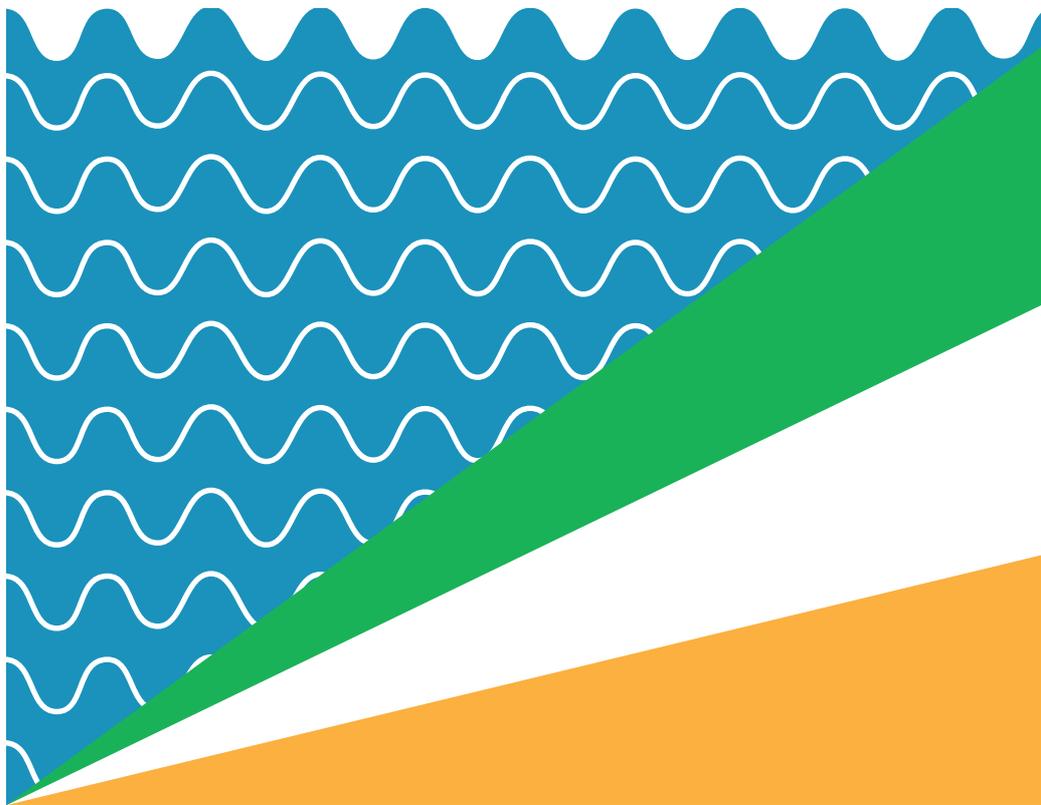


MAY 2017

DEEP END IRELAND



REPORT OF ACTIVITY TO DATE

Authored by Dr Patrick O'Donnell & Prof Susan Smith
on behalf of the Deep End Ireland group
(www.deepend.ie)

Deep End Ireland

REPORT OF ACTIVITY TO DATE

TABLE OF CONTENTS

SUMMARY	3
DEEP END GENERAL PRACTICE – THE EVIDENCE	4
The International Context.....	4
The Irish Context	5
The Future	5
DEEP END IRELAND ACTIVITY TO DATE	7
REPORT OF FORMAL LAUNCH OF DEEP END IRELAND	8
Meeting Programme.....	8
Questions Asked of Attendees	8
Methods.....	9
Summary of Results.....	9
WHAT NEXT FOR DEEP END IRELAND?	10
REFERENCES.....	11

SUMMARY

The Deep End Ireland group is made up of a number of GPs serving populations in deprived areas of the country. It was established in 2012 and has been inspired by the original Deep End group established in Glasgow in 2009. This report documents the work carried out to date by Deep End Ireland, and sets out the future direction of the group.

It has been shown in the international literature that patients living in deprived circumstances have worse health outcomes and more complex multimorbidity than the general population. We recognise that there is a need for us to come together and advocate on behalf of these vulnerable patients, and that we as GPs need to support each other in our challenging work.

