



CELTIC

European Cup 1967

ABERDEEN

European Cupwinners Cup 1983



SLIDE 1

I want to recall a day almost 50 years ago when Celtic not only became the first British team to win the European Cup, but did so with 11 players, none of whom had been born more than 30 miles from Glasgow.

When Alex Ferguson's Aberdeen team beat Real Madrid to win the European Cup Winner's Cup in 1983, they were the last team to win a European competition with players all from the same country.

The purpose of these examples is not to argue against immigration. It is to show that local people can do extraordinary things, if they work together and believe in what they are doing.

The exceptional potential of general practice

“With great effort any doctor can get to know all his patients, even in a city with high migrant turnover. Only thus can he think in terms of a responsibility, not only to the patient sitting in the surgery, but to the whole population for whose care he is paid and for whose health he is responsible. He can then see his role as the ultimate custodian of the public health on a defined section of a world front in the war against misery and disease.”

Julian Tudor Hart, 1973
Lancet Career Guide for Medical Students



SLIDE 2

There was a famous paper entitled “The extraordinary potential of the consultation”. I’ve changed that to “The extraordinary potential of general practice,” drawing inspiration from Julian Tudor Hart, still writing in the BMJ last week, in his 90s, but writing here for medical students over 40 years ago, “With great effort any doctor can get to know all his patients, even in a city with high migrant turnover. Only thus can he think in terms of a responsibility, not only to the patient sitting in the surgery, but to the whole population for whose care he is paid and for whose health he is responsible. He can then see his role as the ultimate custodian of the public health on a defined section of a world front in the war against misery and disease.

Which is what he did, in the microcosm of his practice at Glyncoirwg in South Wales, helped hugely by his wife and partner Mary Hart. It’s not an example that can be followed exactly, but I have been inspired by it

THE SECRET OF GATEKEEPING

THERE IS NO GATE (at least, to unscheduled care)

ONLY A GATEWAY (that patients can go through at any time)



SLIDE 3

General practice is important. The gatekeeping role keep the NHS afloat, keeping most care in the community. Of course, there isn't an actual gate, only a gateway that patients can go through at any time, to Out of Hours, A&E or an acute hospital bed. The NHS under-resources general practice at its peril. What keeps patients in the community is satisfaction with the care they received, and the avoidance of complications.



BARBARA STARFIELD ON PRIMARY CARE

1. Health services with strong primary care systems are more efficient
2. Social differences in health are greater for manifestations of illness severity (including mortality) than for occurrence of illness
3. **The major impact of health services is on the severity and progression of ill health**
4. Equity of access to health services, by itself, is not a useful strategy in industrialised countries. What matters is *use of appropriate* health services

SLIDE 4

As Barbara Starfield pointed out, the main contribution of health care is to reduce the severity of established conditions and delay their progression, thereby preventing, postponing or lessening complications.

NOT ONLY

Evidence-based medicine (QOF, SIGN)

BUT ALSO

**Unconditional, personalised, continuity of care,
provided for all patients, whatever problems
they present.**

SLIDE 5

That's achieved partly via the delivery of evidence-based medicine, but also, and equally important, via unconditional, personalised continuity of care for all patients, whatever condition or combination of conditions they have.



SLIDE 6

The elephant in the room is that if this isn't done equitably, pro rata according to need, health inequalities will widen, something that has yet to be said in any UK report on health inequalities.



Ubiquitous, endemic complexity

The value of previous encounters

Empathy and trust

A “worried doctor”

Setting the bar high

Every patient matters

BJGP, June 2015

SLIDE 7

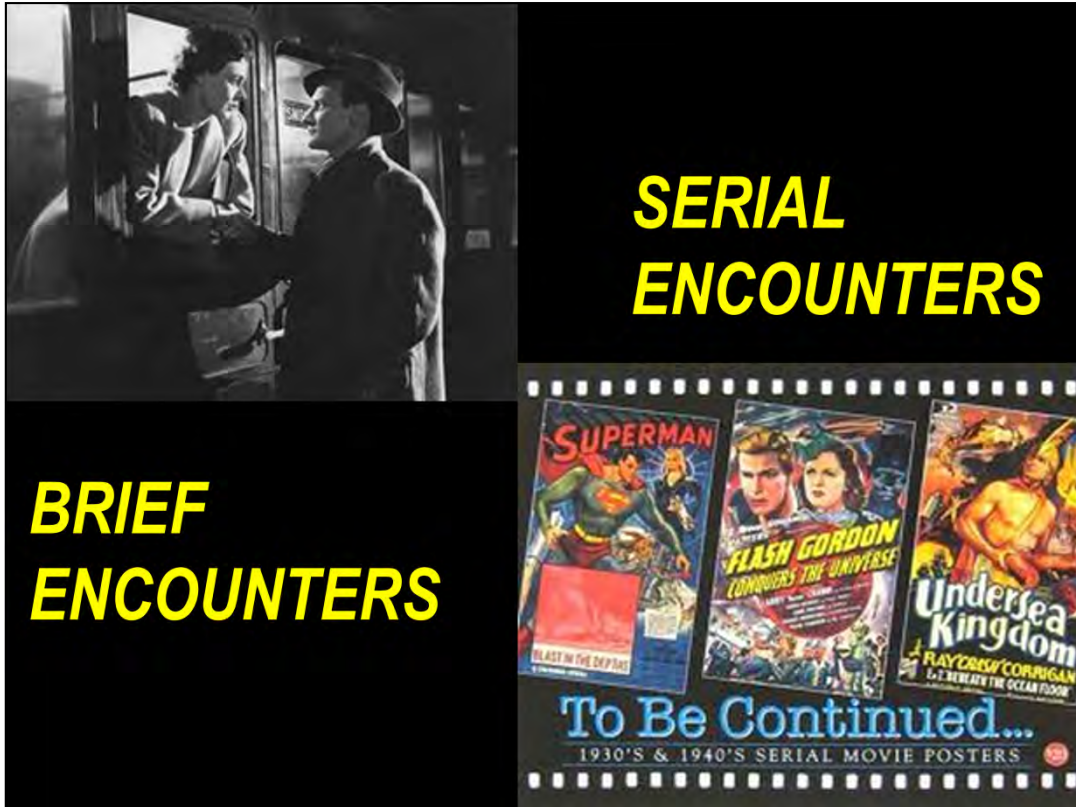
I spent a day shadowing a GP in Scotland’s most deprived general practice. I saw endemic multimorbidity and social complexity; the importance of previous encounters and shared knowledge; for anything much to be achieved in a short consultation; the value of empathy and trust; I didn’t see any worried well patients, but I did see a worried doctor, taking it upon herself to anticipate problems and take avoiding action; she set the bar high; every patient mattered.



3 Deep End GPs with more than 60 year's experience of one place

SLIDE 8

That was just one day in the life of a GP. At Govan Health Centre in Glasgow, these three GPs have over 60 year's experience of one community between them. What might they have achieved in thousands of days, throughout their professional lifetimes?



SLIDE 9

In life, as in the film, nothing very much happens in brief encounters. It's the serial encounter that matters, all the contacts strung together, with starts, stops, re-starts, diversions, events, successes, failures, but underlying it all, consistent direction.

RELATIONSHIPS WITH PATIENTS

Initially face to face, eventually side by side

Julian Tudor Hart
A NEW KIND OF DOCTOR

SLIDE 10

As Tudor Hart put it, initially face to face, eventually side by side. In deprived areas, self help and self management are destinations not starting points.

SCHEHEREZADE



TELLING 1001 TALES

SLIDE 11

In Tales of the Arabian Nights, Scheherazade had to make up a new story every day. Her life depended on it. That's also the business of general practice, making up thousands of stories, building knowledge and confidence, helping patients live long and well, avoiding the complications of their conditions.

