



Royal College of
General Practitioners

TIME TO CARE

Health Inequalities, Deprivation and General Practice in Scotland

**RCGP Scotland Health Inequalities
Short Life Working Group Report**

December 2010

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ACKNOWLEDGEMENTS

Special thanks for help in drafting this report go to:

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EXECUTIVE SUMMARY

The NHS is only one aspect of the measures required to address Scotland's problems of poor health, but it is an important part and there is an opportunity to lead the world in showing what an equitable health service can achieve.

Scotland is fortunate in having a high quality general practice and primary care work force in areas of severe deprivation, which are characterised by poor health and premature mortality, but they are under-resourced and poorly supported for the work that needs to be done.

The inverse care law states that the availability of good medical care tends to vary inversely with the need for it in the population served. A clear message from this report is that unless the root cause of the inverse care law is addressed then the health inequalities resulting from it will persist.

The remit of the RCGP Scotland Health Inequalities Short Life Working Group (established June 2008) was to produce a comprehensive, evidence-based position paper addressing Scotland's continuing problem of inequalities in health. At the outset, it was decided not to simply produce a review of the limited research literature nor an externally-produced toolkit for practitioners to follow. Instead, we chose to listen carefully to the experience and views of general practitioners working in the front line of NHS Scotland serving the 100 most deprived practice populations. However, we included general practitioners in remote and rural areas (outwith the top 100) and also commissioned a review of deprivation in remote and rural areas. Our main conclusions are:

- Practitioners lack time in consultations to address the multiple, morbidity, social complexity and reduced expectations that are typical of patients living in severe socio-economic deprivation.
- Opportunities for anticipatory care are often fleeting and may be lost if there is not the opportunity to connect quickly with other disciplines and services that are closely linked to the practice.
- Practices provide contact, coverage, continuity, flexibility and coordination, and need to be recognised and supported as the hubs around which other services operate.

- The only route by which practices in severely deprived areas can improve patient's health and narrow health inequalities is by increasing the volume and quality of the care they provide.
- When public funding is under severe pressure it is especially important that NHS resources are targeted where they are most needed.
- NHS support services should be audited in terms of the support they provide for practices working in the front line.
- Further work with GPs and practice teams outwith the 'deep end' practices and in remote and rural areas is required to establish the impact of deprivation on patients and primary health care workers in these areas

In moving this agenda forward, the Keep Well Forward Planning Group and Primary Prevention Steering Group of Scottish Government Health Department will be of considerable importance. RCGP Scotland also looks forward to working constructively with GPs and practice teams in deprived areas, community health partnerships, Scottish Government Health Department, NHS Health Scotland, NHS Education Scotland and other stakeholders to help address these complex and important issues over the coming months and years.

FOREWORD

The introduction of the National Health Service (NHS) in 1948 established the principle of universal access and the provision of comprehensive health care which is free at the point of use. Access to general practitioners was rationed in the same way as bread, eggs and butter in World War 2 - everyone receiving the same amount. But this was at a time when there were very few effective treatments and the role of primary care at that time, which was almost exclusively general practice, was largely reactive in nature.

Although socially generous, and a huge step forward, it was not long after the establishment of the NHS (just over 20 years) that the limitations of this approach were described and formulated as the *inverse care law*, whereby the availability of good medical care tends to vary inversely with the need for it in the population served. Initially, the consequences were largely confined to issues of access and delays in treatment, but as the NHS has acquired a large armamentarium of interventions of proven effectiveness, the consequences of the inverse care law have become more serious. If some parts of the NHS are better able to deliver good medical care than others, the NHS can itself produce widening inequality in health.

The operation of the inverse care law is seen most clearly at the level of consultations in deprived areas, which are characterised by time constraints, greater morbidity including physical, psychological and social problems, less patient enablement and greater practitioner stress. All aspects of good quality care are more difficult to deliver in such circumstances.

In recent years there has been no satisfactory or direct response by successive Governments to the reality of the inverse care law. Keep Well, the Scottish Government's flagship programme for anticipatory care in deprived areas, did not include the large majority of practices serving severely deprived populations. Adoption of ASSIGN, the new Scottish cardiovascular risk score, prepared during the development of SIGN 97, seeks to address this by including deprivation and family history as new Cardiovascular Disease (CVD) risk factors. This will more than double the eligible number of men and women who are considered to be at high risk (ten year risk of cardiovascular event $\geq 20\%$), needing assessment, negotiation, treatment and review.

Responses to inequalities in health which miss the mark, spend scarce resources in areas where needs are less, and add to the caseloads of practices in deprived areas without additional resources are unlikely to alter Scotland's national statistics on inequalities in health. The NHS needs to connect more effectively with its front line GPs and practice teams. Current support for this front line of the service confines its efforts to that of a holding operation. Sixty years after the establishment of the NHS, it is time to put this part of the NHS on the front foot.

At the outset, the working group made three decisions. First, given the plethora of reports on inequalities in health, collating research evidence, there was no need to produce another report of this type. Second, the report would not comprise a “toolkit” for general practitioners, implying that others know the answers and general practitioners simply need to implement the solutions. Third, the working group would engage with general practitioners working in the most deprived areas, capture their experience and views, and communicate these findings to others. This would focus on the 100 practices serving the most deprived communities in Scotland (which we named the ‘Top 100’ practices) but would also include general practitioners working in remote and rural areas out-with the Top 100 as there are many people living in pockets of severe deprivation which are not large enough to register within analyses of deprivation based on datazones. We also commissioned a short review of the literature on the challenges faced by these communities (Chapter 4).

The TOP 100 general practices serve a population of 430,000 Scots, including 50% of people living in the 15% most deprived postcode datazones in the country. 50-90% of all patients registered with the 100 practices live in such areas. Most other patients in these practices also live in deprived areas, but with lesser levels of socio-economic deprivation than the most deprived 15% of the population.

It is important however, to recognise that, outside the Top 100, the other 50% of people living in the 15% most deprived postcode data zones are registered with about 700 other general practices in Scotland, which also provide care for more affluent populations and thus serve a more heterogeneous population. Focusing on the most deprived 100 general practice populations and targeting the top 15% of data zones were pragmatic, and to some extent arbitrary decisions. Socio-economic deprivation and its associations with poor health are continuously distributed.

The resulting report highlights the intrinsic advantages that general practice has to offer in helping to address health inequalities. These advantages include population coverage

(almost everyone in Scotland is registered with a practice), flexibility, a patient-centred approach, high levels of public trust, local leadership and the ability to deliver and co-ordinate holistic longitudinal care [1]. The challenge of how to make best use of current and additional resource, whilst utilising the fundamental strengths of general practice, is discussed in the following chapters.

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CHAPTER ONE: BACKGROUND

Health inequalities are socially produced, systematic and unfair.[1] Addressing health inequalities is a moral, social, and political imperative, but despite numerous initiatives over recent decades in Scotland, substantial disparity in health outcomes between those of different socio-economic status (SES) remain. Recent findings show that for those living in the most deprived areas of Scotland compared with those most affluent areas, healthy life expectancy is 19.8 years lower for men and 18.2 years lower for women, with deaths in those under the age of 75 being 3.6 times more likely in the deprived compared with the affluent. Deprived adults are 3.8 times more likely to die from coronary heart disease between the ages of 45-74, and 12.3 times more likely to die of an alcohol related condition.[2] In 2007/8, 45% of adults living in the most deprived decile of Scotland were smokers, compared with 11% in the most affluent decile.[3]

Not only do these figures highlight that little progress has been made in narrowing the health inequality gap, but worryingly, they also show that for adults aged 15-44 years living in the most deprived areas the inequality gap has widened in both absolute and relative terms between 1997 and 2006, with the likelihood of death in this young age group being 4.9 times more likely.[2] As well as premature mortality, health inequalities are associated with significant financial consequences, in terms of morbidity, subsequent ability to work, and health and social care costs.[4]

