



Royal College of
General Practitioners

A graphic of a staircase with silhouettes of people at various stages. At the top is a child, below it two elderly people (one with a cane), in the middle a family of four, and at the bottom a child. The background is dark blue with a horizontal band across the middle and various geometric shapes like squares and circles in lighter shades of blue.

HEALTH INEQUALITIES

INTRODUCTION

Health inequalities, defined as differences in health levels and outcomes between individuals and groups of individuals, are an issue of fundamental importance for general practice. The role of the GP as an expert medical generalist at the heart of the community, and the first point of contact for the vast majority of patients, means that general practice has a pivotal role to play in combatting the causes of health inequalities and dealing with their effects.

As such, a fundamental part of the solution to health inequalities is a strong, well resourced general practice (and wider primary care) service at the heart of the community, with the means to undertake both proactive and reactive care supported by a wider integrated health and social care system.

However, the NHS in its current form is in many ways a primarily reactive service with resources channelled towards providing individual episodes of care, often in an emergency or secondary care setting, and with different parts of a local health economy working in relative isolation due to both structural and cultural barriers to integrated working.

Closely connected to this is historic underinvestment in general practice, meaning that practices are now extremely overstretched and struggling to meet the changing needs of a growing patient population. As such, in the current climate many GPs are unable to dedicate time and resources to managing the effects of health inequalities or designing services that take a more proactive population based approach to the health of their patients.

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Despite many years of commitments from successive governments in the four nations of the UK to tackle health inequalities, there has been little improvement in the differences in health outcomes. Radical action is now needed to urgently address this vital public health issue. This paper sets out the RCGP's thinking on how general practice can best be supported to help mitigate and ultimately tackle health inequalities. Although general practice is of course only part of the solution, a central theme of this paper is that without measures to end the current resource and workforce pressures facing GP services across the UK, health inequalities will continue to get worse. In particular, we believe that action is needed in the following six areas:

- 1** As part of measures to increase the overall size of the GP workforce, put in place incentives to attract more GPs to currently under-doctored areas, ensuring that there is sufficient GP workforce capacity in areas where patient need is highest.
- 2** As part of a wider rebalancing of resources towards general practice, direct more NHS funding into GP and wider primary care services in those areas where health inequalities are currently worst.
- 3** Ensure that the process of piloting and delivering new models of care integrated around patients in each of the four nations of the UK serves to tackle, rather than exacerbate, health inequalities.
- 4** Create a supportive environment for GPs and their teams to take a more proactive population based approach to preventing ill health in their communities, working with other professionals to tackle the underlying causes of health inequalities. However, this cannot be taken forward without an increase in workforce capacity and resources, and must be led by GPs and other professionals from the bottom-up, rather than through imposing top-down interventions.
- 5** Focus on incentivising ways of working that promote continuity of care in areas where patients would benefit most from a continuous therapeutic relationship with their GP — particularly areas where a high number of patients are living with multiple morbidities.
- 6** Fund outreach programmes to help often excluded groups such as those with mental health problems, learning disabilities and the homeless to access general practice.

THE SCALE OF THE CHALLENGE

Health inequalities between individuals and groups of individuals are understood and measured as marked differences in health outcomes, for example, differences in life expectancy and levels of morbidity. These differences, particularly within socially excluded and disadvantaged groups, are well documented:

- 1 In 2010 the Marmot Review concluded that in England people living in the poorest neighbourhoods will, on average, die seven years earlier than people living in the richest neighbourhoods. Moreover, the average difference in disability free life is 17 years. So, people in poorer areas not only die sooner, but they will also spend more of their shorter lives with a disability.¹ Indeed, despite successive governments' efforts to reduce health inequalities the difference in life expectancy between the most and least deprived increased by 7 per cent for men and 14 per cent for women between 1995-7 and 2006-8.²
- 2 The Deep End Project, a study of health inequalities in Scotland in 2013, found that healthy life expectancies are 57 and 61 years for men and women in the most deprived tenth of the Scottish population, compared with 76 and 78 for men and women in the most affluent tenth, a difference of 19 and 17 years respectively.³ Although there has been some fluctuation within this measure, the life expectancy gap for men and women has remained largely static since 1999.
- 3 In Northern Ireland the government has calculated that the difference in life expectancy between the most and least deprived members of society is five years for men and three years for women. The male life expectancy gap has shown no signs of improvement since 2005-7 and, although the female life expectancy gap has improved recently, this is only by a marginal amount.⁴

However, while studying health outcomes is a good way to quantify the effects of health inequalities, health outcomes do not in themselves determine inequality. Health inequalities are not simply a difference in health outcomes but a difference in health outcomes combined with a barrier to accessing the health care system. In addition to physical barriers, such as opening hours and locations, there are many invisible barriers that can lead to this exclusion, including literacy, patient perceptions, staff attitudes, and poor communication. While some of these issues are easy to resolve, others remain more complex, and will require significant action on the part of politicians, policy makers and health practitioners.