10% of patients with 4 or more conditions accounted for

34% of patients with unplanned admissions to hospital and

47% of patients with potentially preventable unplanned admissions

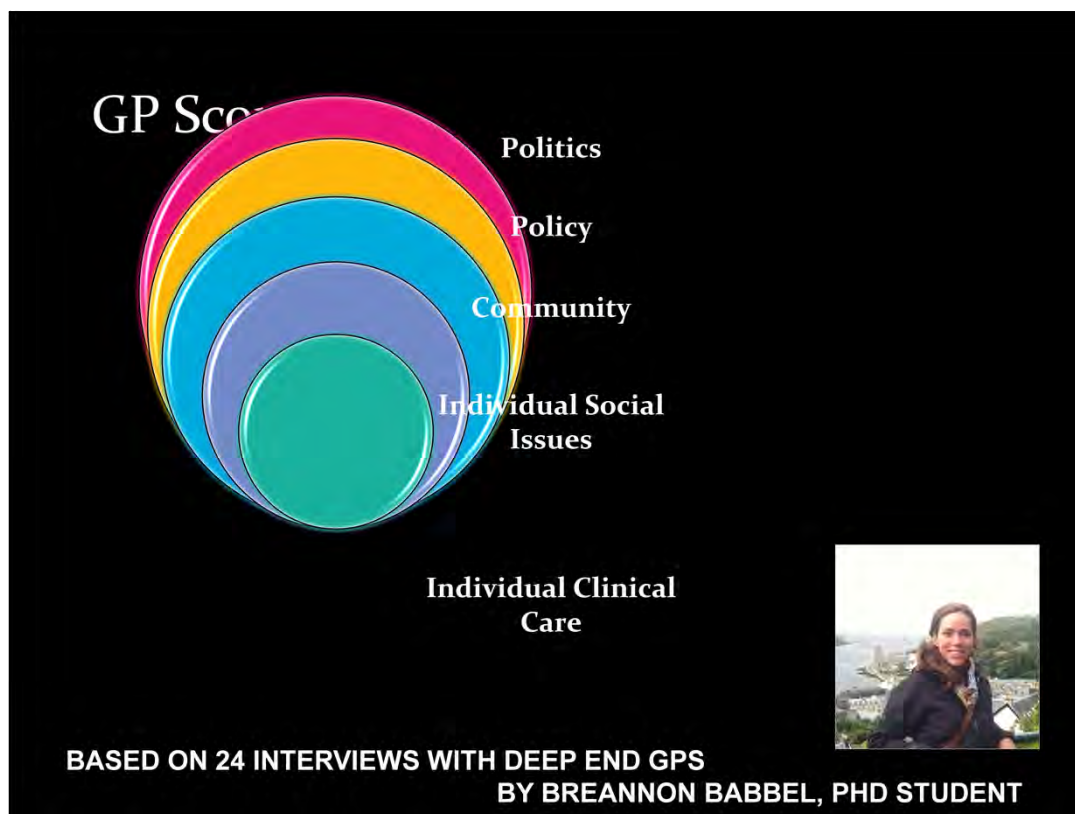
Payne R, Abel G, Guthrie B, Mercer SW.

The impact of physical multimorbidity, mental health conditions and socioeconomic deprivation on unplanned admissions to hospital: a retrospective cohort study.

CMAJ 185 (e-publication ahead of print): E221-E228, 2013, doi:10.1503/cmaj.121349

SLIDE 12

Not every patient needs this, but the 10% of patients in Scotland with 4 or more conditions, who account for a third of all unplanned admissions to hospital, and a half of all potentially preventable unplanned conditions, certainly do.



SLIDE 13

My PhD student, Breannon Babel from Oregon, interviewed 24 GPs working in very deprived areas to ask them what they thought their role could be. Some saw no further than the conventional medical model; others broadened the consultation to include social issues; others looked outside their practice to the local community; while others took advocacy positions, trying to influence local and national policies, engaging with managers and politicians. All of that is possible, but only if GPs have the interest, time and support, enabling them to do it.

ADVOCACY

The social causes of illness are just as important as the physical ones.

The medical officer of health and the practitioners of a distressed area are the natural advocates of people.

They well know the factors that paralyse all their efforts.

They are not only scientists but also responsible citizens, and if they did not raise their voices, who else should?

Henry Sigerist, John Hopkins University

SLIDE 14

Take advocacy. As Sigerist put it, “The practitioners of a distressed are the natural advocates of people. They well know the factors that paralyse all their efforts. They are not only scientists but also responsible citizens, and if they did not raise their voices, who else should?”

ADVOCACY

THE HERALD, TUESDAY, 15.05.2012 PAGE 9 NEWS

Doctors warn austerity is damaging patients' health

GPs in deprived areas see sharp rise in social issues

STEVEN HARTMUTH
The work was particularly gruelling. The 2012 report says that the number of GPs in deprived areas has fallen by 10 per cent since 2008. The report also says that the number of GPs in deprived areas has fallen by 10 per cent since 2008. The report also says that the number of GPs in deprived areas has fallen by 10 per cent since 2008.



On the right, Margaret Cross, left, and Peter Sutherland are part of the Deep End group of GP practices. Photo: Carl Wilson

So many people who are obese will for years be being assessed as capable of work after a cursory assessment

Experiencing budget cuts in the health service has led to a sharp rise in social issues, say GPs in deprived areas. The report also says that the number of GPs in deprived areas has fallen by 10 per cent since 2008.

AND SUNDAY MAIL

Daily Record

HOME NEWS SPORT ENTERTAINMENT LIFESTYLE TV IN YOUR AREA

By Chris Clements | 16 Nov 2013 00:01

Welfare cuts could see further 60,000 Scots kids being dragged into poverty, warn doctors

A SCATHING report from the Deep End Steering Group and authorised by 360 GPs in deprived areas says the bed tax and work capability assessments are damaging the health and lives of the country's most vulnerable people.

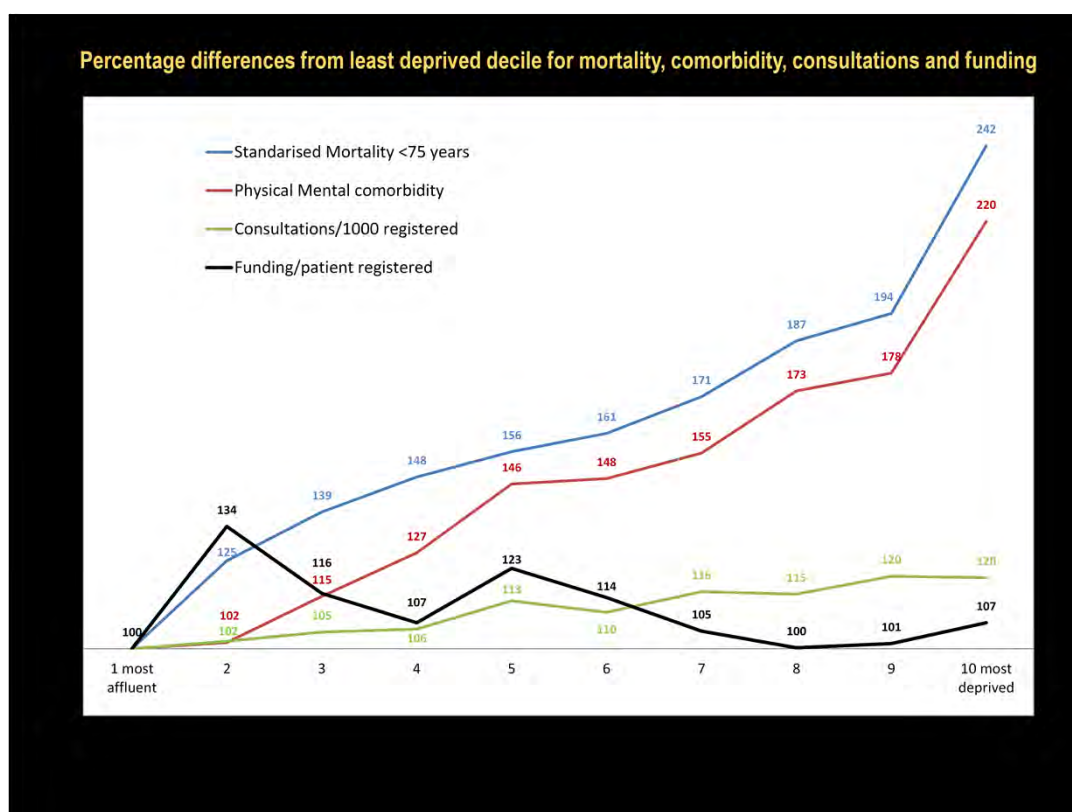


E.ON to freeze its prices

DEEP END REPORTS 16, 21, 25 and 27

SLIDE 15

..... a role exemplified by several Deep End Reports on the havoc being wrought by changes to the welfare benefit system. Based on the recent experience of practitioners and patients, these reports had huge authority, and travelled fast.



