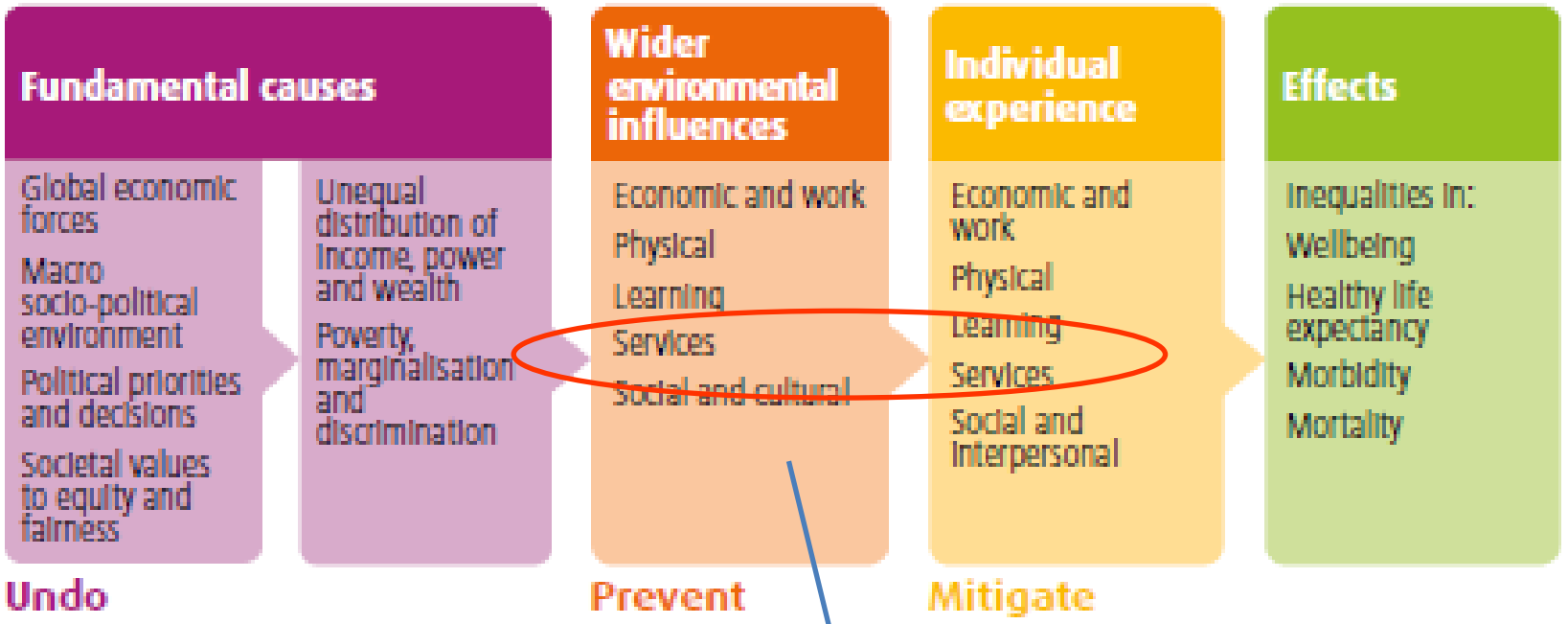
- The inverse care law
- Realities of ‘Deep End’ general practice
- Who are ‘GPs at the Deep End’ and what have they done?
- Where do we go from here?
  - Medical education (e.g. widening access)
  - Postgraduate training (e.g. structural competency)
  - Scope and discretion (e.g. community engagement and advocacy; new GP contract…)



Key actions

- Introduce a minimum income for healthy living.
- Ensure the welfare system provides sufficient income for healthy living and reduces stigma for recipients through universal provision in proportion to need (proportionate universalism).
- A more progressive individual and corporate taxation.
- The creation of a vibrant democracy, a greater and more equitable participation in elections and local public service decision-making.
- Active labour market policies (e.g. hiring subsidies/self-employment incentives, apprenticeship schemes) and holistic support (e.g. subsidised childcare, workplace adjustments for those with health problems) to create good jobs and help people get and sustain work.