The persistence of health inequalities globally reflects an underlying inequitable distribution of fundamental social, political and economic resources.[5] Health inequalities cannot be solved by the NHS alone as recently highlighted by Professor Sir Michael Marmot in his strategic review of health inequalities in England post 2010 [6] However, healthcare - and in particular primary care – can have an important and significant impact on the health of populations.[7] If health inequalities are to be addressed effectively via NHS activity, this can only occur by increasing the quantity and quality of care for those with the greatest level of need. In general terms, this means improving general practice and primary care in the most deprived areas of Scotland. The evidence suggests that important short-term gains can be made in reducing health inequalities by changing how NHS services are delivered.[9] It is well recognised that the effectiveness of health interventions among those who are disadvantaged and have the greatest need can be diluted by various factors including difficulty in accessing interventions and lower rates of delivery in deprived areas [10,11]

Alongside Public Health and related interventions in Scotland such as Keep Well [9] general practice has an important role in programmes aiming to reduce health inequalities by improving health in deprived areas. For example, the Quality and Outcomes Framework (QOF) of the new GMS contract has largely abolished SES inequalities in QOF-incentivised clinical domains.[12] However, there is less evidence of recent improvements in the quality of general practice and primary care in deprived areas beyond the QOF domains, and the kinds of measures which QOF can incentivise are relatively limited.[13]

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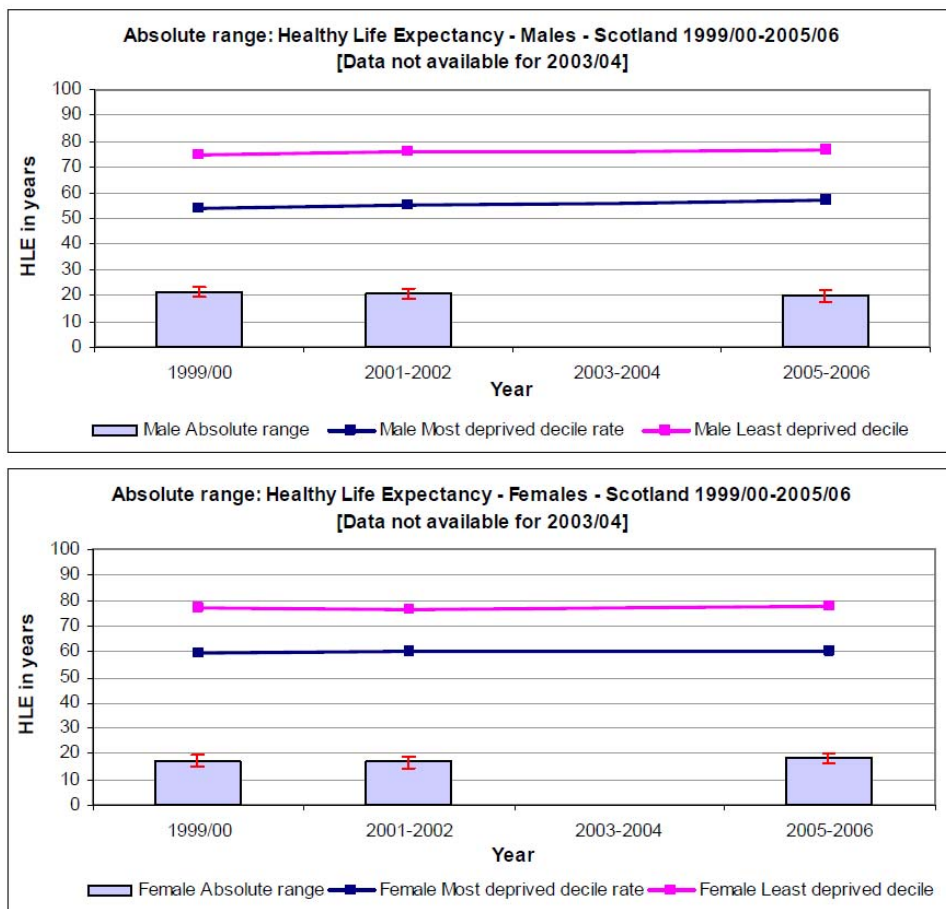
CHAPTER TWO: GENERAL PRACTICE AND DEPRIVATION

Deprivation and mortality rates

As indicated in the introduction, little progress has been made in Scotland in the last decade in narrowing the large differences in life expectancy across the socio-economic spectrum. The following table, produced by the Platform Project [1], shows the proportion of all deaths in 2001/02 occurring under the age of 70, in deciles of general practice populations, ranging from the most affluent (decile 1) to the most deprived (decile 10). On average, the most deprived 10% of the Scottish population has 70% more male and female deaths under the age of 70 than the most affluent 10%.

Decile	No of Practices	% female deaths <70	% male deaths < 70
1	89	14.4%	24.6%
2	104	16.4%	29.0%
3	110	16.3%	29.0%
4	107	16.4%	31.9%
5	92	18.8%	30.6%
6	102	18.9%	32.9%
7	97	20.0%	33.6%
8	108	22.2%	35.0%
9	100	22.3%	38.0%
10	122	24.2%	43.4%
ALL	1031	19.2%	33.3%

The figure on the next page shows that the difference in healthy life expectancy between males and females in the most and least deprived deciles of the Scottish population remained static between 1999/00 and 2005/06.[2]

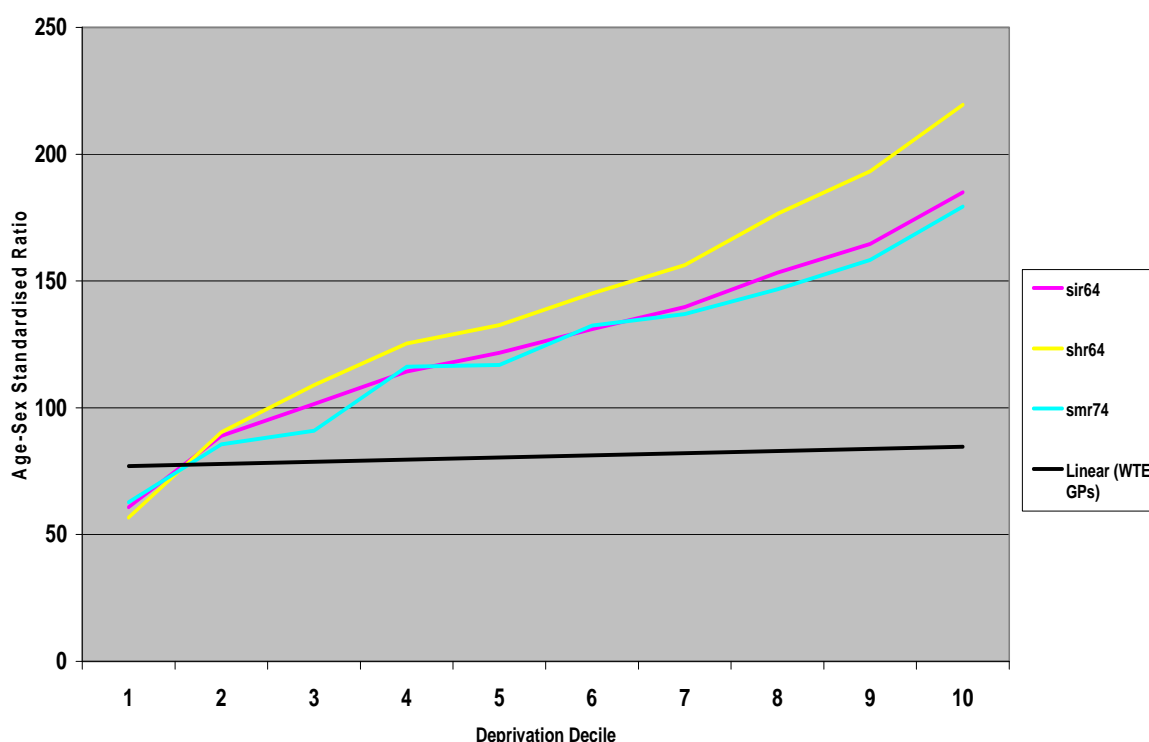


(Note: the red bars for each column indicate the uncertainties in each estimate of absolute difference in HLE).

Deprivation and the Inverse Care law

Analyses carried out as part of the Primary Care Observatory Project by the University of Glasgow Department of General Practice and the Glasgow Centre for Population Health has demonstrated the relatively flat distribution of general practitioner workforce across the socio-economic spectrum, despite a 2.5-3 fold increase in the prevalence of health problems.

