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.

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.

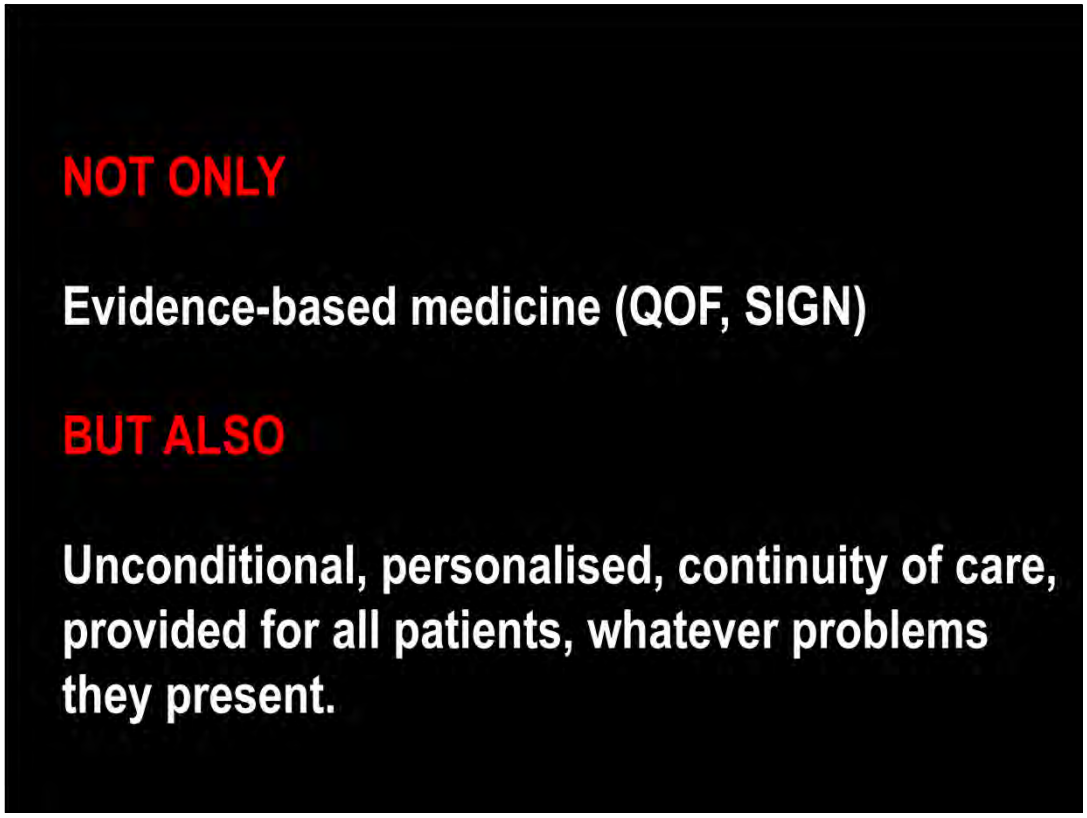
Which is what he did, in the microcosm of his practice at Glyncorrwg in South Wales, helped hugely by his wife and partner Mary Hart. It's not an example that can be followed exactly, but I have been inspired by it

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.

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.