SLIDE 16

However, that's not the main focus of our advocacy. The figure divides the Scottish population into tenths, richest on the left, poorest on the right. Premature mortality in blue and complex multimorbidity in red more than double in prevalence across the spectrum, while general practice funding per patient, in black, is broadly flat. We have horizontal equity in terms of access, but not vertical equity in terms of needs-based care. The consequences in the bottom right hand side of the slide include: GP consultations that involve more problems, but are shorter and achieve less. Unmet need accrues. Inequalities in health widen. Because general practice is less able to cope, patients are more likely to use emergency services. Hospitals feel the pressure.

INVERSE CARE LAW

“The availability of good medical care tends to vary inversely with the need for it in the population served”.

The inverse care law is a health policy which restricts care in relation to need.

The difference between what practices can do and could do.

SLIDE 17

Tudor Hart's Inverse Care Law described how the availability of good medical care tends to vary inversely with the need for it in the population served. But it's not a law; it's a man-made policy that restricts care in relation to need. And it's not about bad care in poor areas. Rather, it's the difference between what practices can do, and could do, if they were better resourced.



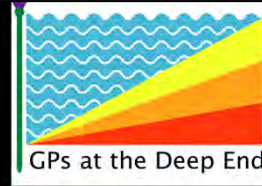
IS THE NHS FAIR?

i.e. equitable based on need

In providing emergency care	YES
In providing specialist care	NO
In providing primary care	NO

SLIDE 18

People think that because the NHS deals with emergencies in an equitable way, it does so for everything, but that's not the case with access to specialists, nor with ordinary general practice.



Give care services more resources

Our health service should be at its best where it is needed most

SCOTLAND has an admirable record of providing comprehensive health care which is free at the point of use, and has been steadfast in protecting its NHS from the ravages of market competition, which continue to threaten the NHS in England.

However, as the continuing statistics on health inequality show, NHS Scotland has still to address the inverse care law, whereby the availability of good medical care tends to vary inversely with the need for it in the population served.

While NHS resource distribution formulae and general practitioner contracts have recognised for a long time the increased health problems, multiple morbidity and needs for care of elderly populations, they have been much less effective in providing resources to meet the increased health problems, multiple morbidity and social complexity of

younger patients living in very deprived areas.

As general practitioners working in the 100 most deprived general practices in Scotland, we are the front line of the NHS in Scotland as it battles with health inequality. We are in daily contact with large numbers of patients, with unrivalled levels of continuity and coverage, and have substantial experience and knowledge of the health problems of people living in Scotland's poorest communities, including vulnerable children, and those struggling with mental health and addiction problems, in addition to physical ailments.

The inverse care law in Scotland is not a matter of good medical care in affluent areas and bad medical care in deprived areas. It is the difference between what general practice and primary care can currently achieve, in meeting the needs of

patients in very deprived areas, and what could be achieved if the service were better resourced to address levels of need.

The major issue which must be addressed, and whose solution requires political action, is the shortage of time within consultations to address a patient's needs in very deprived areas. Although other measures are needed, without this essential building block, the NHS will continue to fall in its attempts to narrow health inequalities.

Longer consultations are needed to work with patients on their problems, to take a preventive approach and to instigate links to other services.


The NHS has many challenges to face, but should be at its best where it is needed most. We call on political parties contesting the forthcoming election to commit themselves to eliminating the inverse care

law in Scotland. Their first step should be to provide general practices in the front line with additional time for patient consultations.

Members of the Deep End Steering Group: Georgina Brown, GP, Springburn Health Centre; John Budd, GP, Edinburgh Homeless Practice; Peter Cawston, GP, Drumchapel Health Centre; Margaret Craig, GP, Powal and Springburn; Susan Langridge, GP, Possilpark Health Centre; Stewart Mercer, Professor of Primary Care Research, University of Glasgow; Catriona Morton, GP, Craigmillar Health Centre; Anne Mullin, GP, Govan Health Centre; Jim O'Neill, GP, Lightburn Medical Centre; Euan Paterson, GP, Govan Health Centre; Petra Sambale, GP, Koppoch Medical Centre; Graham Watt, Professor of General Practice, University of Glasgow; Andrea Williamson, GP, Glasgow Homeless Health Services.

SLIDE 19

We have argued that the NHS needs to be at its best where it is needed most; otherwise health inequalities will widen.



Cabinet Secretary for Health, Wellbeing and Sport
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The Scottish Government

Our ref: 2015/0643178
14 January 2016

Thank you for your email of 14 December asking about the distribution of primary care funding relative to need on behalf of your constituent Dr Andrea Wilkinson

As you know, tackling health inequalities are a key priority. We are in regular contact with senior representatives from the Deep End group of practices and officials last met during September. A number of issues were discussed and a series of officials subsequently attended a meeting of the Deep End steering Group on Friday 23 October at Glasgow University.

Professor Watt raises the important question of how funding is distributed and, in negotiating a new Scottish GP contract from 2017, we are reviewing the Scottish Allocation Formula (SAF) to ensure it distributes funding fairly. We have always been clear that the approximate 60% of GP funding allocated through the SAF must change to reflect changing circumstances. We will take full account of Professor Watt's findings as we deliver a new GP contract for 2017 and the accompanying revised allocation formula.

We have already started to take significant steps towards long term, sustainable, transformational change that will improve our health services. By reforming the general practitioner contract, we are reducing bureaucracy and giving GPs more time to devote to the complex problems that patients can face, particularly in areas where patients face the greatest inequalities and health issues.

As part of this transformational change, as you will be aware, on 15 December 2015, I announced we have agreed with BMA in Scotland that GPs will be demarcated from the contract from April 2016. This means greater stability of funding and services for GP Practices, removing bureaucracy and freeing up more GP time to spend on face to face patient care. This will also mean GPs will use their clinical judgement to provide the right care for each individual patient without having to tick boxes for certain checks being carried out or questions being asked.

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SHONA ROBISON


The future of general practice is one where care is provided by multi-disciplinary professional teams, planned and delivered within the localities that need them and where professionals collaborate across the boundaries of primary, secondary and social care.

The important role of the GP in the evolving localities within the new Health and Social Care Partnership is integral to this agreement, and will help ensure that decisions about all aspects of care and services to patients in localities will be informed by the expert input of the GP. To support this, we are investing over a million pounds in a programme for local GP leadership and networking.

All of this is focused on high quality care and improved health outcomes that will provide a more connected, streamlined working across health and social care and voluntary support services. This will ensure that professionals are able to support patients facing wider social issues which are having an impact on their health and wellbeing.

Thank you, again, for your email. I hope the information provided is helpful in responding to your constituent.

We have always been clear that the approximate 60% of GP funding allocated through the SAF must change to reflect changing circumstances. We will take full account of Professor Watt's findings as we deliver a new GP contract for 2017 and the accompanied revised allocation formula.



SLIDE 20

Our First Minister Nicola Sturgeon and Cabinet Secretary for Health Shona Robison have both said they expect the needs of deprived areas to be addressed via the GP contract. We shall see.



SLIDE 21

It used to be that a single-handed GP knew everything and did everything, like Dr Ciriani here at Kremmling, Colorado, but no more

INVENTING THE WHEEL

HUB

Contact
Coverage
Continuity
Comprehensive
Coordinated
Flexibility
Relationships
Trust
Leadership



SPOKES + RIMS

Keep Well
Child Health
Elderly
Mental Health
Addictions
Community Care
Secondary Care
Voluntary sector
Local Communities

INTEGRATED CARE DEPENDS ON MULTIPLE RELATIONSHIPS

SLIDE 22

The intrinsic features of general practice – patient contact, population coverage, continuity, flexibility, long term relationships and trust – are essential, they make general practice the natural hub of local health systems, but they are not sufficient. Links are needed to a host of other resources and services.