Age & Sex Standardised Census Health Measures by Greater Glasgow & Clyde Deprivation Decile



(NOTE: SIR is a measure of long term limiting illness recorded in the census. SIR64 applies to the population aged under 65 years. The SHR64 measurement represents self-reported health in those aged under 65 years, taken from the FORM 2001 Census. The SMR summary measures represent standardised mortality ratios for people aged under 65 and 75 years respectively) [3]

Other recent research in Scotland has shown the practical consequences of this mismatch of resource and need [4]. This research involved characterising more than 3,000 general practice consultations in the most deprived areas of the west of Scotland versus the least deprived areas and showed that consultations in the most deprived practices were characterised by :-

- Higher demand
- Shorter time available
- Greater psychological and physical morbidity
- More multi-morbidity
- Less enablement reported by patients with complex problems
- Greater GP stress

Qualitative research on consultations in deprived areas of Scotland [5] has found that patients place high value on the consultation and communication skills [6] with GPs who understand the realities of life in such areas and whom they can trust as both competent and genuinely caring. Without this, they may judge doctors and other healthcare professionals as socially distant and emotionally detached. Relational continuity, empathy and sufficient time in consultations are the key factors in achieving this. Subsequent research on consultations in deprived areas by the same research team has found that the patients' perceptions of the GPs' empathy, as measured by the Consultation and Relational Empathy (CARE) Measure, does indeed result in higher patient enablement and better health outcomes and that these are enhanced by longer consultations and better continuity of care [7,8].

The following quote, taken from ongoing research being carried out by Dr Rosaleen O'Brien and colleagues at Glasgow University, illustrates the important role that general practice can play in the lives of patients. The quote is from a an interview with a 60 year married old man living in an area of high deprivation in Scotland who suffers from diabetes, chronic obstructive pulmonary disease (COPD), alcohol problem, and depression. Although he had successfully self-managed his diabetes and COPD in the past, he acknowledges that his depression and alcohol problem hinder his ability to manage at present. In the interview he describes a very positive relationship with his GP. Implicit in his description is that he particularly values his GP's willingness to offer support that takes into account his personal characteristics and circumstances.

Well when I'd seen the doctor the previous time I told her about being a bit depressed, I have got an alcohol problem and things like that....I've told her all that, em, because she's a professional. She's a GP.

I've told my wife what I've told the doctor now as well when I came back from her so, em, I got a lot of relief from doing that and today when I came in I could talk right away to her [the GP] because I could feel that...she was asking me the right questions and , em, she seemed to know, obviously through her own experience, which, you know, is the medical training side of things, she...I got more relief. Yeah.

She followed up several types of avenues: anti-depressants, counselling, AA, all the other things, em, 'these are options that you could try' . But what I said, and what you've picked this up as well, I'm a loner and I don't like that...I'm not going to go to the counselling or alcoholism or AA'. I says...so she gave me options . That's the sort of things she asks....I'm being monitored, seen on a regular basis em. Yes I feel that's good. That support is there, you know.

The Top 100

Because evidence from research in this area is limited, the working group decided to draw on the rich resource of experienced practitioners by holding a meeting of the 100 practices serving the most deprived communities in Scotland. The characteristics of these practices are given below, and in the next chapter we describe the events held and the information gathered. We also invited GPs from rural areas of Scotland which had significant problems of deprivation, of which four attended. The most deprived 15% of the population (based on SIMD scores) is generally used as the target population for health policy concerning inequalities in health. The proportion of patients meeting this criterion ranges from 48% of patients in the 100th most deprived practice to 91% of patients in the most deprived practice. In general, therefore, the threshold for being in the top 100 practices is that more than half of the practice population is in the most deprived 15% of the Scottish population.

The 100 most deprived practices are based in 10 community health (and social care) partnerships.

CHP	No of top 100 practices in CHP	% of all practices in CHP
Glasgow East CHCP	28	84
Glasgow North CHCP	18	
Glasgow West CHCP	16	39
Glasgow South-West CHCP	14	
Glasgow South-East CHCP	9	
Inverclyde CHP	5	7
Edinburgh CHP	5	
Dundee CHP	2	
Ayrshire CHP	2	
Renfrewshire CHP	1	
TOTAL	100	28%

The average list size of the Top 100 is 4300. The average list size of the 5 Edinburgh practices is 8524. Thus, although Edinburgh practices comprise only 5% of the 100 top practices, their registered populations comprise 10% of the total served by the top 100 practices. Only 8 practices in NHS GG&C have list sizes over 7500.

LIST SIZE	No of Practices
<1500	7
1500-2499	16
2500-4499	42
4500-7499	23
7500+	12

The Top 100 includes 17 single handed practices in Scotland, all in Glasgow.

In terms of voluntary 'additional' activities, 45 of the Top 100 practices reported taking part in undergraduate teaching, 27 in postgraduate training, 46 in research (through the Scottish Primary Care Research network), 67 in the Scottish Primary Care Collaborative, 23 in the Scottish Programme for Implementing Clinical Effectiveness (SPICE) (an initiative designed to promote consistent recording and use of clinical data), and 4 in RCGP's Quality Practice Award (QPA) (a criterion-based quality accreditation process) and 37 practices took part in the Scottish Government's Keep Well initiative. (see next chapter)

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CHAPTER THREE: GENERAL PRACTICE AT THE DEEP END – VIEWS FROM THE ‘TOP 100’

The first meeting of General Practitioners at the Deep End took place at Erskine, Glasgow on 16th September 2009. Since then, what has become known as the Deep End Project has involved three more meetings, with another 8 activities planned. This chapter summarises progress so far.

The Top 100

The Erskine meeting involved practitioners from two thirds of the 100 most deprived practices in Scotland. The meeting was based on the sharing of experience and views – a valid but neglected source of evidence. This was the first time in the history of the NHS that such a group had been convened or consulted. The focus on practices serving populations with the most concentrated deprivation in Scotland was novel and important. In the summary session, several GPs commented on the almost immediate and strong group identity of practitioners from the 100 most deprived practices and the positive nature of the meeting.

A GP from Edinburgh commented, *“I was in groups made up entirely of non-Lothian GPs. What was striking was not only that we got on well, but on how much convergence there was in terms of the problems we face. I was in the primary/secondary care group and virtually everything said by Glasgow GPs, I could have said first about Edinburgh – to a surprising level of detail. That problems seem to be so very generic and uniform across the board hopefully means that there might be generic and uniform answers too”*.

The nature of the meeting was that it raised many more issues than could be addressed in detail. The meeting was planned to promote discussion and exchange between general practices, as a preliminary to more detailed work, the development of agreed proposals and engagement with the many external agencies and organisations with which general practices work.

It was clear from the views expressed at the meeting that Scotland does not have many of the problems of general practice in deprived inner city areas elsewhere, which have provided the context for much of the recent primary care development in England. Despite the heavy burden of health needs and demands, and their impact on both patients and staff,

general practice serving areas of concentrated deprivation in Scotland is characterised by high quality (as measured by the QOF), high morale (as demonstrated by involvement in additional professional activities) and high commitment to improving services for patients (as evident by the discussions at the meeting).

It was noted that practices serving deprived areas could only address the issue of “inequalities” indirectly, by increasing the volume and quality of service for their patients, but that much could be achieved, with and without additional resources, by the NHS making better use of general practice as a force to improve the health of patients in deprived areas, and thereby help narrow inequalities in health.

The meeting strongly affirmed, indeed took for granted, the strengths of the general practice primary care model, based on contact, coverage, continuity, co-ordination, flexibility, relationships, trust and leadership. There was frustration, however, at lack of resources, lack of support, lack of identity and marginalisation of general practice within current NHS arrangements. A strong theme was the problematic and dysfunctional nature of many external relationships, including those with non-practice-employed staff, local authority services and community health partnerships. It was felt that federations of practices, led by elected GPs, could save money, maintain morale, retain staff and reduce sickness absence. Such an approach would also improve inter-professional and inter-practice communication through protected learning time, with additional educational and service development opportunities by also involving hospital consultants.

The topics selected for discussion during the Erskine meeting, and for the three subsequent meetings, were a mixture of issues of particular relevance to deprived areas (e.g. mental health, patient empowerment, resource allocation and support for practitioners) and issues of relevance to all general practices (e.g. multi-professional working, relationships with secondary care, infrastructure and premises and relationships with Community Health Partnerships (CHPs) and Community Health & Care Partnerships (CHCPs)). The following section provides more detail on topics discussed at the Erskine meeting and at three subsequent meetings held in January 2010.