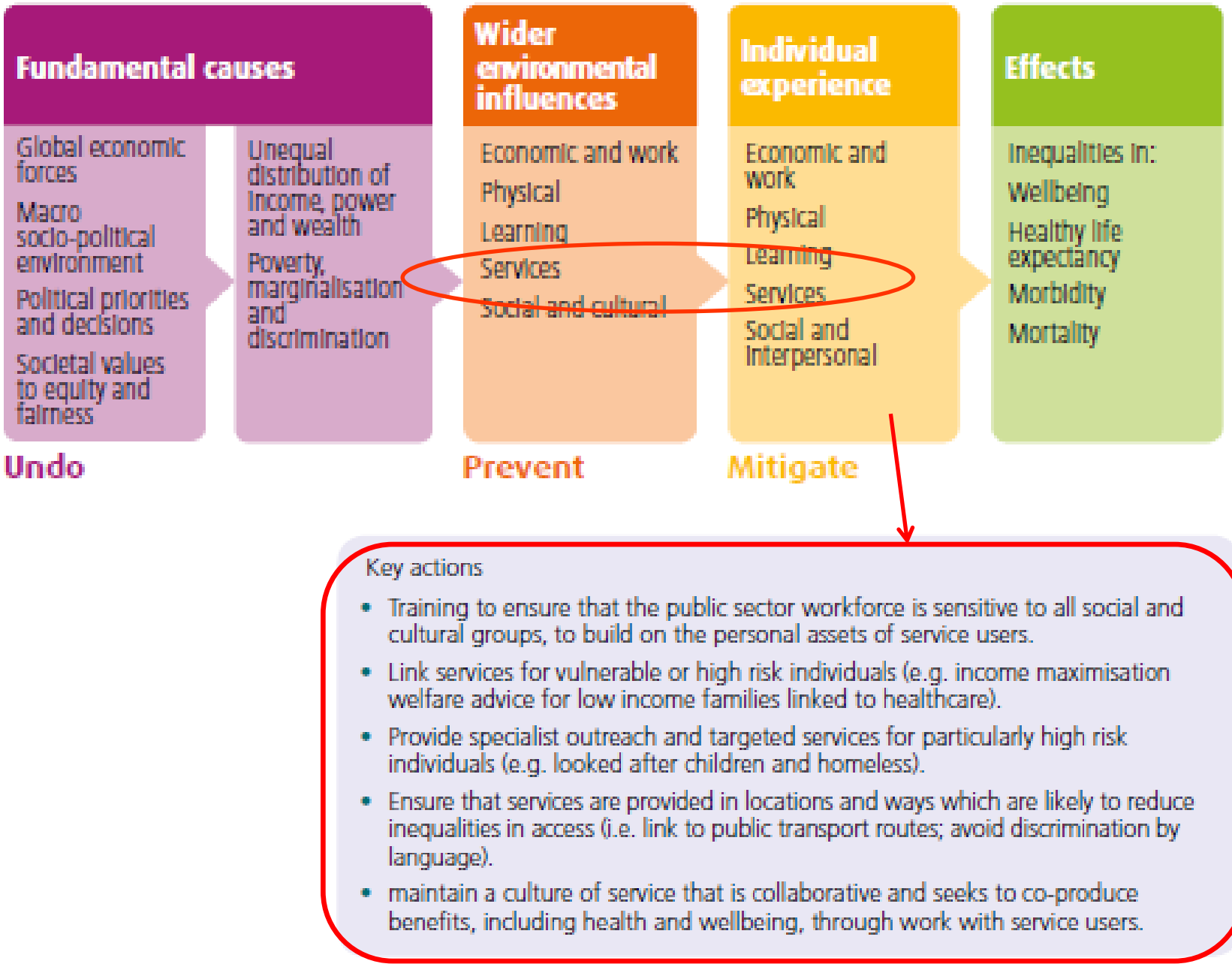
NHS Health Scotland (2016). Health inequalities: What are they? How do we reduce them?
http://www.healthscotland.com/documents/25780.aspx



Key actions

- Ensure local service availability and high quality green and open spaces, including space for play.
- Drink-driving regulations; lower speed limits.
- Raise the price of harmful commodities like tobacco and alcohol through taxation and further restrict unhealthy food and alcohol advertising.
- Protection from adverse work conditions (greater job flexibility, enhanced job control, support for those returning to work and to enhance job retention).
- Provision of high quality early childhood education and adult learning.

NHS Health Scotland (2016). Health inequalities: What are they? How do we reduce them?
http://www.healthscotland.com/documents/25780.aspx



NHS Health Scotland (2016). Health inequalities: What are they? How do we reduce them?
http://www.healthscotland.com/documents/25780.aspx

The impact of general practice

NOT ONLY

Evidence-based medicine (QOF, SIGN)

BUT ALSO

Unconditional, personalised, continuity of care, provided for all patients, whatever problems they present.

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Inverse care law

*"The availability of good medical care tends to vary inversely with the **need for it** in the population served"*

*"This inverse care law operates more completely where medical care is **most exposed to market forces**, and less so where such exposure is reduced.*

*The market distribution of medical care is a **primitive and historically outdated social form**, and any return to it would further exaggerate the maldistribution of medical resources."*