THE ROLE OF GENERAL PRACTICE IN COMBATting HEALTH INEQUALITIES – AND ITS LIMITS

The contribution of a strong primary care sector to health outcomes is well established^{5 6} and a strong, properly resourced general practice service is essential if the UK is to reduce and eventually end health inequalities. General practice is unique as the only part of the health service that provides whole-patient care, through the GP's role as an expert medical generalist providing individualised care to patients in the context of their wider social environment. General practice is also the only part of the service that is truly universal in that the vast majority of patients are registered with a GP practice, and GPs do not 'discharge' patients from their care. As such, continuity of care and preventative care — two important tools in combatting health inequalities — form a fundamental part of the work of a GP and their team.⁷

However, it is important to recognise that general practice can only ever be one part of the solution to tackling health inequalities. All parts of the health and social care system need to work together to combat health inequalities, and much of the work that GPs can do to make a difference in this area needs to be taken forward in collaboration with other professionals. We need to ensure that the right levers are put in place to facilitate integrated working, and that this is done in a way that reduces health inequalities.

More broadly, many of the causes of health inequalities are outside of the remit of the health and social care system as a whole to address. This paper focuses on what the NHS can do to tackle health inequalities, and what role GPs can play within this – but in doing so it must be recognised that important factors such as deprivation require much wider action from government and society as a whole.

CAUSES OF HEALTH INEQUALITIES

The causes of health inequalities are numerous and often interconnected, and as such can be difficult to quantify. However, if an individual is affected by any of the following issues then it will affect their health outcomes.

DEPRIVATION

Poverty is the single biggest indicator of relative ill health, with individuals within deprived areas in the UK experiencing higher levels of morbidity, multimorbidity and having a significantly lower life expectancy than those in the least deprived areas. The factors behind these differences in health outcomes are complex and interconnected. However, areas of high deprivation are characterised by the following factors:

- **Public health issues:** Individuals living in the most deprived areas of England are more likely to be affected by public health issues, such as obesity, smoking and alcohol related diseases. In Scotland, 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. In addition, in 2007/8, 45 per cent of adults living in the most deprived decile of Scotland were smokers, compared with 11 per cent in the most affluent deciles.⁸ Although there has been a decrease in the proportion of people affected by public health issues such as smoking or alcohol abuse in recent years, this decline has taken place at a much slower rate amongst the most deprived members of the population.⁹
- **Multimorbidity:** Multimorbidity is one of the biggest drivers of poor health outcomes, as not only will individuals have more ill health as a whole but the existence of two or more concurrent illnesses complicates the way in which the patient interacts with the health service. Multimorbidity occurs most frequently in deprived areas, at 10-15 years earlier than in affluent areas. The most common co-morbidity in deprived areas is long term mental health problems.¹⁰ Multimorbidity is one of the major issues facing the health service with the number of people with three or more long term conditions predicted to rise from 1.9 million in 2008 to 2.9 million in 2018.¹¹
- **Living conditions:** Overcrowded and unsuitable housing and high levels of unemployment are also features of areas of deprivation, and factors that impact upon health outcomes, albeit ones that lie outside of the capability of the health service to combat.

DIFFICULTIES ACCESSING THE HEALTH AND SOCIAL CARE SYSTEM

Difficulties accessing the healthcare system are one of the major drivers behind health inequalities. Traditionally socially excluded groups, such as the homeless, sex workers, and Gypsies or Travellers, often struggle to engage with the healthcare system and consequently have significantly worse health outcomes than equivalent individuals within the wider society.

Homelessness is one of the biggest indicators of a lack of engagement with the health system. The impact of rough sleeping on the wider health and life expectancy of individuals is well recognised: a recent evaluation by Crisis found that the average life expectancy of the homeless in England is 47, as opposed to 77 for the general population.¹² This is partly because of the administrative barrier that the lack of a fixed address places in the way of accessing primary care, but also due to the fact that homelessness tends to be associated with poor mental health and drug abuse, both of which limit the ability of individuals to interact with the health system and wider society, as well as impacting negatively on their overall health.