The Key Topics raised by the Top 100 were:

- A. Needs, demands and resources
- B. The nature of consultations in deprived areas
- C. Mental health issues
- D. Vulnerable families
- E. Multidisciplinary working and attached families
- F. Relationships with Community Health Partnerships
- G. The primary/secondary care interface
- H. Keep Well and ASSIGN
- I. Community development
- J. Learning, education and support
- K. Primary care structure and collaboration

A. Needs, demands and resources

While GPs and the primary care team often know where health improvements could be made, others control the budget. GPs and the practice team often know (from their day-to-day work) who is falling through the gaps in services (e.g. patients with combined mental health problems and addiction problems) and feel they could co-ordinate and deliver services better and faster, in a setting familiar to patients. This would improve both attendance rates and continuity of care. GPs in deprived areas also feel they need some financial recognition of their demanding role.

At the subsequent meeting on this issue, it was agreed that unmet need in deprived areas is huge and the demand on general practice seems unrelenting. Patients' medical needs are intimately inter-woven with emotional, psychological, financial and social problems. GPs strive to work holistically across the entire gamut of bio-psycho-social domains, often swimming against the tide and commonly feeling stressed, rushed, and exhausted. Complexity and multi-morbidity are the norm rather than the exception in deprived areas and this occurs at a younger age than in the patient population. The interface with secondary care is often problematic for a variety of reasons.

GPs have an important advocacy role, as well as a generalist medical role, in helping their patients deal with their numerous and complex problems. This is possible because of the nature of general practice, and the values of GPs who choose to work in deprived areas. Continuity of care provides 'constancy' to patients, which is unique and important but requires active work and tenacity on the part of the GP.

Potential ways forward include enhancing and extending the primary care team based in the practice in order to address the mismatch of need and demand, and enhance the efficiency of current services. For example having mental health staff, social workers, alcohol counsellors, financial advisors, etc based 'in-house' in the practice would improve attendance rates of patients and inter-agency working.

Ways of improving closer working with secondary care included joint GP/consultant clinics, consultant advice on difficult cases (to reduce referrals) and allocated times for telephone or email advice.

Ways of enhancing the management of complex patients by the GP and primary care team include better continuity, targeted longer consultations, and training and support for the primary care team including GPs.

Remuneration of GPs should include a deprivation weighting in the global sum, QOF and enhanced services that accurately reflects the context of working in a deprived area and the extra resources it takes to attain quality patient care.

B. The nature of consultations in deprived areas

A key issue concerns the nature of encounters in deprived areas, involving the heavy burden of need, significant co-morbidity, low expectations and self efficacy, shortage of time and high levels of practitioner stress, and their implications for education, training, research and service development. Many practitioners regretted the devaluing of consultations, considered to be the heart of general practice, by the financial incentives of the new GMS contract.

The ideal is that patients are able to take charge of their health, by making informed choices which suit them. It is not about being passive or becoming a rampant consumer of health care. GPs should ensure they treat all patients with respect and promote their self efficacy

in the consultation. Caring for ourselves (i.e. GPs) will allow GPs to remain sensitised to this and help create a positive culture in the practice and a cohesive practice team.

The group discussed how patients and GPs can develop a shared action plan that the patient will feel is worth adhering to. Key issues were values, relationships and engagement. The group highlighted the importance of trusting relationships amongst all involved with patient care (as many as possible and at least the 'core' team) and the significance of existing relationships between GPs and other health care professionals and the patient as a potent motivational force.

There is a need to explore how best to engage with patients. All stages of education should include communication and motivational skills. GPs and practice staff should be catalysts for change. There is a particular need to explore other ways to encourage people with low expectations (of self, society and health care) to become more actively engaged in their health and well-being and with the healthcare system.

C. Mental health issues

Mental health problems are of major importance in deprived areas, not only because of their high prevalence but also their frequent occurrence in association with other health and social problems. General practices need help in addressing these issues, which led to discussion about the types of help available.

Community projects like Stress Centres were perceived as potentially very helpful but long waiting lists make them less meaningful to patients in acute distress. One practice had been involved in a research project with Community Psychiatric Nurse (CPN) attachment to a general practice and the evaluation was positive. There was discussion why this evidence did not lead to a roll out of CPN attachments to general practice.

Access barriers and segregation of mental health services lead to patients being lost in referral systems (e.g. patients with addiction problems and psychiatric co-morbidity). It was noted that some services, with adequate funding, deliver excellent care.

D. Vulnerable families

Working with vulnerable families is an everyday aspect of general practice in deprived areas. Through many types of contact, practice teams have substantial knowledge about the most vulnerable families in their registered population. Several recent NHS developments,

such as changes in midwifery, health visiting and child surveillance have undermined this knowledge.

General practices offer constant, accessible, informal and unconditional contact and support (irrespective of age), referral to other services when necessary, and continuing support when other services cannot respond. The case-finding approach in general practice appears an insufficiently valued mechanism for matching need to service provision and preventing, delaying or ameliorating more serious problems.

Withdrawal of child surveillance in deprived areas is considered a mistake, given the high yield of health and social problems. The current “rationalisation” of health visiting appears to devalue the importance of shared knowledge, continuity, relationships and trust, concerning the wider “at risk” population of vulnerable families.

Practices should have effective ways of regularly sharing information about vulnerable families; they need regular updates concerning the availability of other local services; they also need improved working relationships with social work and the school health service, based on personal continuing contact with individual social workers and school health nurses.

Practices should identify their lead professional for vulnerable families, co-ordinating activities within their practice and considering the ways in which they could work more effectively with other practices and other agencies.

It is important for the system to take account of the views and experience of families using services. There is also a need for more effective and quicker dialogue between practices providing front-line services and those responsible for local and national policy on child welfare and vulnerable families. There is a need for research on how health and social work can cooperate to support children.

E. Multidisciplinary working and attached workers

A major issue identified by the meeting was the need to identify, strengthen, and support effective methods of multidisciplinary team work within general practice and primary care, with a particular focus on employment relationships.

There was a strong feeling that joint working is easier and more effective when attached workers are employed by the practice. In general, practice employed staff are retained for many years and have low levels of sickness absence. Where this is not possible, the nature of the attachment, including types of contact, communication and lines of accountability, is the key to the success of joint working.

Where individual practices are small, a geographical coalition of practices could share these staff. Benefits would be better inter-professional communication, less duplication of effort, appropriate skill mix and better control of activity.

F. Relationships with Community Health Partnerships

Problems with CH(C)Ps were highlighted and solutions posed. Levels of disengagement of CH(C)P and social work management with practices, and problems of attached nursing staff vary considerably between areas.

CHCP management in some areas was considered out of touch with practices. Specific issues included a perception of coercive management styles, de-motivation of the nursing workforce, a lack of understanding of achievements of practices, allocation of resources to management structures rather than to “coalface workers” and a general suspicion of GPs.

CHCPs were criticised for not engaging effectively with GPs, poor communication, a creeping erosion of the primary health care team and the observation that they appear to respond to Scottish Government initiatives but not to proposals made by local GPs.

G. Primary/secondary care interface

Discussions included patient access, referral pathways and communication between GPs and consultants. The GPs would like more access to investigations and wanted consultant opinion on referrals for some disease areas, instead of patients ending up lost in “care pathways”.

Possible solutions to patients failing to attend appointments were discussed (e.g. a more reliable ambulance service, text reminders and support workers facilitating attendance). It was felt that secondary care has to share responsibility for the follow up of some ‘DNA’ patients and at a minimum to detail reasons for referral on ‘DNA’ letters. Suggestions for improving communication included e-mailing discharge letters, or actionable tasks and specifying medication changes.

There was a strong desire to engage with consultants locally and to have the option to “consult” secondary care via designated phone-in times, as an alternative to formal referrals. GPs perceive an increasing lack of a holistic approach in secondary care due to increasing specialisation and quicker turnover. As a result of this, the group felt that some form of communication pathway where consultants offer advice and flexibility concerning urgent outpatient appointments would be beneficial.