Tudor Hart, J. (1971). THE INVERSE CARE LAW. The Lancet, 297(7696): 405-412

Inverse care law

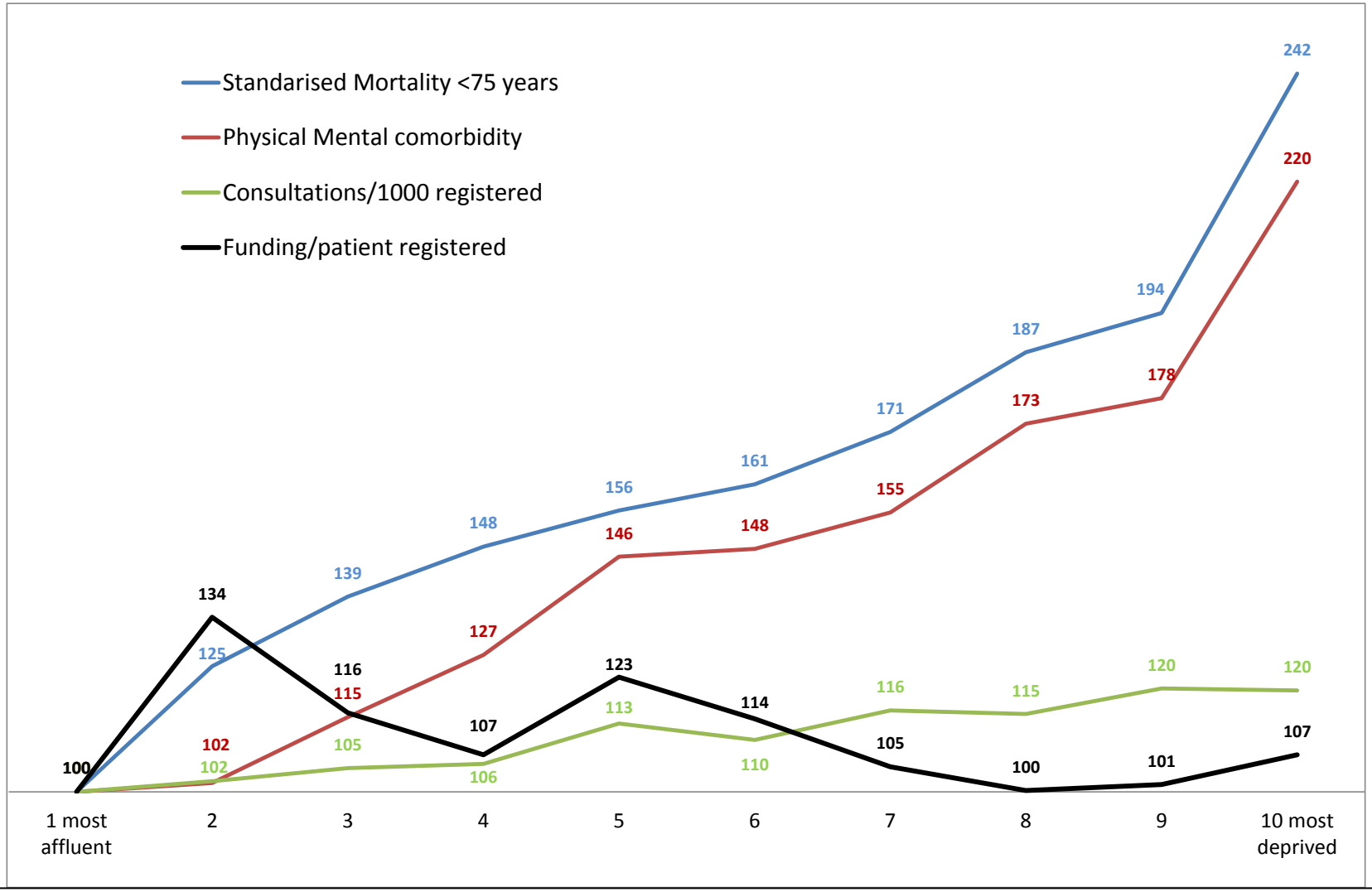
*"The availability of good medical care tends to vary inversely with the **need for it** in the population served"*

Not the difference between good and bad care, but between what general practices *can* do and what they *could* do with resources based on need.

The inverse care law is a policy of the NHS which restricts care in relation to need.

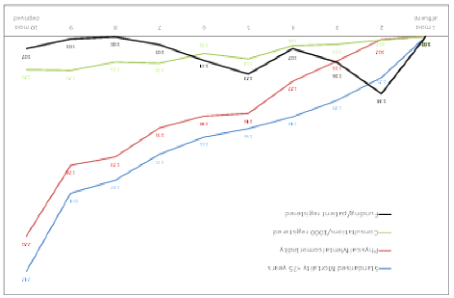
Tudor Hart, J. (1971). THE INVERSE CARE LAW. The Lancet, 297(7696): 405-412

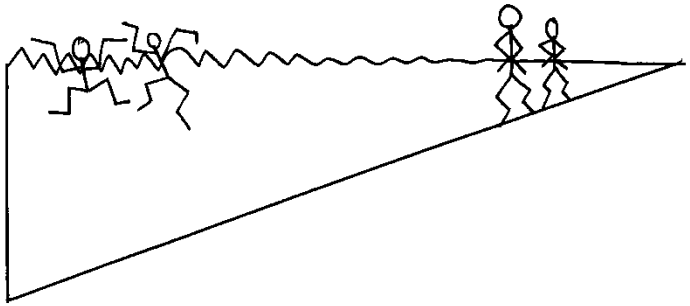
Inverse care law today



McLean G, Guthrie B, Mercer SW, Watt GC. ***General practice funding underpins the persistence of the inverse care law: cross-sectional study in Scotland?*** BJGP 2015; 65(641): 799-805.