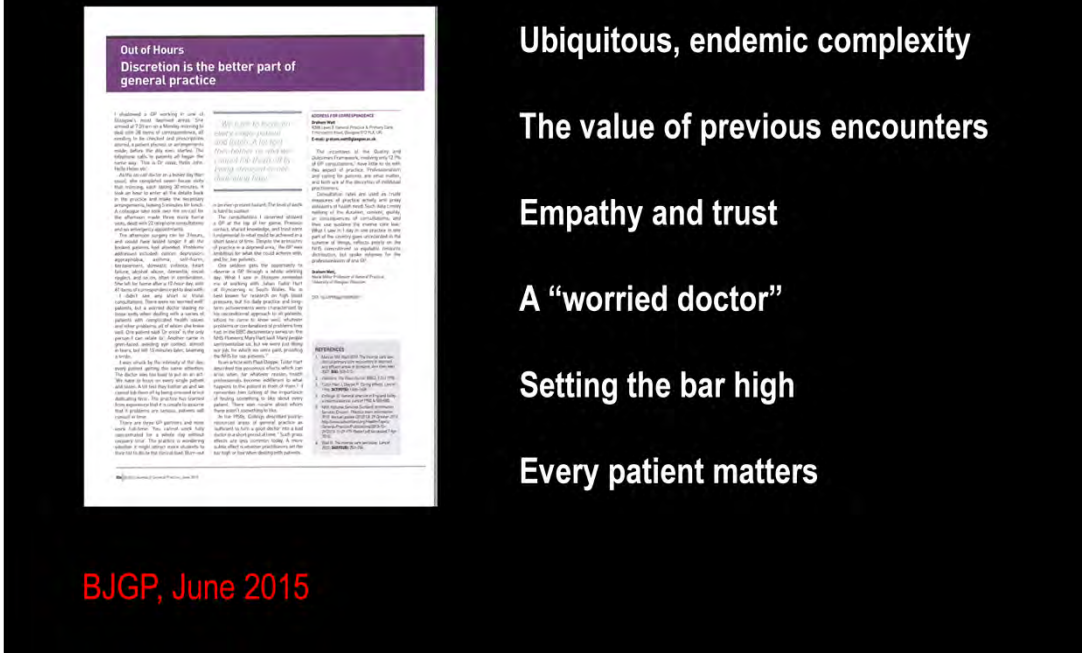


SLIDE 5

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 of 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.



SLIDE 7

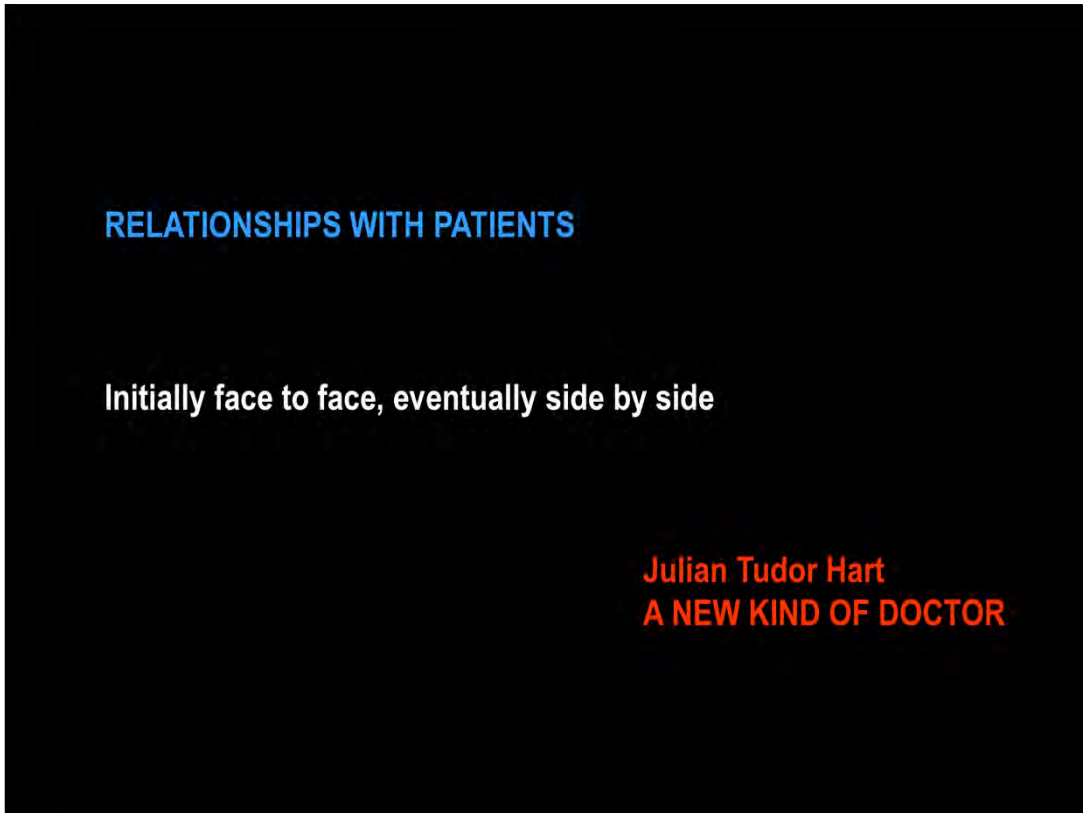
I spent a day shadowing a GP in Scotland’s most deprived general practice. I saw endemic multimorbidity and social complexity; the importance of previous encounters and shared knowledge, for anything much to be achieved in a short consultation; the value of empathy and trust; I didn’t see any worried 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.

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.