H. Keep Well

Equally Well, the current Scottish Government policy on Health Inequalities, confines its coverage of the contribution of general practice to narrowing health inequalities to Keep Well, the flagship national anticipatory care programme. There was little or no mention of Keep Well by the ‘Top 100’ GPs at the Erskine meeting. Only 37 general practices out of the most deprived 100 practices currently take part in Keep Well (25 of the 85 practices from Glasgow and 12 of the 15 practices from outside Glasgow). 19 Keep Well practices were represented at the meeting.

General practice experience of Keep Well was discussed at a subsequent meeting funded by NHS Health Scotland, at which it was agreed that Keep Well had largely worked well, providing a boost for preventive activities via increased ascertainment and provision of specific health improvement activities. Government commitment is needed to maintain the work that has been started. Ascertainment is not yet complete and there was uncertainty as to how much effort should continue to be expended in maximising response rates. (Note: The way forward for the Keep Well programme is presently undergoing SGHD consultation with NHS Scotland as at June 2010).

In Keep Well practices, there is a need to provide continuing support as the focus shifts from initial ascertainment to long term support and follow up. Keep Well should also be initiated in the large number of severely deprived practices which have not so far taken part in the programme. The arrangements required for continued follow-up and support are different from those required for initial ascertainment and need to be more closely integrated within routine practice activity.

To avoid fragmentation of services, with predictable effects on patient uptake, it is desirable that key health improvement services are provided “in-house”, within practice settings, via

staff attached from other agencies. There is an urgent need to develop such an approach in response to the increasingly serious and prevalent health effects of alcohol misuse.

The meeting also discussed the implications of recent NHS policy endorsement of ASSIGN as the recommended cardiovascular risk scoring system, which includes deprivation and family history as new CVD risk factors. ASSIGN was considered to provide a welcome opportunity to increase and improve the targeting of CVD risk in deprived areas, for men and women, but effort is needed to standardise its use across practices.

Without additional resources, commensurate with changes in caseload, it is likely that ASSIGN will be used opportunistically within consultations, rather than for screening. For both Keep Well and ASSIGN, there is concern that Government initiatives are leaving deprived practices with lots to do without the resources to do it.

I. Community development

The Top 100 GPs believe that community development needs to return to the grassroots in helping to generate social capital in their practice areas. GPs and practices can be an important part of this on a range of levels. GPs have an important positive role to play in the community. If locum funding were available it could enable GPs to participate in publicised community events.

GPs need to find out what activities and supports are in the community; but this can be difficult, when not living in their practice areas. This could be aided by teambuilding days with external facilitators (e.g. a team building day cleaning up a littered area on a community walking route, with an accompanying article in the local paper).

J. Learning, education and support

The NHS does not currently provide mechanisms by which practices working in areas of concentrated deprivation can readily share experience, information and evidence concerning the nature of their task. Such collaboration is possible, however, as demonstrated by the high levels of participation (67%) in the work of the Scottish Primary Care Collaborative. It would be useful to review the ways in which the many NHS support organisations (for education, quality, IT, research and development) might work more effectively to support practices in the front line.

Following the example of the Glasgow Centre for Population Health report: *The Shape of Primary Care in NHS Greater Glasgow and Clyde* (which has not so far been distributed within general practice) consideration should be given to whether and how an intelligence function could be established to inform the activities and outcomes of practices serving the most deprived areas, learning from examples elsewhere, such as the Lothian Primary Care Data Group and the Lothian GP Deprivation Interest Group.

Sharing-best practice both within practices and with neighbouring practices was another theme. Some GPs wanted to know how 'successful' others in their practice were in terms of achieving positive outcomes. Delegates felt that sharing such data locally would facilitate the adoption of best and more efficient practice (including staffing structure, telephone triage, house call requests, follow-up visits, reception team role, use of health-care assistants etc).

Several of the delegates discussed the intensive mentoring, reflection and support received by current GP registrars, and felt that some components of their ongoing peer support would be beneficial (and fill a "void") for GPs post-CCT. GPs spoke of the need for meaningful and personal protected time with other GPs (not "alone in a room in the surgery") to facilitate such support.

There was discussion as to whether having an appointed health inequality GP for each practice (similar to a special interest) would be beneficial. The group felt that a support group akin to the Lothian Deprivation Interest Group, would be beneficial.

Work is also needed on whether there are particular educational, training and continuing support needs for the leadership roles of practitioners working in areas of concentrated deprivation.

GPs AT THE DEEP END – MOVING FORWARD

The immediate challenge following the 'Top 100' meeting was to build on the engagement, enthusiasm, ideas and precedent generated, to normalise the extraordinary nature of the first meeting and to enable the top 100 general practices become a more effective voice and force for improving primary care.

A steering group was formed to plan the next stages of the project and to engage with supporting organisations, including the Royal College of General Practitioners, the Scottish Government Health Department and the Glasgow Centre for Population Health. Current objectives are:-

- To continue the process of drawing on the experience and views of Deep End practices
- To maximise participation within the Deep End group
- To increase multidisciplinary involvement in Deep End meetings
- To engage with the external partners of general practice
- To develop solutions to the problems identified

With additional funding from these organisations, principally for locum funding to allow practitioners to attend meetings, the following activities are planned for the middle of 2010:

Singlehanded GPs at the Deep End

- addressing the needs of the smallest practices

Patient encounters in deprived areas – what can be achieved and how?

- addressing the challenges of anticipatory care, multiple morbidity, self help and health literacy

GP trainers at the Deep End

- considering the educational and training implications of clinical practice and leadership in practices serving very deprived areas

Vulnerable Families (Second Meeting)

- building on the previous meetings and engaging with other professions and services to develop better ways of joint working

Alcohol

- considering the problems caused by alcohol in very deprived populations and how services can work more effectively

The challenges of an ageing patient population

- considering the contribution of general practice to maintaining independent living by elderly people in very deprived areas

Engaging with communities

- A review of examples of community engagement and “social prescribing” by Deep End practices
- A “learning journey”, led by Andrew Lyon, with groups of GPs visiting a diverse range of work settings

CHAPTER FOUR: RURAL DEPRIVATION

A third of the population of Scotland lives in rural areas.[1] The tools used to measure deprivation are most relevant for urban settings and thus may fail to identify rural areas where socio-economic deprivation exists, and some parameters of socioeconomic status (e.g. car ownership which is essential in the absence of public transport) may obscure the presence of rural poverty. Rural populations are sparse and heterogeneous and thus rural areas may be classified in a way that fails to recognise small pockets of quite severe deprivation. The “rural idyll”, where a community is largely populated with commuters and retired professionals invariably can hide small but severe instances of poverty. [2]

Health outcomes

Mortality rates for road traffic accidents [3,4] asthma [5], and cancer [6], are worse in rural areas. Cancer is diagnosed at a later stage [7] and intervention rates for coronary artery disease are lower [8]. Rural patients are admitted to hospital less frequently than urban patients [1]. Screening interventions for mammography and diabetic retinopathy reduce with distance. A combination of absolute health deprivation (the absence of services or a delay or physical barrier to provision of medical services) and socio-economic deprivation thus significantly challenge health service delivery in rural locations.

Due to issues of poor access in rural areas, primary health care teams have an obligation to develop and sustain appropriate clinical pathways, or develop local services as effective specialist care is often unobtainable for large sectors of their community. These access issues often result in tension between specialists, who fail to recognise the necessity for compromise on what they perceive as quality and primary care. For example there is a 3-fold variation in access to specialist cancer inpatient care throughout Scotland. [9] Many rural cancer patients have to travel thousands of miles to obtain care in specialist units [10]. It is likely that this inequality in health care access is independent of socio-economic status. Thus, it can be extrapolated from this that many patients are either not receiving any care, or are receiving care from their general practitioner either through a health centre or community hospital. In the absence of a solution for this from secondary care, then primary care must take on the responsibility or else rural patients will continue suffering from inequities in the delivery of health care in this way.