GENERAL PRACTITIONERS AT THE DEEP END





GPs at the Deep End

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‘Deep End’ context

ISSUES AFFECTING DEEP END COMMUNITIES

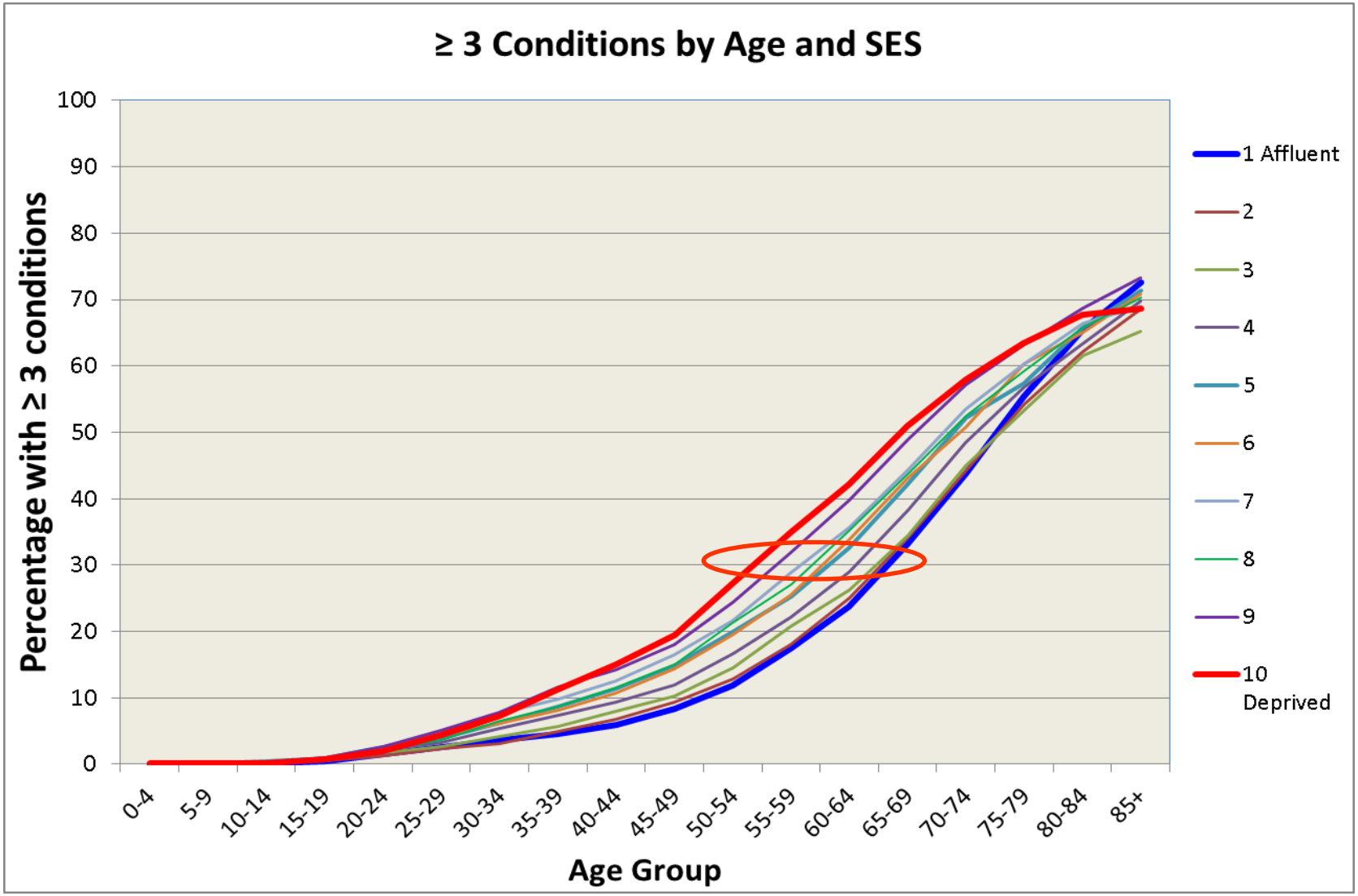
- Unemployment
- Benefits sanctions
- Cuts to services
- Drugs and alcohol
- Child protection
- Asylum seekers
- Vulnerable adults
- Bereavement

KEY POINTS ABOUT DEEP END ENCOUNTERS

- Multiple morbidity and social complexity
- Shortage of time
- Reduced expectations
- Lower enablement
- Health literacy
- Practitioner stress
- Weak interfaces

Mercer SW, Watt GC. ***Clinical primary care encounters in deprived and affluent areas of Scotland*** Annals of Family Medicine 2007; 5: 503-510.

Context (2) – 'premature multimorbidity'



Barnett et al. (2012) ***Epidemiology of multi-morbidity and implications for health care, research, and medical education: a cross sectional study***. Lancet. http://www.ncbi.nlm.nih.gov/pubmed/22579043

WHERE ARE THE 'MOST DEPRIVED' POPULATIONS ?

BLANKET DEPRIVATION

50% are registered with the 100 "most deprived" practice populations
(from 50-90% of patients in the most deprived 15% of postcodes)

POCKET DEPRIVATION

50% are registered with 700 other practices in Scotland
(less than 50% in the most deprived 15% of postcodes)

HIDDEN DEPRIVATION

200 practices have no patients in the most deprived 15% of postcodes

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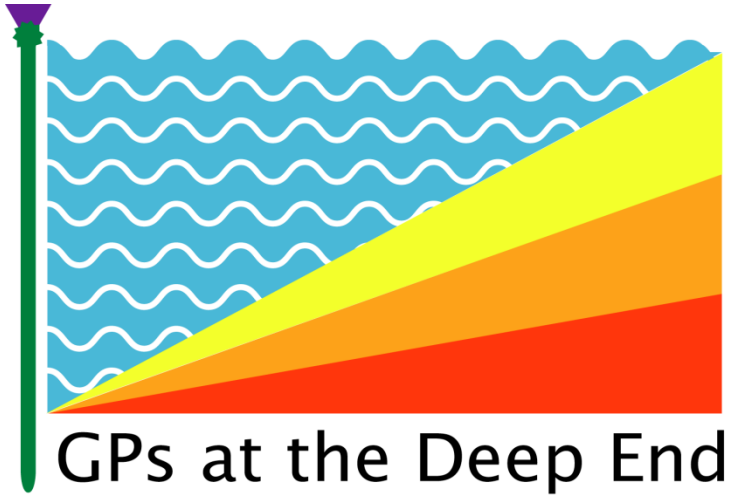
Deep End achievements?