Gypsies or Travellers are another section of society that experience markedly worse health outcomes than the general population, with 42 per cent of English Gypsies suffering from a long term condition, as opposed to 18 per cent of the general population.¹³ Again, as with homelessness, this can be explained by a lack of access to non emergency health care, due in part to administrative barriers but also in part to social and cultural barriers.

Recent immigrants and asylum seekers may also have trouble navigating the health system as they often have little awareness of available services and speak limited English, while the provision of translation services is patchy and underfunded. The need for a translator can also add extra time to a GP consultation, time which is in short supply in under-doctored areas (which traditionally are associated with high levels of immigration and poverty).

The RCGP has published a paper on Patient Access to General Practice which explored some of these issues in detail, and looked at the challenges faced by groups such as those with mental health problems and learning disabilities in accessing GPs services.¹⁴

GENERAL PRACTICE AND THE 'INVERSE CARE LAW'

In 1971 Dr Julian Tudor Hart articulated the 'inverse care law' that states that "the availability of good medical care tends to vary inversely with the need for it in the population served". This is evidenced by the phenomenon of 'under-doctored' areas — that is an uneven distribution of GPs in relation to health need, resulting in many areas not having sufficient GPs to meet patient need.

In Scotland, despite wide differences in health needs, the general practice workforce is flatly distributed, leading to areas of most need not being serviced by enough doctors. In England, the Centre for Workforce Intelligence has estimated that in terms of GP coverage and deprivation, the poorest quintile of (the now defunct) PCTs has a considerably lower number of GPs (62.5 per 100,000) than the richest quintile (76.2 per 100,000).¹⁵ In addition, a 2010 National Audit Office report on health inequalities found that, although the number of GPs in areas with the greatest health needs has increased in recent years, GP levels, weighted for age and need, are still lower in deprived areas.¹⁶

The effect of this distribution may be manifest in the fact that there is a relatively strong correlation between areas with high numbers of patients reporting problems with getting an appointment and those that have the fewest numbers of GPs per head. In England those living in the 23 CCG areas that have fewer than 35 Full Time Equivalent (FTE) GPs per 100,000 are around 60 per cent more likely to be unable to get an appointment than those living in CCG areas with more than 45 FTE GPs per 100,000.¹⁷

The geographical distribution of GPs is linked to regional training capacity and programmes, with most GPs taking their first job in their region of training. The policy of increasing GP training vacancies uniformly across all regions in England has resulted in greater competition for GP training places in regions which are relatively over-doctored across the south of England, and lower competition for training places in regions which are relatively under-doctored with the perverse outcome of potentially exacerbating the fill rate in the areas of highest need.

PATIENT ENGAGEMENT WITH THEIR OWN CARE

A lack of patient engagement with their own health and care has a well understood impact on relative health outcomes, with research showing that patients who have so called low 'health activation' are two to three times more likely to have unmet medical needs and to delay medical care compared with more highly activated patients, even after controlling for income, education and access to care.¹⁸

This lack of engagement can take the form of low take up of screening or immunisation programmes, a failure to use doctors appointments to their full advantage, an inability to properly manage long term conditions, or a lack of healthy behaviours, such as good diet and exercise; all of which have a marked impact on health outcomes. Low levels of health activation cut across all social determinates with patient activation levels only moderately correlated with markers such as socio-economic status, age, education, income and gender. Given that it is estimated that 60 to 70 per cent of premature deaths are caused by behaviours that could be changed, it is vital that patients are encouraged to become more involved in their own health and wellbeing.¹⁹

RURAL AND REMOTE AREAS

An often overlooked factor in the discussion of health inequalities is that degrees of rurality can also have a stark effect on health outcomes. Rural and remote areas in all parts of the UK, but particularly those within the Highlands and Islands of Scotland, experience a number of issues that contribute to inequalities in health outcomes between rural and urban locations. Examples include, trouble attracting GP trainees to work in an area, an increased workload due to the challenges in providing healthcare over a large geographic area, and a lack of basic infrastructure.²⁰ These issues are often compounded by the high number of elderly people found in rural areas, with funding systems often not built to take into account the unique needs of an elderly isolated community.

In addition, rural patients are far more likely to experience difficulty accessing healthcare than those living in urban areas, due to relative levels of isolation, and the lack of reliable basic transport services, combined with poverty and morbidity or disability.

