

- Consider the Common Assessment Framework (CAF) as a friend. It is the best tool we have for analytical assessment of complex cases not unlike the landmark RCGP trial I mentioned above.<sup>4</sup>
- Look at the RCGP/National Society for Prevention of Cruelty to Children Toolkit for Safeguarding Children and Young People (section on Child Protection Conferences, page 36).<sup>5</sup> You will note that it highlights the three main headings of the CAF: child's developmental needs, parenting capacity, and family and environmental factors. The Toolkit goes on to consider key points to include from a GP perspective. Perhaps use this to set up your own template.

If we manage to contribute to make even one or two children's lives better per GP per year through safeguarding, we may be rewarded by seeing their health and wellbeing improved and may even be thanked by future GPs who have one or two adults less scarred forever by child abuse and neglect.

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## Busy doing different things

I have worked in practices serving both affluent and deprived patient populations. Therefore, I have no hesitation in stating that GPs across the board are busy. However, it strikes me that we are often busy doing different things.

I recognise the challenges associated with caring for relatively affluent older patients<sup>1</sup> and those with good health-literacy skills.<sup>1</sup> I also have no doubt that 'Deep End' practitioners<sup>2</sup> aspire to the core values of general practice, namely; to be excellent medical generalists who provide whole person medicine and patient advocacy.<sup>3</sup> However, Deep End GPs are often constrained by limited resources in the context of deprivation, making consistent attainment of such values hard to achieve.

GPs serving more affluent populations arguably face a heavy workload but in a very different social context, that, albeit a potential challenge to the delivery of health care, is less likely to lead to detrimental health outcomes. The latest 'report card' on health inequalities in Scotland serves to emphasise this reality, when compared to the most affluent quintile: healthy life expectancy for males in the most deprived quintile is 18.8 years lower, and those aged 45-74 years are 4.7 times more likely to die from coronary heart disease, 9.2 times more likely to die from an alcohol-related disease, and are twice as likely to die of cancer.<sup>4</sup> The Deep End project serves to remind us that these practices are battling against the odds in the face of real and significant health needs. Such statistics cannot be ignored and a focus on 'workload,' with practitioners assessing how busy they are compared to their peers, risks obscuring these harsh facts.

Health inequalities cannot be solved by the NHS alone. However, the delivery of health care in Scotland, where a flat-line distribution of resources persists despite differential health needs, is clearly not best serving the population. The recent report on the quality of primary care in England<sup>5</sup> suggested that before quality can start to improve, GPs and their teams will need to look beyond their surgery walls. Addressing health inequalities is another context where we need to consider the 'bigger picture'. Arguably to date, we have failed as a professional group to rise to this challenge.<sup>6</sup>

We must fully appreciate the extent of the problem and be under no illusions that while we may feel that 'we're all in at the deep end paddling hard to keep afloat',<sup>1</sup> the statistics tell a different story.

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## GP commissioning can unlock the full potential of research within the NHS

Jonathan Gaffy's editorial on research for commissioners is very welcome.<sup>1</sup> He is right to identify GP commissioners' potential role around research governance and how they may benefit from collaboration with researchers to develop and evaluate their services. There is, however, good reason to consider, whatever their eventual form, that the birth of these new commissioning organisations is a once-in-a-generation opportunity to integrate a comprehensive culture of research within the NHS.

GP commissioners are in a position to routinely specify, in contracts, that their providers deliver research-responsive services ensuring that recruiting people to research studies is core and becomes everyday practice. Currently, whether or not a service provider gives patients access