2009 – first time that 'Deep End' GPs had been convened and consulted in the history of the NHS…

- Identity
- Engagement
- Profile
- Voice

Phase 1	Meetings
Phase 2	Publications, Presentations and Profile
Phase 3	Opportunities, Influence, Resources
Phase 4	Implementation, Lobbying

Projects LINK Workers, Care Plus, Bridge, Benefits, Alcohol, Housing, Pioneer Scheme

3rd National Meeting, 2016
Horizon scanning; Meeting with Young Practitioners, 2015

REPORT 20 : Deep End Proposals – engagement with Government
What can NHS Scotland do to prevent and reduce inequalities in health?

Slide adapted with permission from Prof Graham Watt

4 Areas of activity

GPs at the Deep End

1) **Evidence / Experience**

2) **Advocacy**

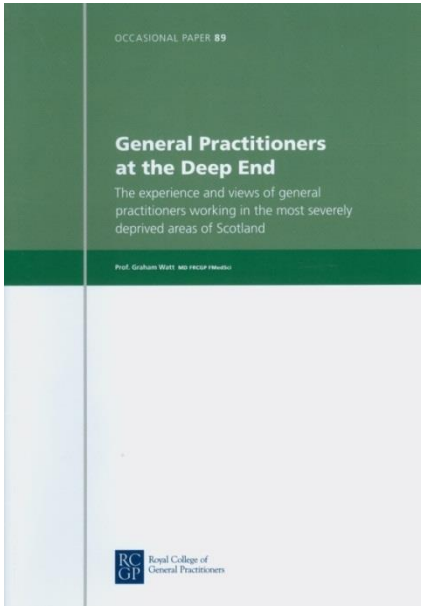
3) **Service development**

4) **Professional development**

1) EVIDENCE

1. First meeting at Erskine
2. Needs, demands and resources
3. Vulnerable families
4. Keep Well and ASSIGN
5. Single-handed practice
6. Patient encounters
7. GP training
8. Social prescribing
9. Learning Journey
10. Care of the elderly
11. Alcohol problems in young adults
12. Caring for vulnerable children and families
13. The Access Toolkit : views of Deep End GPs
14. Reviewing progress in 2010 and plans for 2011
15. Palliative care in the Deep End
16. Austerity Report
17. Detecting cancer early
18. Integrated care
19. Access to specialists
20. What can NHS Scotland do to prevent and reduce heath inequalities
21. GP experience of welfare reform in very deprived areas
22. Mental health issues in the Deep End
23. The contribution of general practice to improving the health of vulnerable children and families
24. What are the CPD needs of GPs working in Deep End practices?
25. Strengthening primary care partnership responses to the welfare reforms
26. Generalist and specialist views of mental health issues in very deprived areas
27. Improving partnership working between general practices and financial advice services in Glasgow: one year on

GPs at the Deep End



www.gla.ac.uk/deepend

2) ADVOCACY

THE HERALD TUESDAY 15.05.2012 PAGE 9 NEWS

Doctors warn austerity is damaging patients' health

GPs in deprived areas see sharp rise in social issues

STEPHEN NAYSMITH
SOCIETY EDITOR

GPs working in the most deprived communities in Scotland have warned of increasing levels of mental and physical health problems among patients affected by austerity.

The Deep End group of GPs, representing 360 doctors in 100 practices, said job losses, welfare reform and cuts to social services were all affecting the health of their patients.

The 100 Deep End group of general practices that serves the most socio-economically deprived areas of the country was set up in 2009. It is backed financially by the Scottish Government.

In a new report, the group says austerity measures are causing increased distress and poverty among their patients, and an increased workload for family doctors.

The GPs add that the growing impact of benefit cuts mean much of their time is taken up with social issues rather than patients' underlying health problems.

In February, the group surveyed members to ask about their experiences of austerity. Doctors responded that patients were suffering deteriorating mental health, and also physical problems.

The report says: "GPs report less time to deal with physical problems, as these are no longer a priority for the patient."

Benefit changes were also a concern for many GPs, because they felt patients were wrongly being declared fit to work in medical tests on behalf of the for work was particularly frustrating.

She said: "So may people who are clearly unfit for work are being assessed as capable of work after a cursory assessment.

"We see people with uncontrolled chronic conditions, who are physically quite disabled or have significant mental health problems. The system seems to maximise their distress.

"The majority appeal and the majority of them win."

The report draws attention to the impact of cuts in other public services, such as education, social work and addiction support. Dr Craig added: "The minimum pricing of alcohol is a great thing, but addiction services are falling by the wayside. Austerity measures also affect children, but social work only have the resources to get involved in the most disturbed and difficult situations."

Dr Graham Watt, professor of General Practice at Glasgow

> **So many people who are clearly unfit for work are being assessed as capable of work after a cursory assessment**

University, helped compile the report. He said: "These GPs are absolutely on the front line. Many of them are frustrated that they can see all this happening but people don't know about it."

Aberdeen South MP Anne Begg chairs the work and pensions select committee at Westminster, and has written to

ON THE FRONTLINE: GPs Margaret Craig, left, and Petra Sambale are part of the Deep End group of GP practices. Picture: Colin Mearns

Cases of concern

Patients and doctors in the report are anonymous to protect confidentiality.