THE COLLABORATION LADDER

Involving joint working between two potential partners

- 0 Never heard of each other
- 1 Have heard but have had no contact
- 2 Contact but no relationship
- 3 Relationship between named individuals
- 4 Joint review and planning

SLIDE 23

Two professionals might work in the same community. On the Collaboration Ladder, zero means they have never heard of each other; 1 they have heard of each other but have never met; 2, they've met but that's it; 3, they work together haphazardly; 4, they sit round a table to review and plan joint work.

RESOURCE POOR

RESOURCE RICH

PEOPLE RICH

PEOPLE POOR



LEADERSHIP OF HUMAN RESOURCES

SLIDE 24

Local health systems can be resource poor but people rich – think of Cuba, or resource rich and people poor – think of the US. Who knows how our local health systems measure up on this scale?



A NEW BUILDING PROGRAMME FOR INTEGRATED CARE

PATIENT STORIES

LOCAL HEALTH SYSTEMS

SLIDE 25

So I close this part of my talk with the need for a building programme, building patient stories on the one hand, building better relationships with colleagues on the other.

**BY POWERFUL
PEOPLE ?**

**BY CLEVER
PEOPLE ?**

**PRIMARY CARE
TRANSFORMATION**

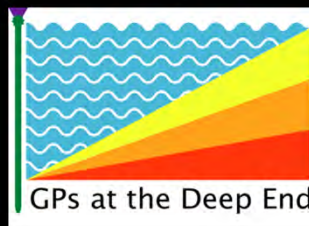
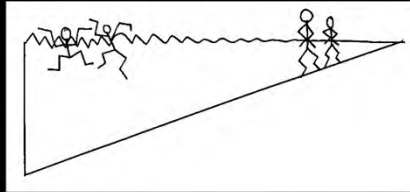
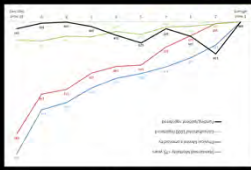
**BY STREETWISE
PEOPLE ?**

**BY THE
PEOPLE ?**

SLIDE 26

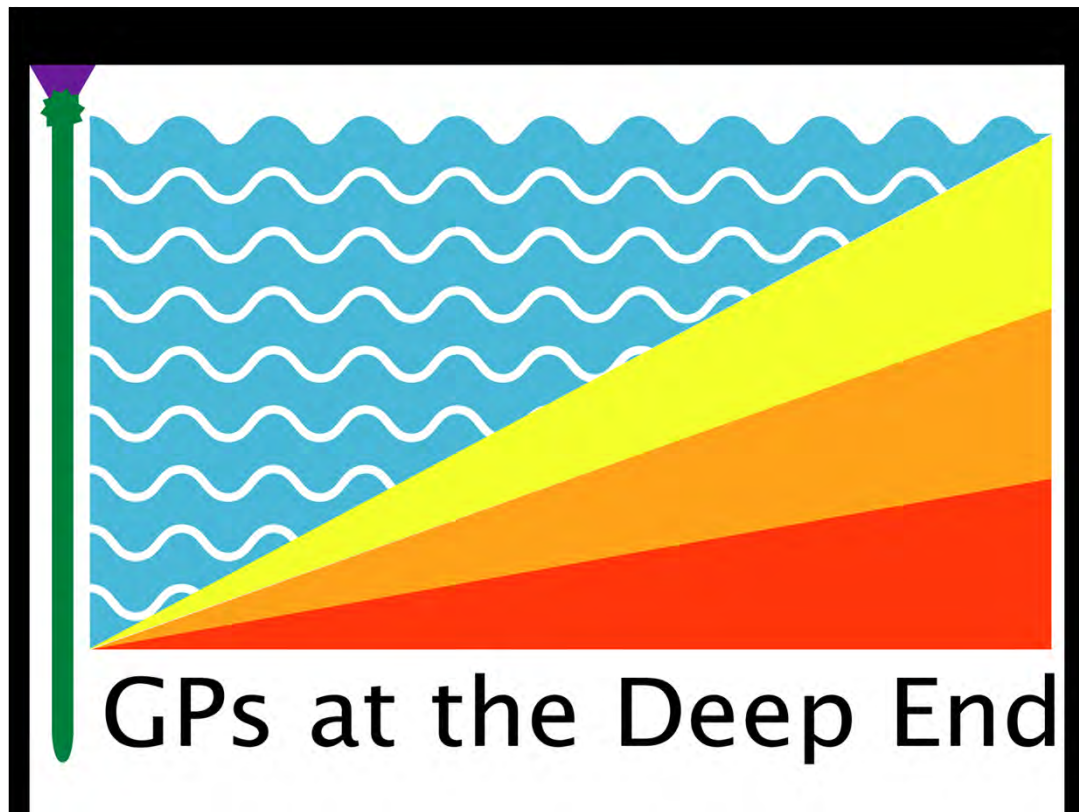
For primary care transformation, we need help from powerful people (they control resources) and clever people (often not as clever as they think), but this work can only be done locally, by streetwise people, who have contact with real people.

GENERAL PRACTITIONERS AT THE DEEP END



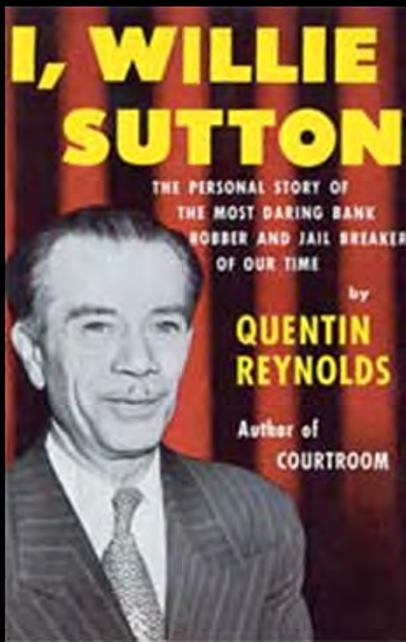
SLIDE 27

Turn the figure upside down, it becomes a swimming pool, with a deep and shallow end, hence General Practitioners at the Deep End, and here are an intrepid pair of Deep End GPs in Possilpark, Glasgow.



SLIDE 28

The logo shows the swimming pool, the steep gradient of need, the flat slope of resource, a sunrise or a sunset, a thistle and a spurtle, that's a traditional kitchen stirring implement. The whole thing is a flag, for rallying under.



QUESTION

WHY DO YOU ROB BANKS ?

ANSWER

BECAUSE THAT'S WHERE THE MONEY IS

WILLIE SUTTON

SLIDE 29

When asked why he robbed banks, Willie Sutton replied, "Because that's where the money is". Why the Deep End? Because that's where the deprivation is.

WHERE ARE THE MOST DEPRIVED POPULATIONS ?

BLANKET DEPRIVATION

50% are registered with the 100 “most deprived” practice populations
(from 50-90% of patients in the most deprived 15% of postcodes)

POCKET DEPRIVATION

50% are registered with 700 other practices in Scotland
(less than 50% in the most deprived 15% of postcodes)

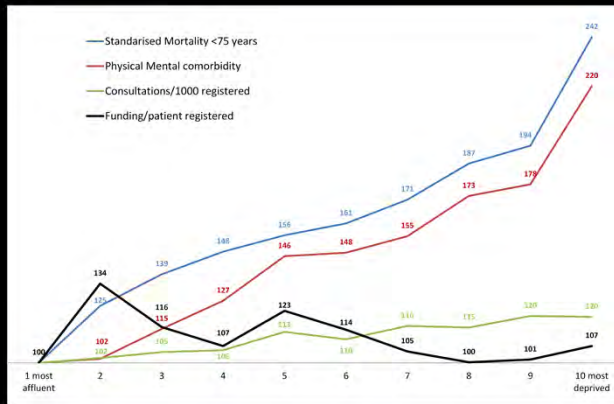
HIDDEN DEPRIVATION

200 practices have no patients in the most deprived 15% of postcodes

SLIDE 30

Not pocket deprivation, the small numbers of deprived patients to be found in most practices, but the blanket deprivation that dominates everything a practice does.