Unscheduled Care

One of the most fundamental changes to general practice has been the loss of 24 hour responsibility for general practice. This has been replaced by a much more centralised form of service delivery, using call centres that often do not have local knowledge, and GP cooperatives and primary care centres, often some distance from the rural patient. Patients in rural areas were found to be less likely to access the call centre. [11] This was unexpected, as seeking telephone advice should be equally accessible to all groups. This study also noted the compounding effect of deprivation in rural patients, and, following a call, patients are also less likely to be seen by a GP which is directly related to the distance from a call centre. [12] The development of a national nurse led triage services and telephone advice should have improved the quality of service and reduced inequities. Evidence from Scotland suggests this has not happened. [13]

Specialist outreach services have been shown to benefit patients and GPs. [14,15] Helicopters have a role to play in delivering specialist support to medical, surgical and anaesthetic emergencies. However evidence that expensive helicopter transfer improves clinical outcome is hard to find, and they may be unavailable for service reasons or bad weather or darkness. Community hospitals provide better access to services for patients, and this should improve service uptake.[16] The challenge is to also provide a quality of service that will negate the negative effects outlined above. There is a cost for that, both in terms of diseconomies of scale and also the need for staffing at a senior level. The way forward appears to be to develop a generalist who can provide clinical care of an extended nature within a hospital setting. This will require specific training, and will present challenges with validation and accreditation.

Empowering rural primary care

What is certain is that general practice in rural areas must encompass a wider range of knowledge and skills, and an ability to be flexible and improvise. RCGP Scotland looked through the core competencies of a general practitioner, [17] and made some additions to these for rural GPs.

Distance from the GP surgery is associated with an increased risk of emergency admissions, and a lower rate of other admissions for in patient management.[18] Survival from cancer is related to travel time to the GP. When travel time to the hospital and other accessibility measures were taken into account, the travel to the GP was found to be the only influential factor. [19]

Looking at other values of general practice within rural communities, the concept of social capital is important. Social capital is the importance of certain organisations or infrastructures within a community. Examples of this might be school, church and medical practice. It is a very ill-defined concept, but is easily recognised within a rural community. However difficult it is to define or measure, it is an important concept and remains a key part of rural general practice [20]. This sense of community and cohesion seems to have lost value, but is the trade-off for poorer specialist services and serves as a focus for advocacy for the disadvantaged and deprived. It would appear that the concept of health services as social capital rather than commodity, although unfashionable, continues in rural areas to the benefit of the rural deprived.

Travelling people: dealing with rural deprivation in an Argyll practice –a case study by Dr Iain McNicol

Since 1980, I have been studying and attending to the needs of The Traditional Travelling Community in The Western Highlands of Scotland, families displaced from the settled community after Culloden in 1745. The work has been Practice based and collaborated with a Primary Care Development Fund Project in 1996 with Mrs Margaret Black, S.R.N. with a Highland wide project (2000-2003) and with Healthy Together Argyll (travellers) Project (2004-2008) and The Scotland Council for Ethnic Minorities. Many colleagues in many disciplines have contributed greatly.

The Problems

Identified Problems are; Low life expectancy (c.55 years in 1995) with excess mortality due to Childhood infections. Infant Mortality, Accidents, especially R.T.A.s, Drownings and Fires, Coronary Heart Disease, diabetes, COPD, Suicide and alcohol/drug related deaths. Related Causes seemed to be the poor literacy rates, poor education and limited life skills for a modern world as well as less need for traditional skills such as Tin-smithing, Pearl fishing, Basket-making, potato picking and berry picking. Poor nutrition, especially excess carbonated, high calorie drinks, damp and cold accommodation, high smoking rates leading to very high passive smoking due to overcrowding. Family size far exceeds the modern nuclear family.

This is all compounded by a deep suspicion of authority and institutions, leading to erratic health care with lack of immunisations, difficulty of access to health care and Registration, lack of Ante Natal and Post Natal care, lack of contraception and little attendance at school with no system of compulsion.

We also identified a number of genetic conditions. These include; Pulmonary Stenosis, Ectodermal Dysplasia, Homocystinuria, cerebral palsy (with good birth history) and an M.S. like illness.

We have used this information to assist with some genetic counselling, but it is a sensitive area for The Travellers. The information we hold on their family trees is useful.

Tackling The Problems

As the Practice seems to have the trust of many Travellers we educated them to the

merits of registering with a GP as the basic entrance to the NHS and encouraged Primary Care attendance and discouraged A&E attendance for medical matters.

We educated our staff especially around literacy. We fought for a Patient Held Record System which although produced has not received Political support from Boards or Practitioners. (Double paperwork)

An education programme for Travellers on Immunisation, preventative medicine, contraception has led to dramatically improved uptake from virtually zero to the Scottish average or above. Alcohol education has seen a reduction in alcohol abuse in the older Travellers. The effect on the younger generation does seem to be positive. At a recent large family funeral in January 2009, there was no sign of drunkenness at all compared with the same family's funeral at the deceased's brother's in 1997, when the majority of mourners were drunk. We held a barbecue at a Travelling site for Smoking Cessation advice and techniques, which led to a significant reduction in smoking amongst the women- less so amongst the men.

We held a free cookery course at a local County House Hotel with a top chef showing how to buy and cook fresh produce producing delicious, healthy meals. This course was enthusiastically taken.

We encouraged Hospital O.P. attendance by arranging double notification of appointments to the patient and the Practice allowing us to encourage attendance and offer support where necessary. We also offered support with benefit claims and Tribunals.

The major thrust with the younger Travellers has been education and with the active support of three schools we have witnessed the majority of Travellers now actively putting their children into Primary school, at least, as opposed to less than 20% in 1995.

The Equal Opportunities Report (2002) and Lord Hosie accepting Scottish Gypsy Travellers as an Ethnic Minority in his 2008 Judgement, have helped. By the end of 2008, the life expectancy of this group has risen from 55 to 61 years.

Much remains to be done especially in Education and Housing if this group is to be allowed to fulfil their definite potential, for their, and society's benefit.

Iain McNicol, General Practitioner Appin Medical Practice 1980-2009

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CHAPTER FIVE: EDUCATION AND TRAINING

One of the findings from the Erskine meeting outlined above was the need for education and training for general practice in deprived areas to be fit for purpose and based on the demands and needs of practitioners in these areas. The meeting particularly identified a need for protected learning time with other GPs and Primary Health Care Team (PHCT) members. They contrasted the intensive support and mentoring currently received by GPs in training with the 'void' that seemed to obtain after completion of RCGP.

The steering group felt that it would therefore be useful to look at the way in which deprivation and health inequalities were addressed in the undergraduate and GP training curricula, as well as the wider field of multi-professional learning. Of the 56 practices represented at the Erskine meeting, 61% took part in undergraduate teaching and 31% in postgraduate GP training.

Undergraduate

The publication of Tomorrow's Doctors 2009 (1) is a stimulus for Scottish medical schools to look afresh at their curricula. Curricular development in Scotland is often addressed via the Scottish Doctor project, overseen by the Council of Deans' curriculum sub-group (2). Input into this may be a useful way of enhancing undergraduate education on Health Inequalities and related subjects.

The conference on 'Health Inequalities in the undergraduate medical curriculum' organised by The RCGP Health Inequalities Group (England) in Liverpool on 26/27th April 2010 enabled university based clinicians, NHS based clinicians and an impressive number of medical students to present and discuss current teaching practice and future aspirations for the teaching of health inequalities in the UK's medical schools. Currently there are numerous excellent examples across the UK's medical schools of educational opportunities for interested undergraduate medical students to learn about health inequalities and deprivation. The majority of this learning is by undertaking Student Selected Modules, (blocks that students opt into, or devise themselves) often in the area of the clinical care of marginalized patient groups such as homeless persons or asylum seekers. The identified challenge is how to ensure that all undergraduate medical students obtain an introduction to the key concepts of health inequalities and graduate with a positive attitude to patients from deprived backgrounds.

An encouraging example of an attempt to influence the core curricula, is that of MEDSIN, (UK wide medical student activism group), in collaboration with Medact, and some medical school educators who have devised a 'UK consensus statement on core competencies in global health for medical students'. They take the view that Global Health is both 'local and global', which includes many strands of health inequalities relevant to UK general practice. This framework sets out how medical schools might like to meet Tomorrow's Doctors 2009 for Global Health and future plans include lobbying the GMC and UK medical schools to adopt their statement. (3)

Postgraduate (GP training)

Under section 5, community orientation (healthy people), the RCGP curriculum (4) has the following learning outcomes:

- The scale of health problems in a locality in terms of incidence and prevalence, and be able to make comparisons with other populations
- The interrelationships between health and social care including the wider determinants of health within communities e.g. housing, employment and education.
- The impact of poverty, genetics, ethnicity and local epidemiology on an individual and a local community's health
- The impact of inequalities and discrimination on health
- The inequalities in healthcare provision: the 'inverse care law'
- The roles of the other professionals involved in public health e.g. school nurses, health visitors and public health specialists.
- The importance of involving the public and communities in improving health and reducing inequalities

It is not clear to what extent these are dealt with adequately in a curriculum with several hundred learning outcomes. The Academy of Medical Royal Colleges (UK) has produced a set of Health Inequalities Curriculum competencies (6). The document is more generic than primary care orientated, and may be more valuable for those working in hospital specialities.