“We see, every day, how society works in a way which systemically undermines the health of its most vulnerable members.”

Iona Heath

The Mystery of General Practice, 1995



Deep End Ireland GPs Prof Susan Smith, Dr John Delap, Dr Edel McGinnity and Dr Patrick O'Donnell attend Leinster House to meet Minister for Health Simon Harris in September 2016

DEEP END GENERAL PRACTICE – THE EVIDENCE

THE INTERNATIONAL CONTEXT

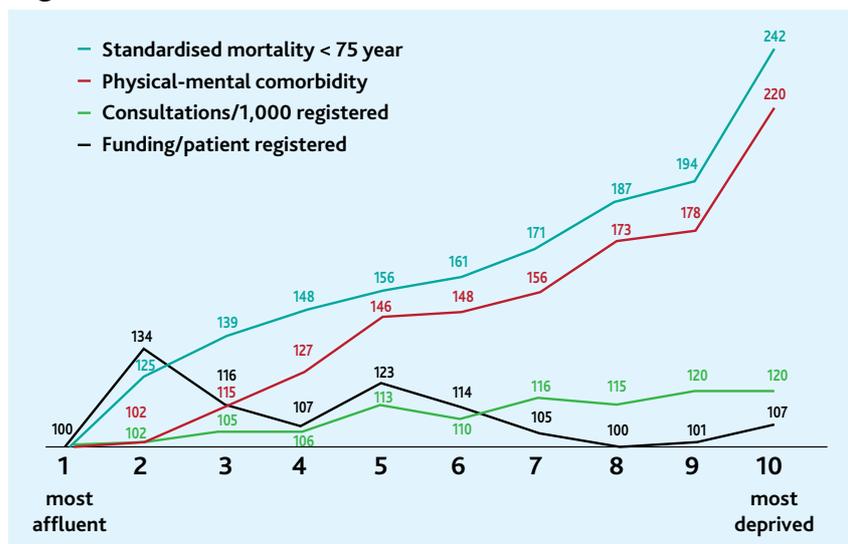
There is strong international evidence that patients living in deprived areas coming from low socioeconomic groups have very poor morbidity and premature mortality rates (Mackenbach et al 2008, Stringhini et al 2010, Hosseinpoor et al 2012). A recent meta-analysis published in *The Lancet* included data from approximately 1.7 million patients and again showed that those from lower socioeconomic groups had greater mortality compared with patients from higher socioeconomic groups (Stringhini et al 2017).

Sir Michael Marmot and colleagues have written extensively on the impact of deprivation on health and life expectancy (Marmot et al 2012, Marmot et al 2010). The often-quoted 'Inverse Care Law' set out by Julian Tudor Hart in the 1970s unfortunately is still relevant, and is seen in action nowhere more clearly than in deprived areas (Tudor Hart 1971). Other evidence from the UK has shown that:

- Patients in deprived areas suffer multimorbidity earlier in life (Barnett et al 2012)
- There is higher demand for GP consultations in these areas (Boomla et al 2014)
- But yet, deprived areas were served by fewer primary care services (Reeves and Baker 2004).

Bringing these strands together, (McLean et al 2015) carried out a study involving 956 general practices in Scotland, and compared funding, consultation rates, mortality and comorbidity across different socioeconomic groups (see Figure 1). While general practice funding remained relatively constant, health needs were significantly higher in more deprived groups. Practices in the most deprived areas could only address this by increasing their consultation rates within the constraints of the funding on offer. The study highlighted the possibility that the way the funding for general practice was being disbursed may actually have been preserving health inequalities rather than reducing them.

Figure 1



With these increased pressures on general practice, (Mercer and Watt 2007) found that high levels of ill-health and multimorbidity in deprived areas of Scotland created challenges for the patients, the practices, and the GPs involved. This ultimately led to "poorer access, less time, higher GP stress, and lower patient enablement." Not surprisingly, 'burnout' rates for GPs were notably higher in those caring for patient populations with higher levels of deprivation (Pedersen and Vedsted 2014). It was in the context of all of these challenges that the original Deep End group was formed in Scotland in 2009.