Percentage differences from least deprived decile for mortality, comorbidity, consultations and funding



“Over 2 million Scots in the most deprived 40% of the population received £10 less GP funding per head per annum than over 3 million Scots in the most affluent 60%”

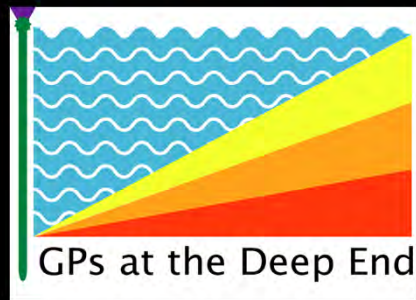
SLIDE 31

Bear in mind that the Inverse Care Law applies not just in the Deep End. In Scotland, over 2 million Scots, the most deprived 40%, get £10 less GP funding per head per annum than over 3 million Scots, the most affluent 60%. That needs a pro rata funding formula.

ACHIEVEMENTS

A lot, quickly and cheaply

- Identity
- Engagement
- Profile
- Voice

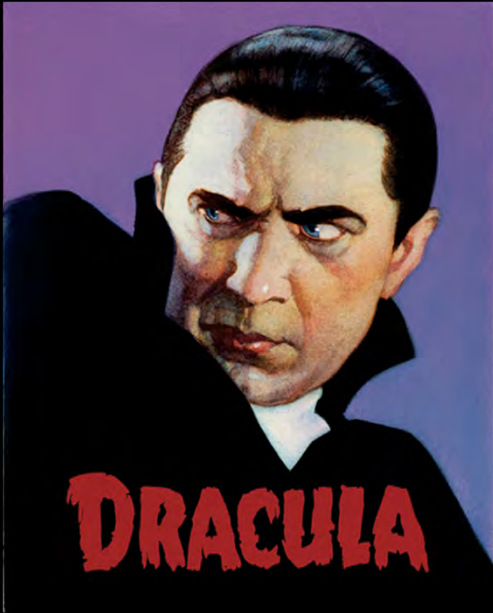


Phase 1	Meetings
Phase 2	Publications, Presentations and Profile
Phase 3	Opportunities, Influence, Resources
Phase 4	Implementation, Lobbying

Projects LINK Workers , CARE PLUS, Bridge, Benefits, Alcohol,
Govan SHIP, PIONEER SCHEME

SLIDE 32

In 20-09, the 100 most deprived general practices in Scotland had never been convened or consulted by anybody. Now they have identity, profile, voice, impact and increasingly, shared activity.



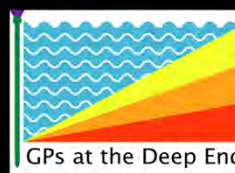
WHAT DO DEEP END
GENERAL PRACTITIONERS
AND COUNT DRACULA
HAVE IN COMMON ?

SLIDE 33

What do Deep End practitioners and Count Dracula have in common? They only come out at night, being occupied during the day. At the beginning we needed a locum budget that got colleagues out of practice, so we could capture their views and experience.

DEEP END REPORTS

1. First meeting at Erskine
2. Needs, demands and resources
3. Vulnerable families
4. Keep Well and ASSIGN
5. Single-handed practice
6. Patient encounters
7. GP training
8. Social prescribing
9. Learning Journey
10. Care of the elderly
11. Alcohol problems in young adults
12. Caring for vulnerable children and families
13. The Access Toolkit : views of Deep End GPs
14. Reviewing progress in 2010 and plans for 2011
15. Palliative care in the Deep End
16. Austerity Report
17. Detecting cancer early
18. Integrated care
19. Access to specialists
20. What can NHS Scotland do to prevent and reduce health inequalities
21. GP experience of welfare reform in very deprived areas
22. Mental health issues in the Deep End
23. The contribution of general practice to improving the health of vulnerable children and families
24. What are the CPD needs of GPs working in Deep End practices?
25. Strengthening primary care partnership responses to the welfare reforms
26. Generalist and specialist views of mental health issues in very deprived areas
27. Improving partnership working between general practices and financial advice services in Glasgow : one year on



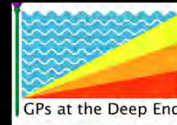
www.gla.ac.uk/deepend

SLIDE 34

Which led to nearly 30 reports, all in short and long forms, available on our website, capturing GPs' experience and views on a range of topics, in language that is jargon-free and easily understood.

ISSUES ESPECIALLY PREVALENT IN THE DEEP END

Mental health problems
Drugs and alcohol
Material poverty
Vulnerable children and adults
Migrants, refugees and asylum seekers
Fitness to work
Sexual abuse history
Homelessness



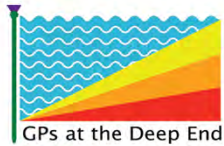
GENERIC ISSUES

How to engage with patients who are difficult to engage
How to deal with complexity in high volume
How to apply evidence

DEEP END REPORT 24

SLIDE 35

For example, this report on CPD needs identified the usual list of topics that occur most often in Deep End practice, but also generic issues, such as how to engage with patients who are difficult to engage, how to deal with complexity in high volume and how to apply evidence when so little of it is based on the types of patients you see in practice.



GPs at the Deep End

Deep End Report 22 Mental health issues in the Deep End

Ten general practitioners and a psychiatrist met on 25 October 2012 to discuss mental health issues in severely deprived areas. A draft report, collating the evidence and experience which were discussed on the day, was considered by the participants, by members of the Deep End Steering Group and by the Lothian Deprivation Inequalities Group. This report has been prepared by Andrea Williamson and Graham West and is presented for further multidisciplinary discussion.

April 2014

DEEP END SUMMARY 22 Mental health issues in the Deep End

Ten general practitioners and a psychiatrist met on 25 October 2012 to discuss mental health issues in severely deprived areas. A draft report, collating the evidence and experience which were discussed on the day, was considered by the participants, by members of the Deep End Steering Group and by the Lothian Deprivation Inequalities Group.

- Mental health problems, and GP consultations involving mental health problems, are more than twice as prevalent in deprived areas as in affluent areas, and are the commonest co-morbidity in deprived areas, and rise in prevalence in direct proportion to the number of patients' other problems.
- Depression (i.e. being on regular antidepressant treatment) is recorded in about a sixth of patients with most chronic medical conditions.
- In consultations for psychosocial problems, patients in deprived areas have poorer health and a greater number of other health problems; consultations are shorter than in affluent areas and patient enablement is lower. GPs report higher levels of personal stress after such consultations.
- In a study of 2000 consultations, the patients who were least likely to report being enabled after seeing their GP were patients in deprived areas with a psychosocial problem.
- The causes of the high prevalence of mental health problems include the burden of other conditions, the long term consequences of difficult experiences in early life and the combination of these factors.
- Theories of childhood attachment, the consequences of complex trauma and 'altruistic load' may lead to better understanding and management of mental health problems and multimorbidity.
- Some patients have difficulty in forming and maintaining relationships, with substantial implications for their use of professional help and health care.
- Medication provides only a partial solution to these problems.
- When care is shared between services, it is essential that the links are quick and effective.
- Although an audit of referrals for first level support of mental health problems in Glasgow showed referral rates to be 62% higher from very deprived areas than from affluent areas, epidemiological data suggests that rates should be double in very deprived areas.
- The HEAT target on waiting times for psychological services has had little impact on mental health issues in the Deep End.
- In practices with large numbers of patients with mental health problems, attached mental health workers could help to provide more integrated care.
- Counselling and third sector support services are seen as vital and more permeable than statutory services, but are under increasing threat as a result of current austerity policies.
- Services for homeless people have pioneered highly integrated and personalised support arrangements for people with long term problems and complex mental health needs, providing a model which mainstream services should follow.
- There is a need for increased professional dialogue, sharing experience, evidence and views as to how such care is best delivered.
- A major conflicting constraint is the inverse care law in Scotland, which results in less consultation time being available in general practices in deprived areas for patients with mental health problems.

"General Practitioners of the Deep End" work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Scottish Government Health Department, the Royal College of General Practitioners, and General Practice and Primary Care at the University of Glasgow.