NHS Education Scotland initiatives

NHS Education Scotland (NES) currently funds a 1 FTE equivalent Higher Professional Training Fellow in the West Deanery, 0.5 FTE HPT Fellow in South East and 0.5 FTE in the

East Deanery. These aim to provide an introduction to the opportunities and challenges of delivering primary care to a deprived practice population.

The Health Improvement team at NES have developed an online inequalities education resource called Bridging the Gap (5), a resource for pre-registration nurses, midwives and allied health professionals. This is a comprehensive and accessible resource. It is currently being used by at least two pre-registration nursing courses. The resource has been available since September 2008 and on completing the resource it is hoped that students, educators and practitioners will be able to:

- Recognise and describe key features of the widening health inequalities gap in Scotland
- Demonstrate an understanding of the contributing factors (wider determinants) to health
- Explain the significance of health inequalities for NHS Scotland services
- Describe ways in which their practice is sensitive to the needs of all patients, service users and colleagues.

NES also hope to adapt the 'Skills for Health' competency programme of the Public Health Resource Unit (7) for PHCT members. However, this is currently population rather than community orientated and would need considerable modification and work to be valuable.

The 2010 RCP (London) report 'How doctors can close the gap- tackling the social determinants of health', (8) endorsed by RCGP (UK) has a number of relevant recommendations in medical education to improve coverage in both undergraduate and postgraduate levels.

Recommendations

1. Further work needs to be done to delineate the extent to which deprivation and health inequalities are covered and assessed in undergraduate medical curricula in Scotland. **As this is *the* major issue for Scotland's health, these should form a prominent vertical strand in all UG curricula, and include opportunities for student selected study modules.**

2. The RCGP curriculum has a well focussed set of learning outcomes for social determinants of health. It is not clear how these are addressed in training, and assessed using Applied Knowledge Test (AKT), Clinical Skills Assessment (CSA) and Workplace Based Assessment (WPBA). **This issue should be discussed in detail with the curriculum board of RCGP (UK)**

3. NES are developing online resources for pre-registration nurses and Association of Allied Health Professionals (AAHPs). **NES, with RCGP should take steps to develop educational resources of value to all clinical members of the PHCT. These should include material suitable for practices with deprived populations in urban and remote and rural locations.**

4. GPs working in very deprived areas have identified learning needs through the Erskine meetings. **Further work should focus on both clinical aspects of CPD and how to share best practice.**

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CHAPTER SIX - *Conclusions and Recommendations*

The TOP 100 general practices at the Deep End serve a population of 430,000 Scots, including 50% of people living in the 15% most deprived postcode datazones in the country. 50-90% of all patients registered with the 100 practices live in such areas. Most other patients in these practices also live in deprived areas, but with lesser levels of socio-economic deprivation than the most deprived 15% of the population. It is important however, to recognise that, outside the Deep End, the other 50% of people living in the 15% most deprived postcode datazones are registered with about 700 other general practices in Scotland, which also provide care for more affluent populations.

In this report we have chosen to largely focus on the top 100 practices, not only because they provide care for patients living in the most severe socio-economic deprivation, but principally because they do so for large numbers of patients, to an extent that dominates the work of the practice. They are a key part of the front line of the NHS, in delivering the contribution of health care services to improving health in the least healthy areas of Scottish society and a flagship for what a National Health Service, committed to universal access, evidence-based practice, health improvement and health equity, can achieve.

General practices are not the only providers of health care in deprived areas, but they are the only providers which combine a large degree of population coverage with continuity, flexibility, coordination, commitment and long term relationships based on mutuality and trust. General practice in deprived areas is a huge resource for addressing health and health care problems in severely deprived areas, with the particular strength of focusing on individuals and families over time, irrespective of the specific nature of their health problems. The challenge is to harness the strengths of general practice as part of an integrated, equitable and efficient health care system.

There is much to celebrate in the achievements of general practice in severely deprived areas of Scotland. Scotland does not have many of the problems of general practice in deprived inner city areas, which have provided the context for much primary care development in England. Despite the heavy burden of health needs and demands, and their impact on both patients and staff, general practice serving areas of concentrated deprivation in Scotland is characterised by high quality (as measured by the QOF), high morale (as demonstrated by involvement in additional professional activities) and high commitment to improving services for patients (as evident by the discussions at the meeting).

The NHS underachieves in deprived areas, however, for a combination of reasons.

1. The relatively flat provision of manpower in deprived areas, compared with increased levels of health burden, means that the system is constrained in what it can deliver. Hence, “General Practitioners at the Deep End” whose prime purpose is to survive and cope, reacting to problems on a day by day basis. A fundamental issue is the lack of capacity to work in other ways.
2. This front line of the NHS lacks identity, existing across administrative boundaries and lacking dedicated support. Prior to the first meeting of the Deep End Project, the 100 most deprived practices had not been convened or consulted in the history of the NHS. There are no mechanisms whereby Deep End practices can meet, share experience and work collaboratively, nor are any of the main NHS support mechanisms (for information, evidence, training) provided in a way that recognises and supports this front line.
3. The lack of alignment of general practice with many other primary care professionals and services, has led to fragmentation, duplication and inefficiency, failing to capitalise on general practice’s structural strengths of contact, continuity, flexibility and co-ordination. Many areas of joint working are poorly developed.
4. A plethora of initiatives to address “unmet need”, health improvement and health inequalities have generally been small, short term, focused on peripheral rather than central issues and lacking sufficient evaluation. The realities of the inverse care law remain.
5. There has been very little investment and support for the leadership role of general practices as hubs for primary care within local communities.
6. The consequence of the lack of successful engagement with general practice is that NHS policy, and the large number of NHS staff employed to promote and implement

General considerations

“Addressing inequalities in health” is an abstract issue, which depends on retrospective comparison of advantaged and disadvantaged areas. A more direct policy objective is to increase the volume, quality and coverage of health care activity in deprived areas, not only in relation to interventions of proven effectiveness but also the general continuity and coordination of care required to reduce severity, delay or prevent complications and maintain healthy behaviours.

There is not only the political challenge to provide additional resources; it is also knowing how best to use additional resources in a culture in which both patients and professionals have become used to expecting less. A balance is needed between actions that can proceed immediately, and those requiring demonstration projects to establish best practice, or research and development to establish effectiveness and value for money. The widespread involvement of practices serving very deprived areas in the activities of the Scottish Primary Care Collaborative shows that widespread, co-ordinated initiatives are possible.

It is important to consider the many levels and ways in which actions can be taken. Community health partnerships, for example, are best placed to co-ordinate the provision of services within geographical areas, but they are less well placed to lead, coordinate or facilitate many other types of activity. A multifaceted approach is required, in which NHS support (information, evidence, education, training etc) is provided at all levels.

Actions to increase the volume, quality and equity of health care delivered by general practice in deprived areas may be taken:

- A. By practitioners when they meet with patients
- B. By practices working as multi-professional teams
- C. By practices organising their resources (i.e. time, space, staff) to best effect
- D. By practices working with similar practices within networks or federations

- E. By practices working with attached staff from other services (e.g. health visitors, community nurses, mental health workers etc)
- F. By practices working with other local services (e.g. health improvement, community care, social work, child health, voluntary sector)
- G. By practices working collectively within a geographical area
- H. By practices working as part of integrated local and national systems

The leadership required for actions A-D exists within general practices, depends on local knowledge and experience and is generally poorly supported by information, evidence, training, protected time etc

The leadership required for actions E-H is more widely distributed and is complicated by the number and variety of interfaces involved.