As such, patients living in rural locations experience poorer health outcomes in some health areas than those living in urban locations. For example, in Scotland mortality rates for road traffic accidents, asthma, and cancer are worse in rural areas, with cancer being diagnosed at a later stage and intervention rates for coronary artery disease being lower than in urban areas.²¹

ISSUES OUTSIDE OF THE HEALTH SYSTEM

While the role of the GP is undeniably central to combating health inequalities, the source of and treatment for health inequalities more often than not lies outside of not only a GP's remit, but the remit of the health service as a whole to address. Indeed, modelling undertaken by the Department of Health in 2010 indicated that approximately 80 to 85 per cent of variation in (the now defunct) PCTs' all-age all-cause mortality performance can be explained by its association with factors such as the local level of income deprivation, educational attainment, median income, socio-economic class and ethnicity.²²

GPs have an important role to play in directing patients towards the relevant parts of the health service or social services. In addition, there is limited scope for GPs to play an active role combating some of the social or economic causes behind health inequalities; for example through schemes such as 'boilers on prescriptions',²³ or if they have the capability, by facilitating community groups.

However, GPs cannot be expected to compensate for inadequacies of the system as a whole. As the Marmot Review correctly identified, there needs to be a whole system approach in order to properly address the causes and effects of health inequalities with service improvements made in areas such as education, housing, employment and the care of the homeless.

WHAT CAN WE DO TO REDUCE AND ELIMINATE HEALTH INEQUALITIES?

This paper considers what actions can be taken to reduce and eventually eliminate health inequalities in the UK. The recommendations below focus on what can be done to better support general practice to have the biggest impact on health inequalities — whilst recognising that this will need to be part of a much wider process.

Recommendation one:

As part of measures to increase the overall size of the GP workforce, put in place incentives to attract more GPs to currently under-doctored areas, ensuring that there is sufficient GP workforce capacity in areas where patient need is highest.

It has been widely recognised that across the UK there is not currently enough workforce capacity within general practice to keep pace with population growth and the growing complexity of providing care to an ageing population. The RCGP has estimated that there is a need to increase the FTE GP workforce by around 10,000 across the UK by 2020.

The four governments of the UK need to put in place measures to increase the size of the GP workforce, but in doing so should focus specific measures on reducing health inequalities by encouraging more doctors to join general practice in currently under-doctored areas.

GPs are much more likely to settle in the area in which they train. An RCGP survey of recently qualified GPs reveals that only 19 per cent of newly qualified GPs are willing to relocate over 60 miles from the place in which they trained. As well as tending to stay in the area local to where they trained, GPs are more likely to choose to work in areas with low unemployment and good amenities. The core strategy to improve the number of GPs in under-doctored areas must therefore be to encourage postgraduate training in the areas of greatest workforce need.

Serious long term investment is needed to attract doctors into under-doctored areas in conjunction with schemes to increase the general practice workforce as a whole. However, these schemes and the requisite funding must be long term, lasting past the end of each parliament.

Actions needed:

- Design and implement incentives to attract more GPs to practise (and stay) in currently under-doctored areas. Such incentives could be financial (e.g. 'golden hello' payments, or support with paying off student loans) but may also take the form of offering enhanced training and career opportunities (e.g. business management and leadership training). In England, the RCGP is working with NHS England, Health Education England and the BMA to put such incentives in place.²⁴ This approach could be replicated in Scotland, Wales and Northern Ireland.
- Future increases in the number of GP training places available should be focused on currently under-doctored areas.
- The governments of the four nations of the UK should commission research to identify areas of greatest need and estimate what numbers of GPs would be needed in order to deliver safe patient care within each area.

Recommendation two:

As part of a wider rebalancing of resources towards general practice, direct more NHS funding into GP and wider primary care services in those areas where health inequalities are currently worst.

The College has elsewhere made the case for a significant shift in NHS resources towards general practice in order to better enable the NHS to meet the changing needs of patients.²⁵ Despite GPs and their teams dealing with 90 per cent of patient contacts, general practice receives (as of 2013/14) just 8.3 per cent of UK-wide NHS resources — its lowest share for over a decade. The need to invest more resources into general practice has been acknowledged by all four governments of the UK, and as a result a number of initiatives have been set up that could begin to reduce historic underinvestment in GP services. These include:

- A £1bn GP fund allocated for investment in GP infrastructure in England over the next four years.
- A £250m transformation fund to begin delivering the NHS England Five Year Forward View — some of which may be used to fund general practice.
- The £3.6bn Better Care Fund, designed to reduce avoidable hospital admissions in England.
- The Prime Minister's Challenge Fund, which is being used primarily to fund extended opening hours in some GP practices in England.
- A £200m fund to deliver the 'accountable GP' initiative in England.
- In Scotland, a £40m primary care fund.
- In Wales, a £30m primary care fund, in addition to previous funding commitments of around £13.5m in total.
- In England it is anticipated that new co-commissioning arrangements between CCGs and Local Area Teams will lead to resources being shifted towards primary care.