Deep End contacts:

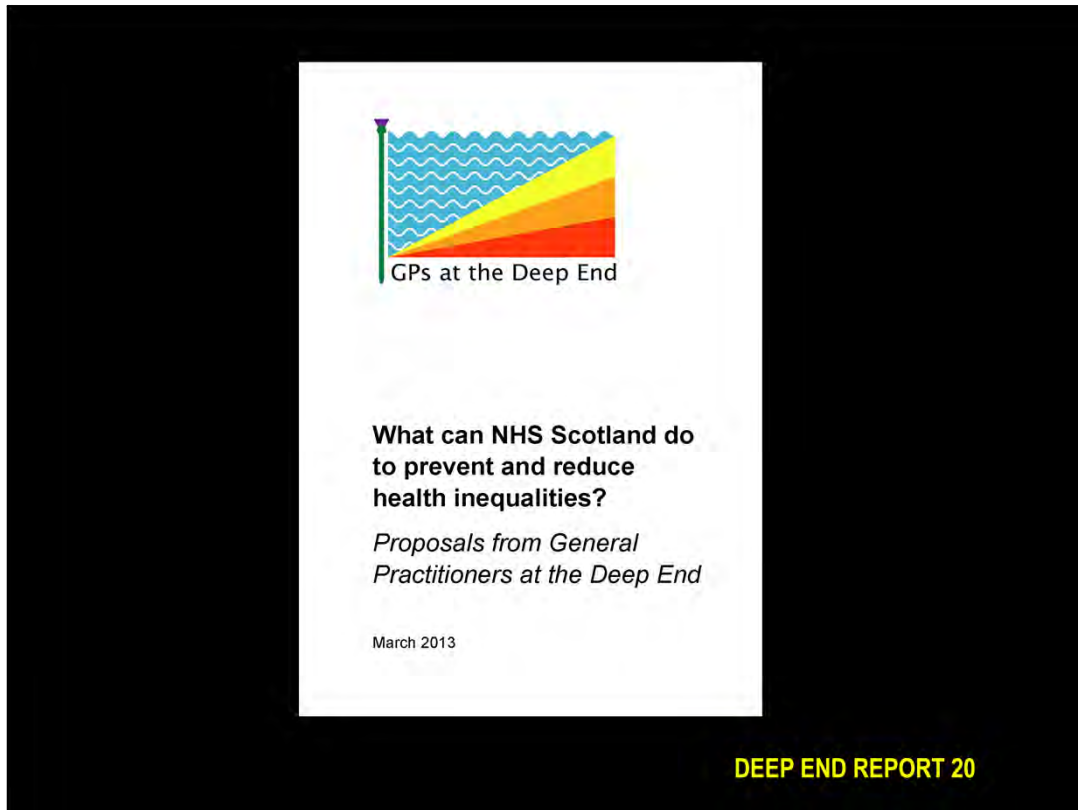
John Ewald Lothian Deprivation Inequalities Group John.Ewald@scot.nhs.uk
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 Para Dunlop Keppoch Medical Practice, Glasgow para.dunlop@keppoch.nhs.uk
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 Andrea Williamson Homerton Health Service, Glasgow andrea.williamson@hml.nhs.uk
 Full report available at www.gps-at-the-deep-end.org.uk



GPs at the Deep End

SLIDE 36

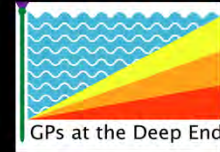
This report on mental health issues complimented out local mental health services but pointed out that they leave a lot for general practice to do, with patients who don't meet referral criteria, are not good at accessing services or who are not made better by the protocols on offer.



SLIDE 37

The Deep End Manifesto was published in 2013, in Report No 20.

SIX ESSENTIAL COMPONENTS



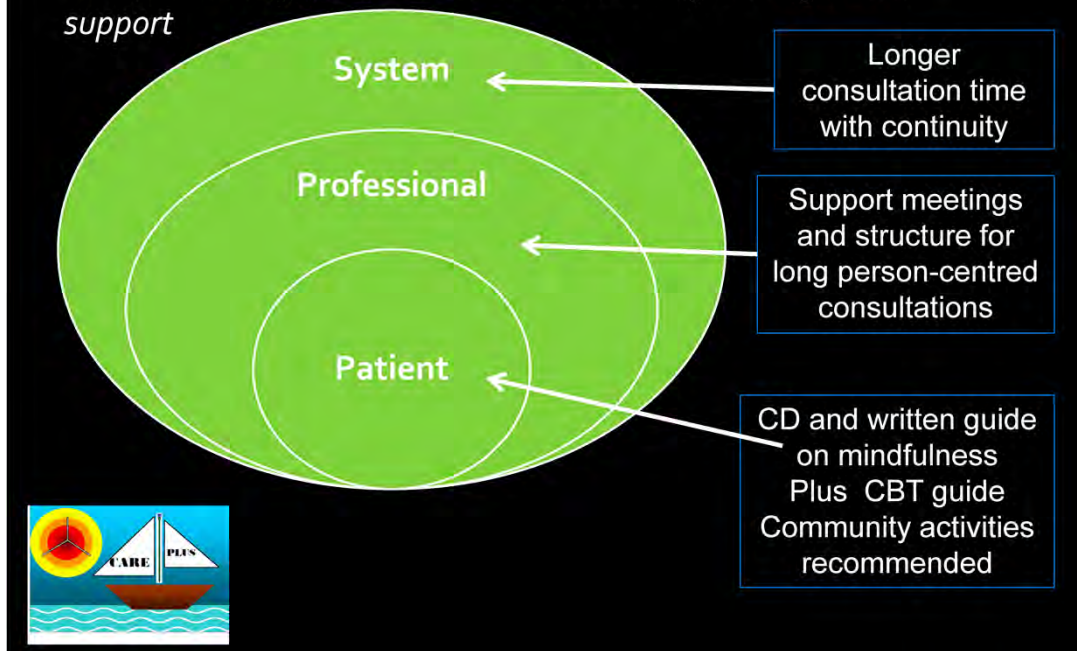
1. Extra **TIME** for consultations (**INVERSE CARE LAW**)
2. Best use of serial **ENCOUNTERS** (**PATIENT STORIES**)
3. General practices as the **NATURAL HUBS** of local health systems (**LINKING WITH OTHERS**)
4. Better **CONNECTIONS** across the front line (**SHARED LEARNING**)
5. Better **SUPPORT** for the front line (**INFRASTRUCTURE**)
6. **LEADERSHIP** at different levels (**AT EVERY LEVEL**)

SLIDE 38

It argued for: extra time, to address the inverse care law; better use of serial encounters, to build patient narratives; general practice as the natural hub of local health systems; better connections across the front line, for shared learning; better support from central organisations; and stronger leadership at every level, sharing power, resource and responsibility. I'm going to describe four projects, giving expression to these aims.

CARE PLUS: a whole-system approach

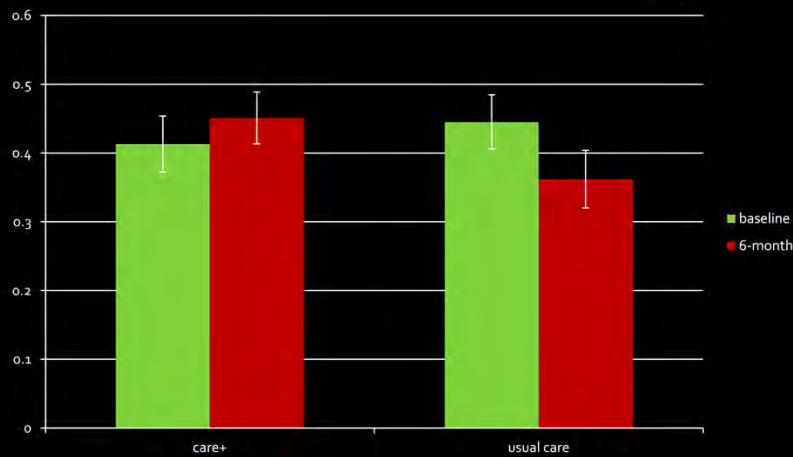
Time, continuity, person centredness and self-management support



SLIDE 39

The recently published CARE Plus Study involved 152 patients in 8 Deep End Practices in a RCT of extra consultation time for complex patients, plus support for practitioners and patients. About an hour extra per patient per year, spent mostly on a long initial consultation.

CARE Plus prevents decline in QOL



Mercer, S. W. et al. (2016) The Care Plus study – a whole system intervention to improve quality of life of primary care patients with multimorbidity in areas of high socio-economic deprivation :exploratory cluster randomised controlled trial and cost utility analysis. BMC Medicine, 14, 88. (doi:10.1186/s12916-016-0634-2)

SLIDE 40

After 6 months and a year, Quality of Life was higher in the intervention group, on the left, not so much because it improved in this group, but because it got worse in those not getting the intervention, on the right. The intervention slowed decline. That's a crucial observation.