- A doctor saw a 40-year-old woman who had been sexually abused as a child and had struggled with alcoholism. "She was found to be capable

worry that her mental health will deteriorate. Her benefits were stopped. She was diagnosed with type 2 diabetes ... instead of working with her setting goals for her diabetes I wrote a letter for an appeal and referred her to the benefit

- Another reports seeing a former labourer in his early fifties who was out of work due to osteoarthritis. His disability allowance had been cut and he was unable to afford his mortgage. "This patient's mental health problems have escalated and he is being seen

psychologically cope with retraining."

- A third case reads simply: "Eastern European pregnant lady with no money or food. Living in squalor with approximately eight other adults. No money available or

Large city hospitals 'are hubs for MRSA'

HOSPITALS in large cities act as "breeding grounds" for the superbug MRSA, which then spreads to smaller regional hospitals and health centres, according to a new study.

Researchers from Edinburgh University found evidence that shows for the first time how the superbug spreads between different hospitals throughout the country.

The study involved looking at the genetic make-up of more than 80 variants of a major clone of MRSA found in hospitals.

Scientists were able to determine the entire genetic code of MRSA bacteria taken from infected patients.

They then identified mutations in the bug that led to the emergence of new MRSA variants and traced their spread around the country.

Dr Ross Fitzgerald, of The Roslin Institute at Edinburgh University, who led the study, said: "We found that variants of MRSA circulating in regional hospitals probably originated in large city hospitals.

"The high levels of patient traffic in large hospitals means they act as a hub for transmission between patients, who may then be transferred or treated in regional hospitals."

E.ON to freeze its prices

ENERGY giant E.ON reassured its five million customers after it pledged to keep residential energy

Daily Record AND SUNDAY MAIL

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News ▸ Politics ▸ Con-Dem cuts

By Chris Clements | 16 Nov 2013 00:01

Welfare cuts could see further 60,000 Scots kids being dragged into poverty, warn doctors

A SCATHING report from the Deep End Steering Group and authorised by 360 GPs in deprived areas says the bed tax and work capability assessments are damaging the health and lives of the country's most vulnerable people.

Tweet 122 Like 406 Send

DEEP END REPORTS 16, 21, 25 and 27

3) SERVICE DEVELOPMENT

Patients need referral services which are:

- **Local**
- **Quick**
- **Familiar**

Attached workers who will work flexibly and quickly according to the needs of patients and practices

“your problem is our problem”

3) SERVICE DEVELOPMENT

GOVAN SOCIAL AND HEALTH INTEGRATION PARTNERSHIP (SHIP)

Additional clinical capacity (2 salaried GPs between 4 practices)