Investing resources in general practice across the UK will be essential to the process of reducing health inequalities. It will be important, however, to ensure that new investment is targeted at those areas where patient need is greatest. There is a risk, for example, that GP practices working in currently under-resourced areas will have less time and space to bid for funding.

Actions needed:

- Efforts need to be made by the four governments of the UK to monitor how resources are being invested in general practice and primary care. This will help provide a national 'big picture' of whether funding is being targeted at areas that need it most.
- Policy makers should consider setting up a specific fund targeted at practices operating in the most deprived areas — including specific funding streams targeted at rural general practice.

In addition, there are longstanding concerns that the formulae through which core GP funding is allocated (known as the Carr-Hill formula in England and Wales and the Scottish Allocation Formula in Scotland) do not currently fully take into account some of the factors behind health inequalities. Research undertaken by the Clinical Effectiveness Group at Queen Mary University of London suggests that practices in one of the UK's most deprived areas have been underfunded by 33 per cent due to the Carr-Hill formula's failure to recognise how deprivation affects GP workload. The research concludes that this is partly due to the fact that deprivation is not included in the banding for sex or age, meaning that the health of the elderly deprived, and the rate of multimorbidities in younger people in deprived areas, are not taken into account.²⁶

In addition, many GP surgeries in rural areas find that the global sum entitlement does not cover the associated costs of providing services to remote and often elderly communities. As such it is important that any adjustment in the funding formula takes into account factors that affect health outcomes above and beyond relative deprivation.

Actions needed:

- An urgent review into the effectiveness of the global sum funding formulae in each of the four nations to resolve the problem of some practices in deprived and/or rural areas not receiving sufficient funding.
- Open up funding streams for practices to 'top up' their funding if they find that there is a change in their practice population (e.g. an influx of asylum seekers into an area), or to take into account short term changes in the practice population's needs.

Recommendation three:

Ensure that the process of piloting and delivering new models of care integrated around patients in each of the four nations of the UK serves to tackle, rather than exacerbate, health inequalities.

The status of the GP as a generalist in long term and repeated contact with the family or individual at risk, can put them in an ideal position to understand and address the underlying causes of ill health, whether they be medical or social. This may involve dealing with the issue in house via multidisciplinary working or co-location, referring and signposting onto relevant external services (including community and social groups), and in some cases directly providing social remedies through innovative initiatives such as the in house debt advice scheme that is currently being run by some GPs in Scotland.²⁷ However, it is important to note that while GPs play a important role in the coordination of patient centred care, patients must not be encouraged to view general practice as the only means of accessing support services relevant to their needs.

The RCGP has long championed the development of new models of integrated care in the community, and the pivotal role that general practice can play here. There is a growing consensus that the NHS needs to deliver more patient care in the community, and focus on prevention and proactive care. As the NHS England Five Year Forward View²⁸ has identified, the NHS needs to take decisive steps to break down the barriers in how care is provided, for example by encouraging groups of GPs to combine with nurses, other community health services, hospital specialists, and even mental health and social care to create integrated out-of-hospital care.

Initiatives across England, Scotland, Wales and Northern Ireland are now underway to encourage the development of new integrated models of care. As with efforts to shift resources into general practice, there is a risk that GPs working in areas where services are most overstretched find that they have less time to design new services and provide the system leadership needed to achieve a transformation of care for patients.

Actions needed:

- There is need for a programme of support, advice and training targeted at GPs and their teams to better enable them to lead the development of new models of care in their area. Any such programmes should take into account the need to provide extra support to GPs working in the most overstretched areas.
- The governments of the UK should look to establish a set of health inequality impact pilots, providing an initially small set of practices in highly deprived areas with increased funding and administrative support.

Recommendation four:

Create a supportive environment for GPs and their teams to take a more proactive population based approach to preventing ill health in their communities, working with other professionals to tackle the underlying causes of health inequalities. However, this cannot be taken forward without an increase in workforce capacity and resources, and must be led by GPs and other professionals from the bottom-up, rather than through imposing top-down interventions.

