Summary of visit
Committee members Willie Coffey MSP, Iain Gray MSP and Colin Keir MSP met with Professor Graham Watt, Dr Susan Langridge and Dr Jim O’Neil from “GPs at the Deep End” to discuss the issues faced by GPs treating patients from deprived areas.

GPs at the Deep End
“GPs at the Deep End”, is a group of GPs working in 100 general practices serving the most socio-economically deprived populations in Scotland. The group provides an opportunity for GPs in deprived areas to share experiences of tackling health inequalities. They explained how advancements in technique had not translated into improvements in patient health and health inequalities had remained.

Issues facing GPs in deprived areas
Average life expectancy is lower in deprived communities (68) compared to those in non-deprived communities (78). In addition, many people in deprived communities have multiple long-term conditions, such as mental health problems, alcohol and smoking related issues, which on average they experience 10-15 years earlier compared with those from other communities. GPs working in deprived areas therefore deal with chronic disease management and have more patients with complex issues, over a longer time period, compared with GPs from more affluent areas.

The members heard that there is a tendency within the NHS to focus on specialisms, resulting in the headline issue being treated, but other symptoms and health problems may be missed. The medical practice is often the only constant in the patients care journey and therefore it becomes a hub for the patient’s care and the GP often has the best picture of the patient’s all-round health. There requires to be a joined up approach to ensure the patients journey can be followed, so it is important that referrals to other departments, such as social work and secondary care, are timely and good links are maintained.

Patients may play down symptoms in the fear that the GP will inform them they have health issues, or in some cases they don’t recognise symptoms, such as believing a heart attack is indigestion. GPs often have to look for clues and signals of symptoms to ensure that such presentations are recognised early. Serial consultations and knowing the family’s background and health history often helps in building a picture of the patient’s all-round health. Many patients from deprived areas have low self-esteem, so are often resigned to the fact that they will become ill, or have a heart attack and have low expectations of good health.

Distribution of GPs
The group highlighted that the distribution of GPs across Scotland was relatively flat, despite there being a higher level of ill-health in the most deprived communities. Therefore, there is a higher demand for services, shorter time available to deal with
patients and that may result in greater GP stress (which may affect the patient encounter and may exacerbate health inequalities). Members heard that there is merit in focussing greater GP resource in the most deprived areas, to build more time into the consultation process, as it is difficult to deal with patients with multiple issues in 10 minute consultations.

In addition, new graduates are less likely to go into general practice medicine as there is a preference for going into health specialisms and they may see general practice as too difficult.

**Views on Keep Well and anticipatory care**

One issue raised was whether national screening programmes, such as Keep Well, process large numbers of patients quickly, but focus on treating the headline issue. They lack the sustainability of the primary care approach which involves long-term, serial consultations to ensure that all aspects of the patient’s health are addressed. Such programmes may also miss parts of the population with complex care needs and multiple problems, who require continuity of care.

It was argued that many of these initiatives are focussed on being busy, rather than making a difference and that some of the patients in their areas could do with anticipatory care at a younger age (such as in their 30s) than some of the programmes currently provide for.

**Key Issues highlighted**

- The distribution of GPs and focussing resources at where there is greatest need, should be considered.
- Serial consultations and more time required within consultations to allow GPs at the Deep End to deal with patients with chronic conditions. Where more time has been built into consultations, patients with complex issues reported greater enablement and doctors were less stressed. Serial consultations also allow the GP to maintain an all-round picture of the patient’s health.
- A more horizontal approach to medical training, should be considered, rather than focussing on specialisms, so that headline and other symptoms can be recognised.
- GPs must ensure they have good relationships with patients to ensure they recognise the signals where patients may be normalising pain (e.g. thinking it’s indigestion) or disguising or denying symptoms. GPs need resilience to deal with such patients. It is important to change attitudes regarding patients’ sense of worthiness and expectations of ill-health.
- Good communication is key to ensuring that patients understand their symptoms and what is happening to them. It is important that these are explained to them without eliciting a fear response and that they end the consultation understanding their symptoms and care plans.
- Good support teams within practices are important, such as nurses, who can do some of the communication with patients to allow GPs to think about patients’ health requirements.
- Referrals to other departments, such as mental health, social work and secondary care should be timely and good relationships and links need to be maintained to ensure continuity of care.
- Providing anticipatory care at a younger age should be considered for deprived communities.
- Patients who are involved in national screening programmes, such as Keep Well, should be supported in the long term to ensure continuity of care.