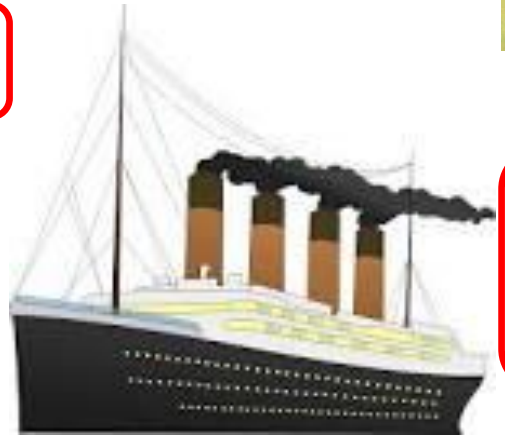
2 attached social workers

2 attached community link practitioners

Support for monthly multidisciplinary team meetings

Protected time for GP leadership

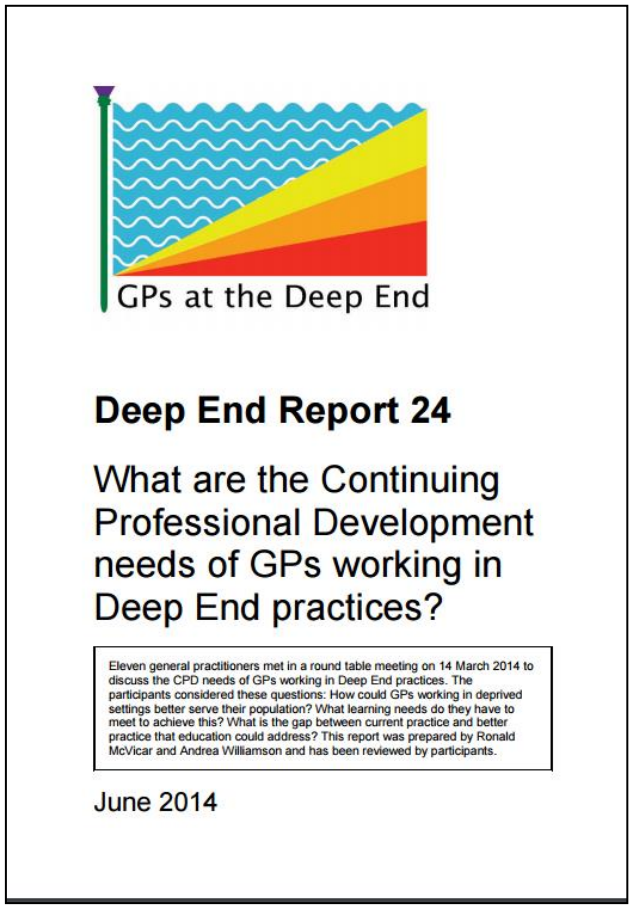
DEEP END GP PIONEER SCHEME



Day release scheme

Shared learning

4) PROFESSIONAL DEVELOPMENT


GPs at the Deep End

Deep End Report 24

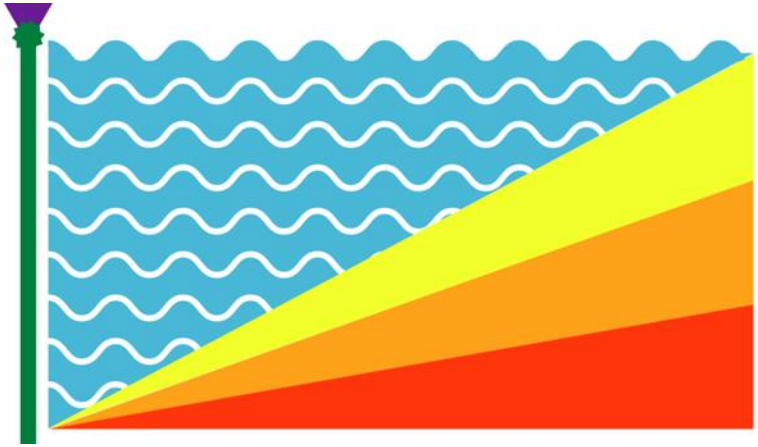
What are the Continuing Professional Development needs of GPs working in Deep End practices?

Eleven general practitioners met in a round table meeting on 14 March 2014 to discuss the CPD needs of GPs working in Deep End practices. The participants considered these questions: How could GPs working in deprived settings better serve their population? What learning needs do they have to meet to achieve this? What is the gap between current practice and better practice that education could address? This report was prepared by Ronald McVicar and Andrea Williamson and has been reviewed by participants.

June 2014

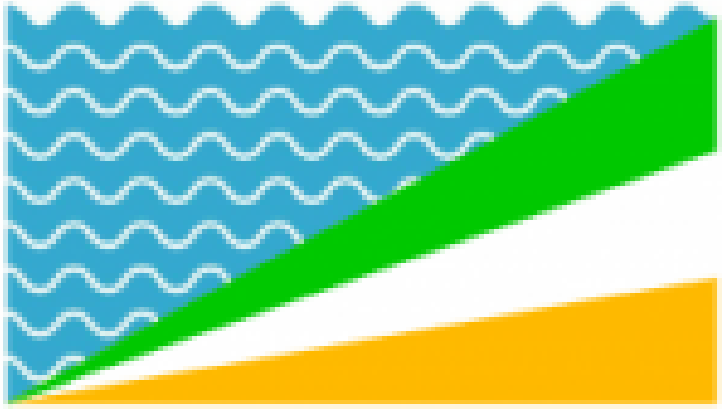
1. Engaging with patients
2. Promoting GP tenacity
3. Drugs and alcohol
4. Safeguarding children
5. Asylum seekers/migrant health
6. Multimorbidity
7. Poverty
8. Vulnerable adults
9. Evidence-Based Medicine (EBM) and unhealthy populations
10. Previous sexual abuse
11. Homelessness

REACH programme → Medical students → GP trainees → GPs



Scotland

Yorkshire & Humber



Ireland

Australia

COMMON CAUSE?

1) To develop a compelling competing narrative
based on the importance of generalist clinical practice

(i.e. unconditional, personalised continuity
of care for all patients, whatever problems they have)

2) To highlight the persistence and significance of the inverse care law

Slide adapted with permission from Prof Graham Watt

POSSIBLE EXPLANATIONS FOR THE WEAKENING OF GENERALISM

Traditional disdain

The most important work of generalists is “out of sight, out of mind”

Effective generalist care is hard to document as it mainly results in non-events

The most powerful and influential institutions tend to be specialist-based

Most research and evidence is specialist-based

Practice-based research is complicated by small numbers and many sources of variation

The arguments that bigger and better general practice is the solution to pressure on A&E departments, health care fragmentation and widening health inequality tends to be rhetorical rather than evidence-based

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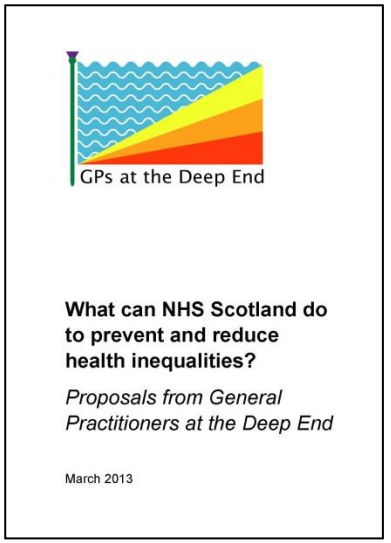
SIX ESSENTIAL COMPONENTS



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)**

DISCRETIONARY ASPECTS OF GENERAL PRACTICE

How broadly to identify the problems that general practice can help (e.g. the medical model or more widely).

How high to “set the bar” in terms of the short, medium and long term objectives of patient care

The length of a normal working day (with average resources, practices can only increase the numbers of patients seen by shortening consultations or lengthening the working day)

The number and type of practice staff to employ

Whether to provide extra-contractual letters for patients seeking support for benefit applications and appeals.