Ill health prevention is one of the most effective ways to combat health inequalities. The Department of Health estimates that in England around 15 to 20 per cent of inequalities in mortality rates can be directly influenced by health interventions which prevent or reduce the risk of ill health, representing thousands of people dying earlier than might otherwise be the case.²⁹

GPs as the expert medical generalist at the heart of the community are ideally positioned to aid with ill health prevention, either through public health initiatives such as immunisations and screening programmes, or by identifying at risk individuals and facilitating interventions. For example, GPs have a strong role to play in encouraging patients to take an active interest in their own health and care. There are a number of ways GPs can help to increase this so called 'patient activation' such as via specific outreach programmes or in the course of the GP appointment.

One of the most effective methods by which a GP can undertake ill health prevention is to take a population based approach to the health of their 'patient list', by monitoring patients on their list who are judged to be in relative ill health or at risk of becoming so, and coordinating a proactive response. However, many GPs feel that they have lost the ability to stratify their list, due to staffing and time pressures that have forced general practice into a reactive rather than proactive stance.

Indeed, in order for GPs to use their patient list in this fashion, they must have access to adequate monitoring data. General practice is rich in data to support such monitoring. For example, data is routinely available on patient demographics, consultations, referrals, secondary care usage, prescribing and outcomes. However GPs often lack the resources to coordinate this data into risk stratification tools for usage within general practice and a lack of coordination and integration with other parts of the health service can lead to this data being underused.

Moreover, due to the complexity of the causes of health inequalities ill health prevention is more likely to be effective when undertaken in tandem with other agencies.

Actions needed:

- CCGs and Health Boards should promote the use of risk stratification and monitoring tools that enable GPs to fully understand health inequalities within their area, including providing appropriate training and support to practices. It is vital that these tools allow the information to be easily shared with relevant nearby services.
- Practices to be offered additional resources to use screening and immunisation programmes as an opportunity to engage patients within a practice area who are not currently actively managing their healthcare.
- CCGs to work with all local health and social services to produce lists of all available services within an area, including social groups, which would then be made available to all health and social care providers.

Recommendation five:

Focus on incentivising ways of working that promote continuity of care in areas where patients would benefit most from a continuous therapeutic relationship with their GP — particularly areas where a high number of patients are living with multiple morbidities.

There is strong evidence that good continuity of care is vital to achieving positive health outcomes for patients — particularly the growing number of people living with multiple long term conditions. However, often those who would benefit most from continuity of care within general practice have the poorest access to their preferred GP because services in their area are overstretched. The RCGP has long advocated longer consultations for the most complex patients, but this is practically problematic in a climate of limited resources and workforce capacity.

In some areas, GPs are trialling new approaches to promoting continuity of care, such as GP 'micro teams' — groups of two or more doctors who work together to provide continuity of care to an allocated number of patients. Increasingly, however, practices are also seeking to proactively identify patients who would most benefit from improved continuity of care, and using a care planning approach — led from within general practice but in partnership with other professionals — to ensure these patients have access to more personalised, integrated care.

The development of new federated models of care in general practice also presents an opportunity to provide patients with the most complex needs with intensive support and better continuity of care. Some practices are trialling the co-location of other community based services — such as mental health teams, pharmacists, social workers and drug and alcohol teams — who then work closely with the core practice team.

Actions needed:

- Funding and support should be targeted at initiatives to promote continuity of care in currently overstretched areas.
- Practices operating in deprived areas should be given incentives and support to co-locate with services that can enhance continuity of care for patients with the most complex needs.

Recommendation six:

Fund outreach programmes to help often excluded groups such as those with mental health problems, learning disabilities and the homeless to access general practice.

Many GPs currently run healthcare services designed to address the health concerns of patient groups who have trouble accessing the healthcare system in a traditional manner, for example the homeless or asylum seekers. However, while outreach programmes of this type can be seen to be a fundamental part of the work of a GP, many GPs will struggle to provide them due to funding or staffing restraints or a lack of local 'buy in' to transform services. Indeed, even in areas where there is an existing provision of outreach services the issue then becomes the coordination of care across the whole health and social care system for what is essentially an unregistered patient, or moving a patient into more suitable healthcare options once they become more settled.

Actions needed:

- Specific funding streams for outreach programmes to be made more widely available and easier for GPs to access.
- CCGs to work with Local Health and Wellbeing Boards to produce information about the level of homelessness within an area to facilitate the commissioning of new services.

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