They have since published more than 30 reports covering many aspects of caring for patients in deprived areas, the specific challenges these patients and GPs face and the continuing professional development needs of GPs serving these areas (Deep End 2016). The Deep End ideals have since been adopted by an affiliated group in Yorkshire & the Humber, and our own group here in Ireland.

THE IRISH CONTEXT

In Ireland, the evidence base around health and deprivation is not yet as well developed as that in the UK or other international settings. At present our capacity to record data on health and integrate that with geographical or socioeconomic distribution is poor. There is no universal systematic registration of patients with a GP close to where they live (as in the NHS), and we have a public-private mix of patients in the general practice system.

Patients with low income attend general practice under the general medical services (GMS) contract. This is based on an annual capitation payment from the government to the GP for each patient. The average capitation payment is fixed regardless of number, length or complexity of patient visits. For patients covered by this GMS contract, the Inverse Care Law particularly applies in relation to access to diagnostic testing and secondary care services. There is also large variation in access to other vital clinical and social care services including child and adolescent mental health services, psychology, speech and language therapy and social workers.

The Irish College of General Practitioners has published two reports on the needs and challenges faced by general practices in areas of deprivation (Osborne 2015, Crowley 2005). The most recent one in 2015 concluded with the recommendations that:

- There should be increased investment in GP and primary care
- There should be financial incentives created to attract and retain GPs working in deprived areas
- GPs training in areas of deprivation should be promoted and there should be more education on the issues commonly seen in deprived areas
- There should be structured support for practices in deprived areas, eg. premises at low rent, increased allowances for technology, etc.

These recommendations were made against the backdrop of the early stages of a national economic recovery and the negotiation of a new GMS contract between GPs and the State for the provision of services.

THE FUTURE

Taking on board all of these factors, we feel that Ireland needs to adopt health policies that recognise that people living in deprived circumstances have worse health outcomes than the rest of the population. We also feel that supports are needed specifically for GPs and primary care teams who are working to effectively manage the care of these patients. There are many potential policy changes that could contribute to achieving these goals, including:

- Commitment to the identification and **appropriate resourcing** of general practices providing care for the most disadvantaged communities.
- Primary care **infrastructural development** in disadvantaged areas. The Primary Care Strategy proposed that primary care teams be co-located with GPs in new primary care centres. Far fewer centres than were originally planned have been developed. Access to proper infrastructure is the only way we can provide the increased services that primary care can, and should be delivering in these areas. This means there is a need to support GPs in disadvantaged areas with the development of these centres; for example using tax

breaks or low rents. Infrastructural development in these areas will not happen without some certainty of the future funding of general practice and incentives.

- The **prioritisation of primary care teams (PCTs)** in disadvantaged areas. Unfortunately, there are many gaps in HSE staff membership of PCTs as posts are left unfilled when staff members leave. We suggest that the staff recruitment embargo be lifted in the most disadvantaged areas.
- Recognition in any **new GMS contract** or primary care resourcing system of the need to incorporate some type of deprivation index that will allow additional support for practices to respond to those with greater medical need. This could come in the form of an adjusted capitation per patient based on patient socioeconomic characteristics, or a practice grant for practices in disadvantaged areas, along the lines of the existing Rural Practice grants. The 'one-size fits all' approach that currently exists only serves to deepen the divisions in healthcare provision and perpetuates the inverse care law. Other innovative options could be explored, such as funding salaried GPs (within the current partnership structures to ensure clinical governance) or employing nurse practitioners to support GPs and practice nurses working in these deprived areas.
- Resources for **diagnostic services**, such as radiology, need to be targeted to where they are needed most.
- **Access to secondary care** is an ongoing problem for patients in areas of deprivation as they mainly rely on public hospital services. Waiting lists for public patients for many specialties are over a year long. This could be said to be contributing to the increased mortality rates in disadvantaged areas as it leads to diagnostic delay for conditions such as cancer.