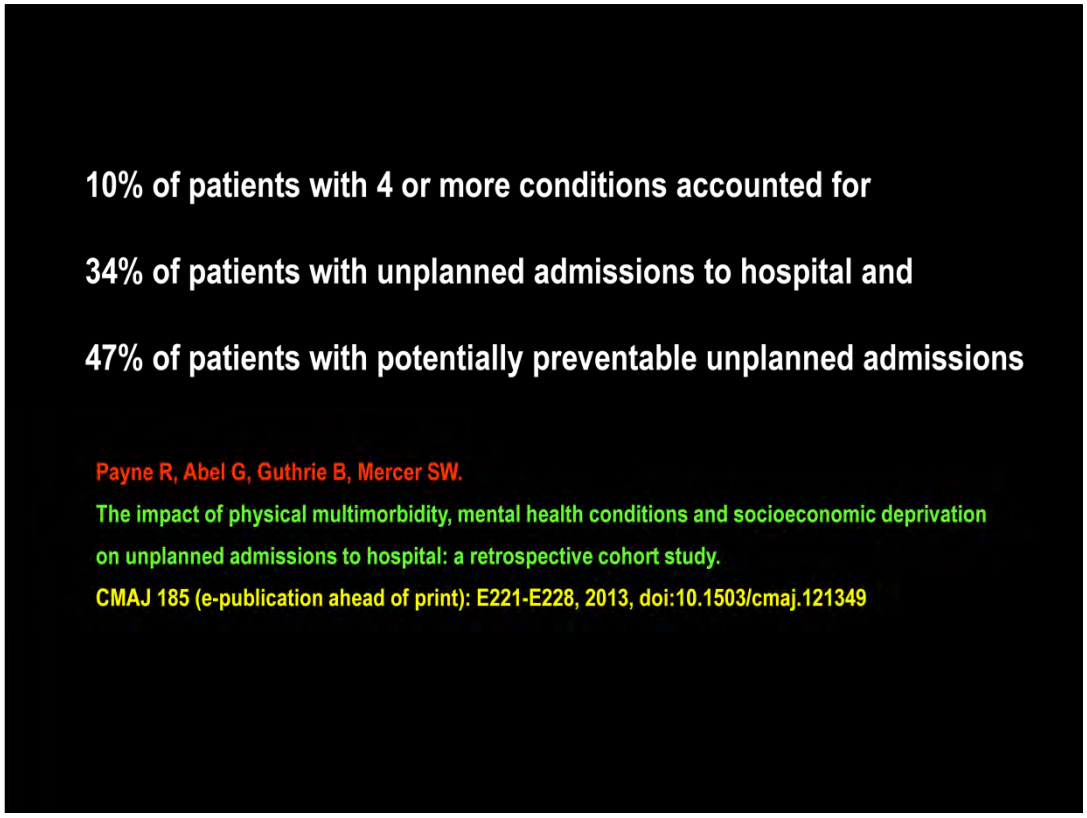


SLIDE 10

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.