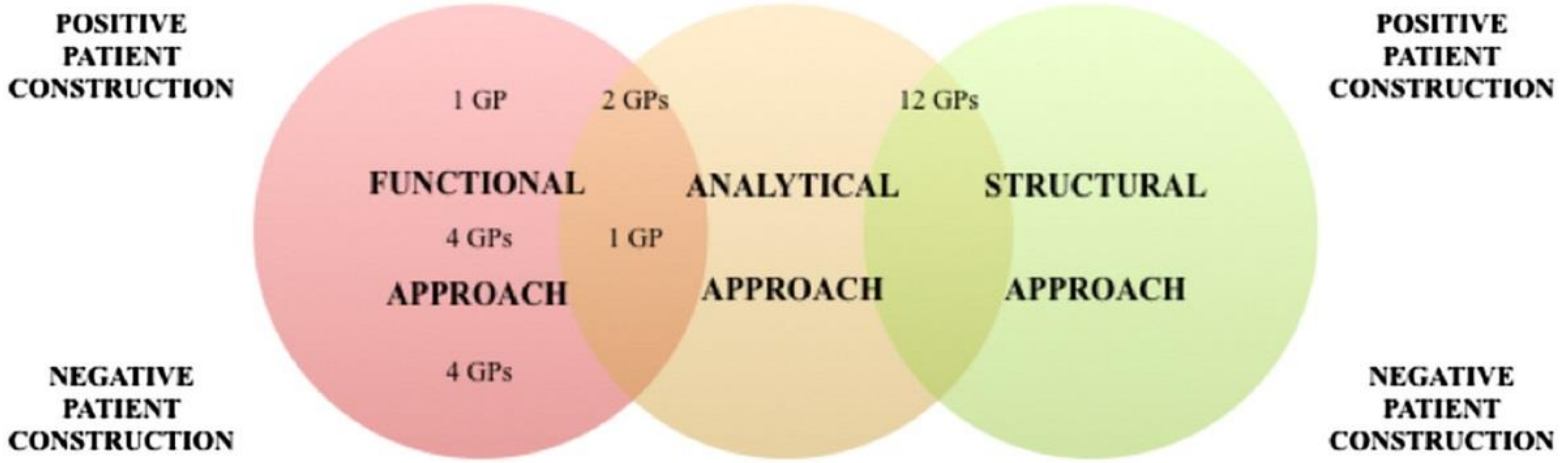
Whether to invest time in developing links with local community resources for health.

Whether to take part in optional activities, including teaching, training, research or development projects

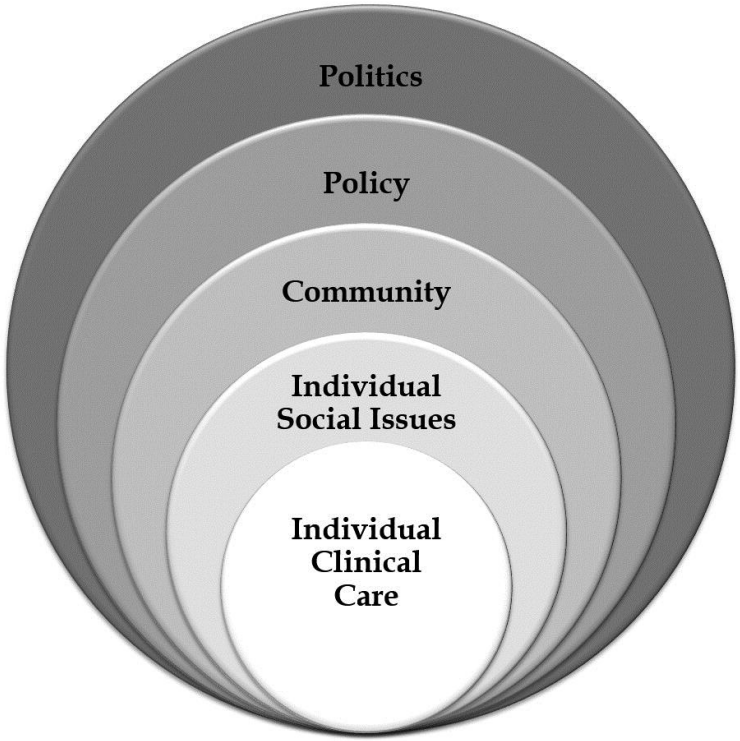
Whether to pursue a leadership role in representing general practitioners, or in developing the local health system

Whether to take part in advocacy, fighting against the conditions and policies which cause poor health in patients

Slide adapted with permission from Prof Graham Watt



"…only those GPs fluent in discussing structural causes of health inequalities discussed obligations to change local systems via strengthening community linkages and to influence higher level policies related to the SDH. This suggests that while there is a degree of what Metzl and Hansen deem 'structural competency' amongst some GPs working in disadvantaged areas, the scope remains to deepen this competency more broadly."



Babbel et al. ***How do general practitioners understand health inequalities and do their professional roles offer scope for mitigation? Constructions derived from the deep end of primary care*** Critical Public Health 2017; DOI: 10.1080/09581596.2017.1418499

Summary

- If the NHS is not at its best where it is needed most… health inequalities will widen
- Challenging context
  - Increasing workloads, social/medical complexity
  - More part-time, portfolio careers
- Where do we go from here?
  - Medical education (e.g. widening access)
  - Postgraduate training (e.g. structural competency)
  - Scope and discretion (e.g. community engagement and advocacy; new GP contract…)
  - **Protected time** for both service and professional development
  - **Shared learning** within and between practices

Thank you for listening…
Any questions?

David.blane@glasgow.ac.uk

@dnblane

deependgp@gmail.com

@deependgp