Many of these main points were recommended in the recent Oireachtas Committee on the Future of Healthcare **Sláintecare Report** in May 2017; including wider availability of community diagnostics, full staffing of PCTs and addressing waiting lists for public hospitals. The Sláintecare Report cited the Inverse Care Law when setting out the scale of the problems facing low-income patients who are trying to access the care they need (Tudor Hart 1971). Particular attention was also given to the challenges these same groups of patients face with multimorbidity. Deep End Ireland were noted to have made submissions to the committee that were acknowledged in the final report, and the hope is that many of the recommendations will be further analysed and implemented.

DEEP END IRELAND ACTIVITY TO DATE

2010-2013

- GPs working in disadvantaged areas started to meet informally in 2010
- Large meeting of GPs held in September 2012 to raise awareness of common issues in deprived areas. Dr Petra Sambale from the Deep End Group in Scotland and the Minister Róisín Shortall presented to the group
- 2012-2013 regular meetings for education, support and to try and formally identify or map the practices in deprived areas nationally
- Funding allocated by the ICGP towards mapping and research study

2014

- Meetings to advance the Deep End agenda with:
 - Minister of State for Health, Róisín Shortall
 - Health Service Executive (HSE) National Director Primary Care, John Hennessey
 - Officials from the Department of Health
 - HSE Health Intelligence Unit, Trutz Hasse and Dr Maeve Anne Wren to consider mapping

2015

- Presentations on the Inverse Care Law at the Irish Medical Organisation AGM and the ICGP Summer School
- ICGP support for the Deep End; meetings recognised for CPD purposes and GMS study leave
- The ICGP report on GP in areas of deprivation is published with input from our group
- Agreement with the original Deep End GP group in Scotland that we can use the 'Deep End' name in Ireland and they provide ongoing advice and support

2016

- Article in ICGP *Forum* Journal on the establishment of the Deep End Ireland group
- Regular CPD meetings involving interested GPs in person, and others from Cork and Limerick by conference call
- Intense work on mapping practices and deprivation, with questionnaires sent to identified practices.
- Article in ICGP Forum Journal about the practice mapping and seeking contact from interested GPs
- Presentation to Oireachtas Committee on Future Healthcare
- Meeting with Minister of Health Simon Harris
- Formal launch of Deep End Ireland group with Professor Graham Watt in attendance, October 2016

REPORT OF FORMAL LAUNCH OF DEEP END IRELAND

The meeting was held at the Royal College of Physicians on Kildare Street in Dublin on Saturday 8th of October 2016. The meeting was advertised in the ICGP *Forum* Journal, on social media and by email to all GPs who had previously attended a Deep End event.

MEETING PROGRAMME

- 09.30 Introduction and welcome: Prof Susan Smith, Department of General Practice, RCSI
- 09.40 Keynote address: Prof Graham Watt, Deep End Project, Scotland
- 10.20 Dr Brendan O'Shea, ICGP
- 10.40 Coffee
- 11.00 Dr Edel McGinnity: Workshop topic presentation
- 11.10 Small group Round Table discussions
- 12.10 Dr Patrick O'Donnell: Plenary discussion

QUESTIONS ASKED OF ATTENDEES

Q1 WHO?

Who should be included in the Deep End Ireland group?

Q2 WHAT?

What issues/topics would you like to focus on?

Also, consider different 'levels' of possible activity practitioner/ practice/ regional /national

Q3 WHEN, WHERE AND HOW?

When, where and how should the group meet?

How should members interact?

How often should events be held?

Summarising points

METHODS

The attendees were divided into small groups in order to address each of the above questions. Flipcharts and markers were provided and at the end of the session the pages with notes from each group were photographed. Each group also had a designated scribe documenting the discussions taking place. Points from each group were then put into table format and this table was analysed for recurring ideas. Notes were also taken during the plenary discussion and these were incorporated. The resulting summary is below.

SUMMARY OF RESULTS

Q1 WHO?

- **GPs only** but develop links/initiatives with Practice Nurse and PHN groups, as well as other relevant community services, eg. addiction, social work, and practice staff
- Widen criteria for Deep End (DE) group membership – '**self-declaring**' rather than by mapping practices alone.