Specific proposals

1. Additional time for consultations with patients in very deprived circumstances, addressing directly the fundamental cause and operation of the inverse care law. Related questions include the purpose, content and targeting of extra time for consultations and the support and training needs of practitioners and patients.
2. Enhancement of multi-professional practice teams via the attachment of staff with specific skills/expertise. Related questions include the expectations and conditions required from all parties to ensure effective joint working.
3. Improved joint working between general practices and other local services e.g., child health, care of the elderly, mental health and addiction, health improvement. This will require a fundamental rethinking of the relationships between general practices and CH(C)Ps.
4. Demonstration projects - coordinating practices and other services working in geographical areas.
5. Recognition of the principle that additional activity should not be expected of Deep End practices without commensurate resources – for example, the roll out of Keep Well to the 63 practices in the top 100 which have not so far participated, and implementation of the ASSIGN score, with its implications for increased case-load.

6. Support and development of Deep End Practices as a multidisciplinary, learning organisation, committed and supported to share experience, information, evidence, activity and education.
7. Recognition, training, support and reward for the leadership required to co-ordinate integrated local services.
8. A project of further work with GPs and practice teams out-with the 'deep end' practices and in remote and rural areas to establish the impact of deprivation on patients and primary health care workers in these areas. Marmot's concept of 'proportionate universalism' – to each according to their needs—is a useful principle to guide both further research and resource allocation.
9. Establish an intelligence function, using routine data to inform Deep End practices.
10. Establish a NHS research and development programme dedicated to the challenge of addressing the inverse care law.

Appendices

EXPLANATION OF THE “TOP 100”

The Scottish Index of Multiple Deprivation characterises datazones, based on local postcodes, in terms of collations of routine data in 7 different domains – income, employment, education, housing, health, crime, and access (defined as distance from main services).

For example, the variables that make up the health domain (with weightings attached to each factor) are:-

- Standardised mortality ratio (0.09)
- Hospital episodes related to alcohol use (0.14)
- Hospital episodes related to drug use ((0.06)
- Comparative illness factor – based on cont of numbers of recipients of Disability Living Allowance, Attendance Allowance, Incapacity Benefit and Severe Disablement Allowance (0.33)
- Emergency admissions to hospital (0.32)
- Proportion of population being prescribed drugs for anxiety, depression or psychosis (0.05)
- Proportion of live singleton births of low birth weight (0.02)

Scotland is divided into 6505 datazones, each containing on average about 850 people. Individual datazones may have substantially more or less than the average figure.

Every patient postcode in Scotland has a SIMD score, based on the datazone in which it is located.

It is not necessarily the case that individual circumstances will match the mean value of all postcodes within the data zone, but on average, localities are well characterised by this approach.

A particular exception concerns pockets of deprivation in rural areas which are often too small to influence the average SIMD score of a datazone.

The 100 most deprived general practices in Scotland are based on a ranking of the mean SIMD score of all patient SIMD scores within general practice lists.

Because of the social heterogeneity which is found within all general practice populations, the most deprived 100 practices also include patients who live in less deprived areas.

50% of people living in the most deprived postcodes in Scotland are registered with the 100 most deprived practices; the other 50% are registered with the remaining 900 or so other general practices in Scotland, in which deprived patients are a minority.

As the most deprived 100 practices include many small practices (see below), the most deprived 10% of practices do not cover the most deprived 10% of the population, which is actually covered by 129 practices.

Appendix II

Lothian Deprivation Interest Group

Background and History

The Deprivation Interest Group (DIG) formed in Lothian in the early 1990s when a group of GPs working in deprived areas started meeting on an informal basis. The principle impetus for this was a concern that the issues of primary care provision in areas of high multiple-deprivation were not represented in local health policy and planning. In 1996 the group developed a funding proposal that was accepted by the Primary Care Development Fund of Lothian Health. A steering group was established with representation on it from the GP group, Public Health, University Dept of General Practice, Primary Care Directorate, a non-executive director of Lothian Health and the DIG worker. A questionnaire was distributed to get the views of the GPs as to the priority areas of work for the DIG project. The areas identified were mental health, chronic disease management and an emphasis on health promotion and preventative work. It was felt that due to workload pressures these health care needs of patients were not being adequately addressed. Underpinning the identification of these priority areas was recognition of the increased levels of ill health in deprived areas and the need for additional health care resources to address this. A work load study of DIG GP practices was carried to get a picture of the content of GP consultations and the social and health problems identified. This found that the highest reported major complaints were of psychological/psychiatric symptoms, therefore, confirming the priority areas identified by the GP group.

In 1999 a report on the DIG project was completed and was influential in the development of the Lothian Health strategy 'Tackling Health Inequalities' (1999). Since that time the DIG GPs have continued to meet regularly and have been supported by the DIG coordinator, who is a GP and is funded for one session per week by Lothian Health in this role. In maintaining the activity of the group the role of coordinator, as highlighted in the original report, is seen as vital.

Role of DIG:

i. Support of Members

Key to the work of DIG are the regular 2 monthly meetings of members. Membership is open to all those with an interest in providing high quality primary care services to disadvantaged groups and communities. Central to this is a commitment to the role of primary care in addressing health inequalities. Membership is made up mainly of GPs with 18 GPs representing 8 practices, but also currently includes a psychiatric nurse, a psychologist, public health consultant, public health

practitioner, an health promotion worker, an academic GP fellow, a Dept. of GP lecturer University of Edinburgh and we now have our first social worker joining the group. Therefore, meetings are multi-disciplinary and generate wide ranging, stimulating and challenging discussions. The priority aim of these meetings is peer support and to provide a safe space for members to raise concerns and issues around providing GP and primary care in a setting of disadvantage and limited resources – an experience that will be understood by and familiar to other members. Given the high levels of GP stress in these settings, as evidenced by Stewart Mercer's research, this function of the group should not be underestimated.

The meetings also afford members the opportunity to shape the DIG coordinators work load and priorities. They provide a forum for members to feed into and have their views represented at both local and national level, with the DIG coordinator preparing and submitting DIG reports to relevant consultation exercises and strategy development processes.

ii. Education and Awareness raising

Members have identified one of the DIG coordinator's responsibilities as being to arrange meetings with an educational component. We have, therefore, had meetings focusing on research such as co-morbidity and breast cancer, on clinical care such as looking at developments in sexual health screening and treatment and diabetic care in deprived settings among others. In June 2009 we organised a day conference looking at the role of General Practice in tackling health inequalities from epidemiological, political, economic, research and clinical perspectives. DIG meetings are frequently organised on specific themes, such as maternity care or mental health services, looking at local policy and service developments, with key policy makers and service planners invited, as a means to raise awareness on health inequalities.

iii. Engagement and Partnership work with Lothian Health Board

DIG offers Lothian Health direct access to a representative group of front line primary care clinicians directly involved in providing health care to deprived and marginalized groups. This offers great potential in terms of partnership working and policy development, with direct access to the views from experienced clinicians on what is likely to actually work in the real world of primary care. A large part of the role of the DIG coordinator is to liaise with Lothian Health on behalf of the group and to represent the group on numerous committees and working groups, such as the Lothian Maternity Strategy Committee, Lothian's Keep Well primary care capacity development group, the steering group for Gypsy-Traveller health visiting project, the mental health programme Equally Connected and the RCGP short life working group on Health Inequalities among others.

iv. Lobbying and Advocacy

Over the years a key role of DIG has been in advocating for high quality accessible primary care services in disadvantaged areas. A good example of effective work in this area was the role DIG played in shaping the NES for practices offering treatment for drug using patients. This has made a significant difference both to the accessibility of this service for a very marginalized group and to the recognition and funding of deprived practices where drug related work is a huge part of the daily workload. DIG has also been involved in lobbying government on deprivation related issues.

Potential Future Developments

There are currently discussions under way to foster closer ties between DIG and Dept of Public Health in Lothian. Housing the DIG coordinator post within Public Health would afford a more effective channel of communication both with the office of the Director of Public Health and the Lothian Health Board, in order to represent the views of members to a wider strategic audience.

Formalizing DIG's link with Public Health and utilizing that support could offer the exciting opportunity for DIG practices to be involved in primary care-health inequalities related research. It would also give DIG more robust administrative support, an area that has been lacking.

DIG is now also looking to get more formally involved in medical education, both at the undergraduate and postgraduate GP training level. Education around inequalities, deprivation and health must be a priority to develop a work force that is sensitive to the issues and has a positive attitude towards providing health care to disadvantaged groups within society.