CARE Plus is very cost-effective

Cost < £13,000 per QALY

**NICE currently supports a cost of £20,000
per QALY**

SLIDE 41

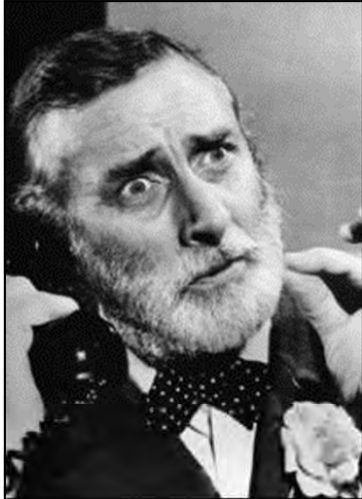
And it was cost-effective, coming well below the NICE threshold. If this were a drug or technology, it would be funded, and sail into policy and practice.



**FIXING IT FOR PATIENTS
WHO ARE FLOUNDERING
BETWEEN DYSFUNCTIONAL,
FRAGMENTED, SERVICES**

SLIDE 42

The Link Worker Programme has embedded a full-time community links practitioner in 7 Deep End practices. They do several things: connecting with community resources, helping patients who need help to access community resources, one to one serial encounters. But when link workers help patients floundering between dysfunctional and fragmented health care arrangements, a bigger issue is being addressed.



I'VE JUST INVENTED A MACHINE THAT DOES THE WORK OF TWO MEN.

UNFORTUNATELY, IT TAKES THREE MEN TO WORK IT

SPIKE MILLIGAN

SLIDE 43

Spike Milligan described a machine that did the work of two men, but took three men to work it. Modern health care in a nutshell.



SLIDE 44

There are too many hubs, or centres doing a particular thing, with referral criteria, waiting lists to control demand, evidence-based protocols to deliver, and discharge back to practice when they're done. All that may be done well, but leaves a lot for general practice to do, with patients who don't fit the criteria, are not good at accessing unfamiliar services or who are not made better by the treatment.

Patients and caregivers are often put under enormous demands by health care systems

Frances Mair, Carl May

BMJ 2014;349:g6680 doi: 10.1136/bmj.g6680 (10th November 2014)

SLIDE 45

When patients with multiple problems have to attend multiple clinics, life is made more difficult for what's been called the "treatment burden". What's convenient for professionals and services is often burdensome for patients. The irony is that while everyone is practising "patient-centred medicine", somehow the patients isn't at the centre.



HEALTH CARE AS A PINBALL MACHINE

SLIDE 46

For some patients, healthcare is like a pinball machine

MESSAGE FROM THE DEEP END

Patients need referral services which are :-

Local
Quick
Familiar

Attached workers who will work flexibly
and quickly according to the needs
of patients and practices

“your problem is our problem”

A machine that does the work of two men
but takes one person to work it

Strengthening the generalist function

SLIDE 47

Link workers often help patients engage with the services they need. In doing so, they support rather than challenge dysfunctional, fragmented systems.

In the Deep End, patients need referral services that are quick, local, and familiar; preferably via attached workers who can work flexibly according to the needs of patients and practices, not external criteria. Accepting that “Your problem is our problem”.

The health care equivalent of machines that do the work of two men, but need only one person to work them, are small local teams of doctors and nurses, working as generalists, unconditionally, knowing their patients well.

THE GOVAN INTEGRATED CARE (SHIP) PROJECT

Additional clinical capacity (2 salaried GPs between 4 practices)

2 attached social workers

2 attached community link practitioners

Support for monthly multidisciplinary team meetings

Protected time for GP leadership

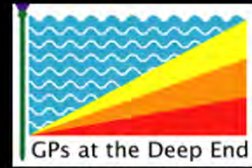


SLIDE 48

The Govan SHIP Project (standing for Social and Health Integration Partnership, but based near shipyards that built the Queen Mary) adds clinical capacity (about 10%) to 4 Deep End practices via permanent locums, releasing a protected session per week for all 15 GPs. There are two attached social workers, 2 attached link workers and support for monthly multidisciplinary team meetings in each practice.



University
of Glasgow



GP USE OF ADDITIONAL TIME AS PART OF THE GOVAN SHIP PROJECT

DEEP END Report 29 : www.gla.ac.uk/deepend

SLIDE 49

This audit described what the 15 GPs did with their protected sessions during two weeks in February. 136 documented activities, of which 76 were extended consultations, in the surgery or at home, and 14 were case note reviews without the patient being present.

CONTENT AND OUTCOMES OF EXTENDED CONSULTATIONS

Length	
20min	Patient with major depressive symptoms/suicide risk and substance misuse; Outcome : planning of future care and involvement of other organisations.
20 min	Patient with newly diagnosed depression and child protection issues; Outcome : during consultation likely COPD diagnosed referred for spirometry/smoking cessation.
20 min	Pregnant patient – major child protection concerns – background of domestic violence and drug misuse.; Outcome : SW contacted and telephone discussion re planned case conference.
30 min	HV to newly diagnosed palliative care patient; Outcome : met with family and discussed management and DS1500.
25 mins	Planned palliative care discussion at home with patient and carer, non-cancer diagnosis; Outcome : clinical expectations discussed to allay fears over management. Linked with secondary care consultant by phone for agreement with treatment plan.
30 mins	Post hospital discharge visit in elderly lady with multiple co morbidities and polypharmacy; Outcome : medication review and link with social services and ACP planning.
30 min	Planned visit to elderly patient and carer with dementia and new diagnosis of advanced malignancy. Outcome : discussion over diagnosis, to some extent prognosis and palliative treatment. Linked into district nursing and palliative care team. ACP planning with carer.
20 min	Child < 5 years frequent attender to surgery with minor self-limiting symptoms. English poor and requires translator. Planned review to discuss support and education of such illness; Outcome : linked in with Health Visitor for further ongoing support which also involves local third sector agencies. Aim to support mother and reduce attendances at general practice.
20 min	Extended consult in surgery for a patient with complex medical and psychosocial needs; Outcome : management plan and education provided.
30 mins	Middle aged patient who has moved to homeless accommodation. Anhedonia, thoughts of self-harm, lack of self-worth and despondent. Little self-care. Patient whom I have known for many years. Family quarrel and patient feeling excluded. Outcome : discussion, DWP benefits arranged, housing officer appointment. Trial anti-depressant and advice in terms of family contact. Review planned for 1 week.
40 mins (including travel time)	Housebound elderly patient, lives alone with carer support. Highly anxious and had prolonged admission for 2+1/2 late 2015. Chest infection and anaemia of uncertain origin; Outcome : reviewed and blood checked. Medication reviewed and amended after discussion. With social support, aim is to pre-empt admission if possible. So far managing in community.

SLIDE 50

Here is a sample of the extended consultations, all for complicated combinations of medical, psychological and social problems. In one sense they are all different; in another, they are all the same, requiring unconditional, personalised, coordinated, continuity of care. This work, driving integrated care based on a re-assessment of patients' problems needs clinical generalists, not nurses or pharmacists working in circumscribed areas. Every case is a demonstration of unmet need, or uncoordinated care, the consequences of the inverse care law, that added clinical capacity can address. Deep End report 29 is on the web and I commend it to you.

THE DEEP END GP PIONEER SCHEME



SLIDE 51

We are most excited by the new Deep End GP Pioneer Scheme.

ELEMENTS OF THE PIONEER SCHEME

6 early career GP fellows (0.8 WTE)

3 extra clinical sessions per week for the practice

2 protected sessions per week for host GPs within the practice

1 protected session per week for lead GP outside the practice

Day release scheme (2 sessions every second week)

Service development projects (2 sessions every second week)

GP coordinator (1 session per week)

Academic coordinator (2 sessions per week)

SLIDE 52

6 early Career Fellows have been appointed, and attached to 6 host practices. Their 8 sessions per week comprise three extra clinical sessions for the practice (about 10% extra), 2 protected sessions per week for host GPs to use as they wish; 1 protected session per week for a lead GP to help run the Scheme; and 2 protected sessions per week for the Fellows to attend a day release programme, addressing their own learning needs as Deep End GPs and, in doing so, producing learning materials and activities for others to use. Fellows and lead GPs will work together a programme of service developments. There are extra sessions for GP and academic coordinators.