Q2 WHAT?

• **Advocacy**

- Knowing and highlighting 'obligations' of government/HSE
- Knowing and highlighting what works nationally and internationally in other DE settings
- Constantly reminding the public, government, HSE, other GPs, GP schemes, local faculties, ICGP etc. of DE issues
- Work on topics/issues relevant to DE patients/GPs, eg. 'one missed OPD appt and you're off the list', more PCT resources available for DE areas, more consult time for GPs in DE areas.

• **Research**

- Use existing data/practice records, eg. smear uptake rates in DE practices
- Describing and quantifying the DE GP workload in Ireland
- Medical students and GP trainees could be involved
- GP trainees could be involved in 'map' of practice population and setting
- Difficulties of capturing complexity of DE patients
- Patient stories and qualitative research important as well as quantitative work
- External 'supports' coming to DE practices, eg. statisticians, researchers
- Try to build evidence that re sourcing DE practices saves money.

• **Education**

- Have input relevant to DE at existing meetings, eg. ICGP conferences
- Sharing information amongst ourselves on local and national services relevant to DE patients and GPs
- Ensure topics relevant to DE patients/practice included in 'general' CPD activities
- Reaching GP trainees to discuss DE issues seen as important.

• **Other initiatives**

- Offer support for GPs; informal and formal, eg. preventing burnout
- Support practice 'link-worker' pilot (like DE Scotland)
- Practice exchanges – DE GPs seeing other practices working.

- **Resourcing**

- Funding DE group activity, eg. research activity, attendance at meetings
- Funding GPs to work in DE areas – what 'models' are most appropriate
- Incentivising care for specific groups, eg. Travellers
- Balance with being seen to constantly ask for more money for GPs

- GPs caring for **vulnerable populations** such as homeless, Travellers have similar needs

- **Vision and mission statement** – what is the vision for DE practices in Irish primary care context.

Q3 WHEN/HOW?

- Consider annual meeting specific to DE issues with inspiring speakers, DE research, DE 'success stories' etc.
- Email and website also useful for communication
- Remember DE GPs/practices outside Dublin
- DE CPD meetings to continue as is – business and education component, can dial in if needed, city centre location
- DE steering committee does not need rigid structure.

WHAT NEXT FOR DEEP END IRELAND?

- We are continuing to map GP practices in areas of deprivation across the country. This requires access to PCRS data with individual patient socioeconomic characteristics such as address to allow mapping to Electoral Divisions
- We have a database of GPs who are interested in being involved and hearing about the work of Deep End Ireland
- We will continue to highlight issues relating to Deep End GP work when engaging with the ICGP, the IMO and other relevant bodies
- We continue to hold continuing professional development meetings for Deep End GPs across Ireland
- We are planning an advocacy strategy for further promotion of Deep End GP issues.

REFERENCES

- Barnett, K.**, Mercer, S. W., Norbury, M., Watt, G., Wyke, S. and Guthrie, B. (2012) 'Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study', *Lancet*, 380.
- Boomla, K.**, Hull, S. and Robson, J. (2014) 'GP funding formula masks major inequalities for practices in deprived areas', *BMJ: British Medical Journal*, 349.
- Crowley, P.** (2005) 'Health Inequalities and Irish General Practice in Areas of Deprivation', [online], available: <http://www.icgp.ie/speck/properties/asset/asset.cfm?type=LibraryAsset&id=39C67A51-C37D-43AA-85C0E6EC3EB8DB94&property=asset&revision=tip&disposition=attachment&app=icgp&filename=29BB98FC-E7C4-A1F3-B8E1A52B531DCBD3.pdf>
- Deep End (2016)** 'General Practitioners at the Deep End - summaries of 29 Deep End meetings held between January 2010 and December 2016.', [online], available: http://www.gla.ac.uk/media/media_514603_en.pdf [accessed
- Hosseinpour, A. R.**, Bergen, N., Mendis, S., Harper, S., Verdes, E., Kunst, A. and Chatterji, S. (2012) 'Socioeconomic inequality in the prevalence of noncommunicable diseases in low- and middle-income countries: Results from the World Health Survey', *BMC Public Health*, 12(1), 474.
- Mackenbach, J. P.**, Stirbu, I., Roskam, A.-J. R., Schaap, M. M., Menvielle, G., Leinsalu, M. and Kunst, A. E. (2008) 'Socioeconomic Inequalities in Health in 22 European Countries', *New England Journal of Medicine*, 358(23), 2468-2481.
- Marmot, M.**, Allen, J., Bell, R., Bloomer, E. and Goldblatt, P. (2012) 'WHO European review of social determinants of health and the health divide', *The Lancet*, 380(9846), 1011-1029.
- Marmot, M. G.**, Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M. and Geddes, I. (2010) 'Fair society, healthy lives: Strategic review of health inequalities in England post-2010'.
- McLean, G.**, Guthrie, B., Mercer, S. W. and Watt, G. C. (2015) 'General practice funding underpins the persistence of the inverse care law: cross-sectional study in Scotland', *Br J Gen Pract*, 65(641), e799-805.
- Mercer, S. W.** and Watt, G. C. M. (2007) 'The inverse care law: Clinical primary care encounters in deprived and affluent areas of Scotland', *Ann Fam Med*, 5(6), 503-510.
- Osborne, B.** (2015) 'Irish General Practice - Working with Deprivation', [online], available: http://www.icgp.ie/go/about/policies_statements/2015/F84D49CD-EC7E-525A-1B0F4EB066E88BBA.html
- Pedersen, A. F.** and Vedsted, P. (2014) 'Understanding the inverse care law: a register and survey-based study of patient deprivation and burnout in general practice', *International Journal For Equity In Health*, 13(1), 121.
- Reeves, D.** and Baker, D. (2004) 'Investigating relationships between health need, primary care and social care using routine statistics', *Health & Place*, 10(2), 129-140.
- Stringhini, S.**, Carmeli, C., Jokela, M., Avendaño, M., Muennig, P., Guida, F., Ricceri, F., d'Errico, A., Barros, H., Bochud, M., Chadeau-Hyam, M., Clavel-Chapelon, F., Costa, G., Delpierre, C., Fraga, S., Goldberg, M., Giles, G. G., Krogh, V., Kelly-Irving, M., Layte, R., Lasserre, A. M., Marmot, M. G., Preisig, M., Shipley, M. J., Vollenweider, P., Zins, M., Kawachi, I., Steptoe, A., Mackenbach, J. P., Vineis, P., Kivimäki, M., Alenius, H., Avendano, M., Barros, H., Bochud, M., Carmeli, C., Carra, L., Castagné, R., Chadeau-Hyam, M., Clavel-Chapelon, F., Costa, G., Courtin, E., D'Errico, A., Dugué, P.-A., Elliott, P., Fraga, S., Gares, V., Giles, G., Goldberg, M., Greco, D., Hodge, A., Irving, M. K., Karisola, P., Kivimäki, M., Krogh, V., Lang, T., Layte, R., Lepage, B., Mackenbach, J., Marmot, M., McCrory, C., Milne, R., Muennig, P., Nusselder, W., Panico, S., Petrovic, D., Polidoro, S., Preisig, M., Raitakari, O., Ribeiro, A. I., Ribeiro, A. I., Ricceri, F., Robinson, O., Valverde, J. R., Sacerdote, C., Satolli, R., Severi, G., Shipley, M. J., Stringhini, S., Tumino, R., Vineis, P., Vollenweider, P. and Zins, M. (2017) 'Socioeconomic status and the 25 x25 risk factors as determinants of premature mortality: a multicohort study and meta-analysis of 1.7 million men and women', *The Lancet*, 389(10075), 1229-1237.
- Stringhini, S.**, Sabia, S., Shipley, M. and et al. (2010) 'Association of socioeconomic position with health behaviors and mortality', *Jama*, 303(12), 1159-1166.
- Tudor Hart, J.** (1971) 'The Inverse Care Law', *The Lancet*, 297(7696), 405-412.