It is a huge opportunity for GP-led, primary care transformation, addressing GP recruitment, retention and new ways of working.

A LEARNING ORGANISATION

Committed to the principle :

that “the best anywhere should become the “standard everywhere”

SHARING

Knowledge

Information

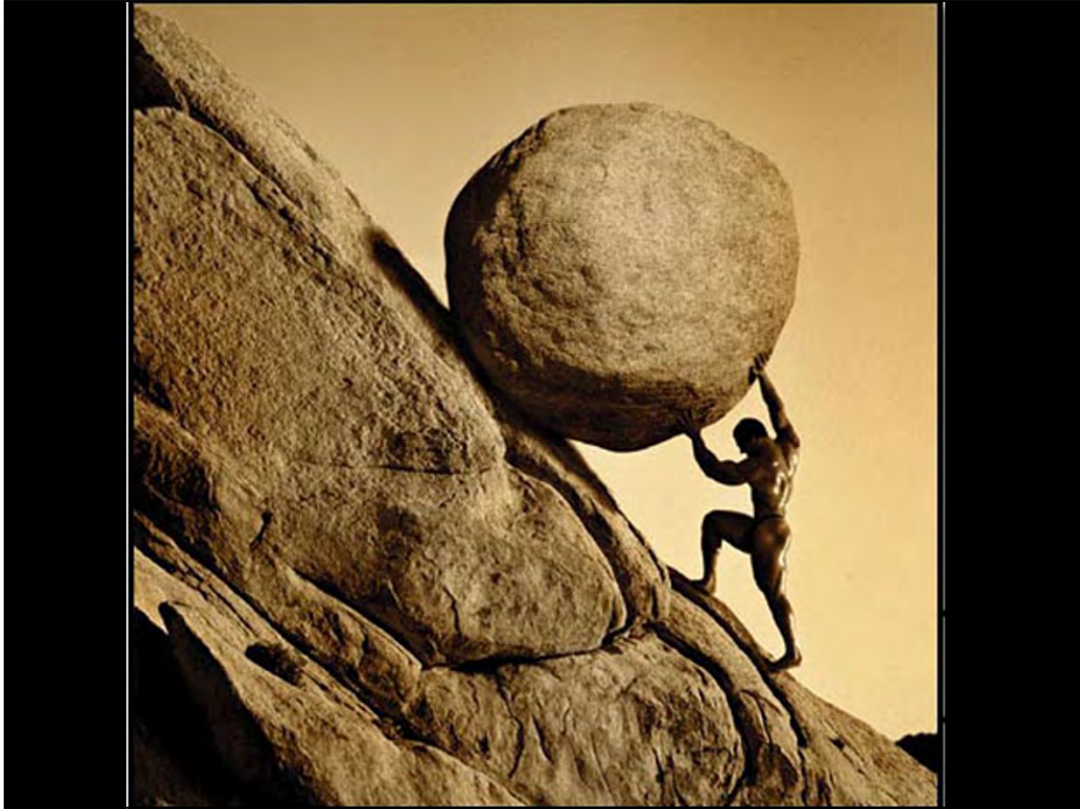
Evidence

Experience

Values

SLIDE 53

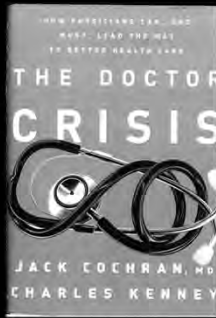
Our aspiration is a learning organisation, sharing knowledge, information, evidence, experience and values, so that the “best anywhere” becomes the “standard everywhere”.



SLIDE 54

It's all a tough call. Progress is a challenge. With the underfunding of general practice, staying in the same place is hard work. The ball could easily roll downhill, never to return.

WHAT MAKES PEOPLE ENJOY THEIR WORK ?



AUTONOMY

MASTERY

PURPOSE



but only after basic needs are met

SLIDE 55

The three essential ingredients of professional satisfaction are autonomy (the ability to make decisions, to fashion the future), mastery (that's the feeling of being valued for what you do and doing it well) and purpose (the sense of having a clear shared direction). In a small way, the Deep End Project is trying to achieve that.

DECISIONS, DECISIONS

Usually based on **EXPERIENCE**

Sometimes based on **EVIDENCE**

Always underpinned by **VALUES**

TASKS FOR ACADEMICS

To draw on the experience

To produce the evidence

To distil the values

To help share learning

SLIDE 56

There's an important role for academic support. Decisions in general practice are usually based on experience, sometimes informed by evidence, always underpinned by values. Academic support can draw on practitioner experience, produce the evidence, distil the values. That's not what Universities generally expect their academics to do.

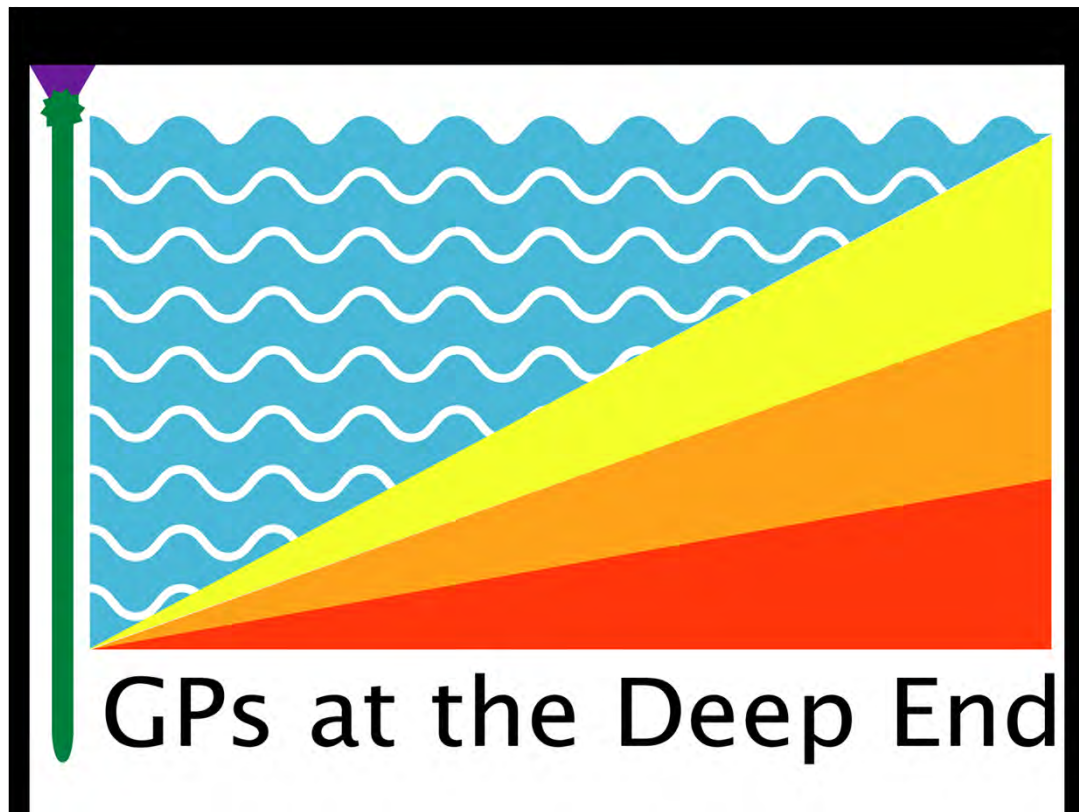
GENERAL PRACTITIONERS AT THE DEEP END



51ST MEETING OF THE STEERING GROUP

SLIDE 57

The heart of the Deep End Project, however, has been the steering group, an informal group of 10 to 16 GP colleagues, meeting every six weeks or so, in their own evening time. We don't usually have food and wine, but after 50 meetings, it seemed reasonable to celebrate. We've now moved to day time meetings with locum funding for clinical backfill. If it hadn't been for the steering group, the Deep End Project would have been just another short term initiative, trying to change general practice from the outside. Instead, we have a thriving academic/service partnership, based on mutuality and respect.



SLIDE 58

Thank you for listening