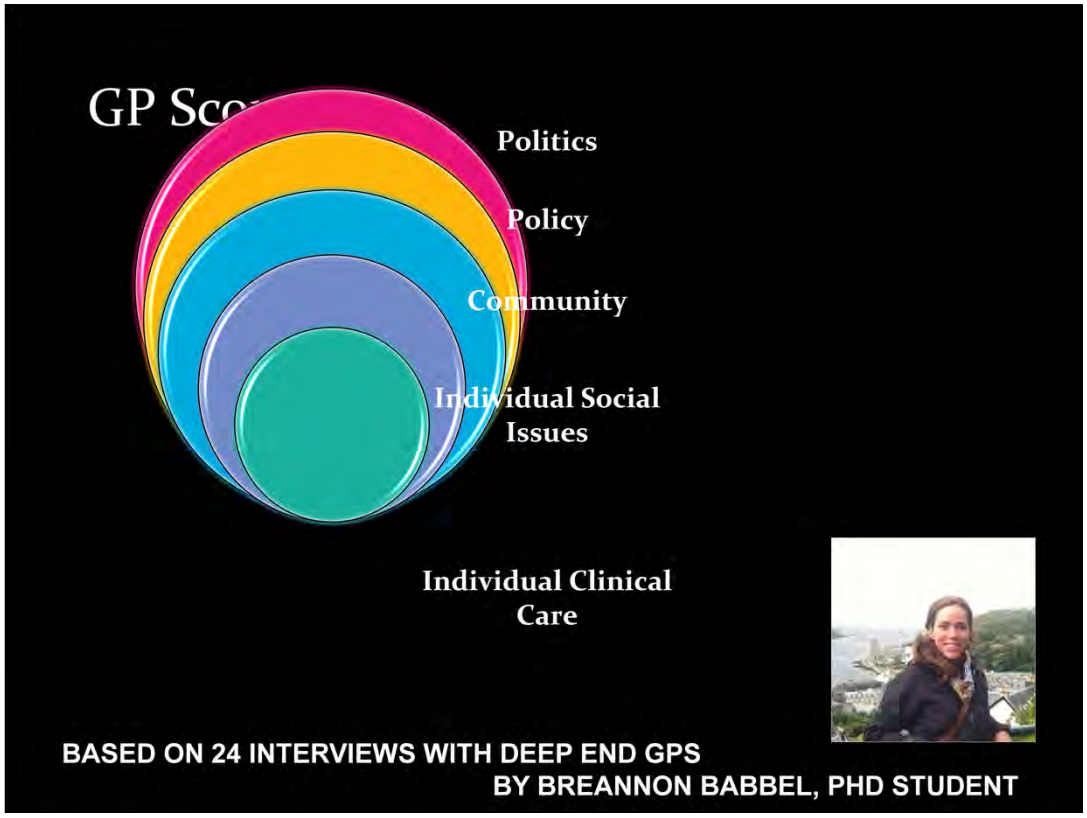
SLIDE 11

In Tales of the Arabian Nights, Scheherezade 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.



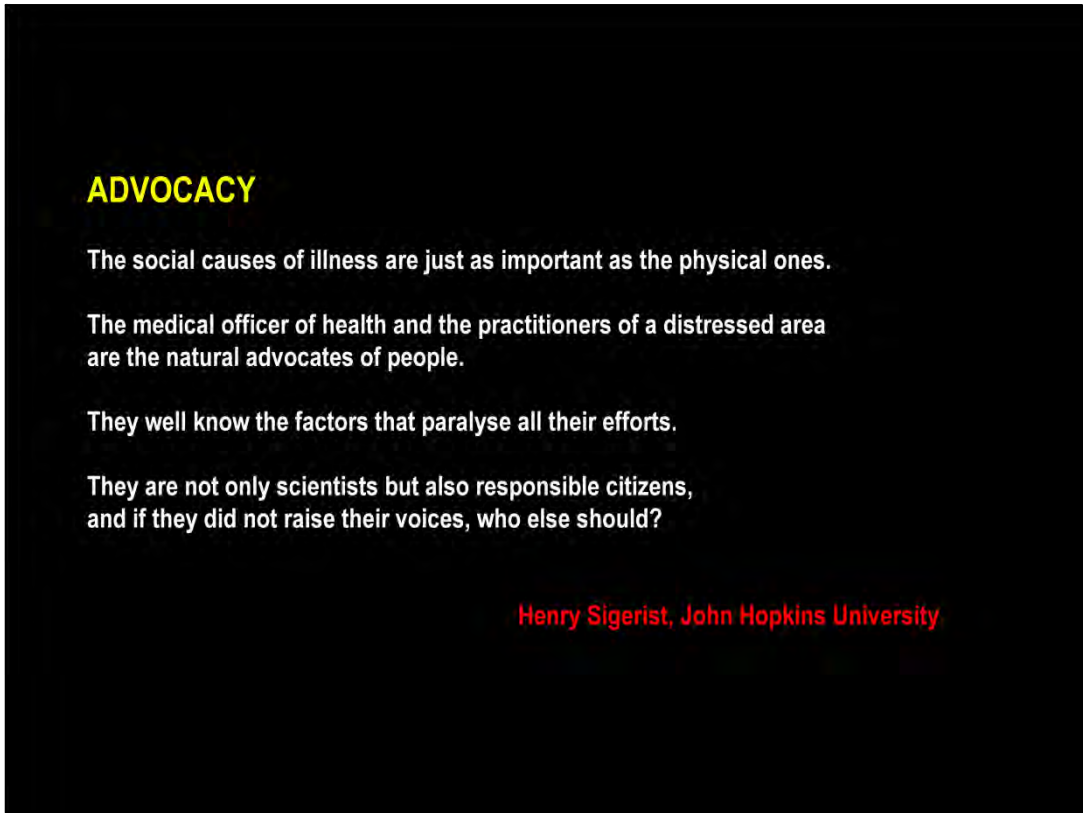
SLIDE 12

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 Babbel 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.

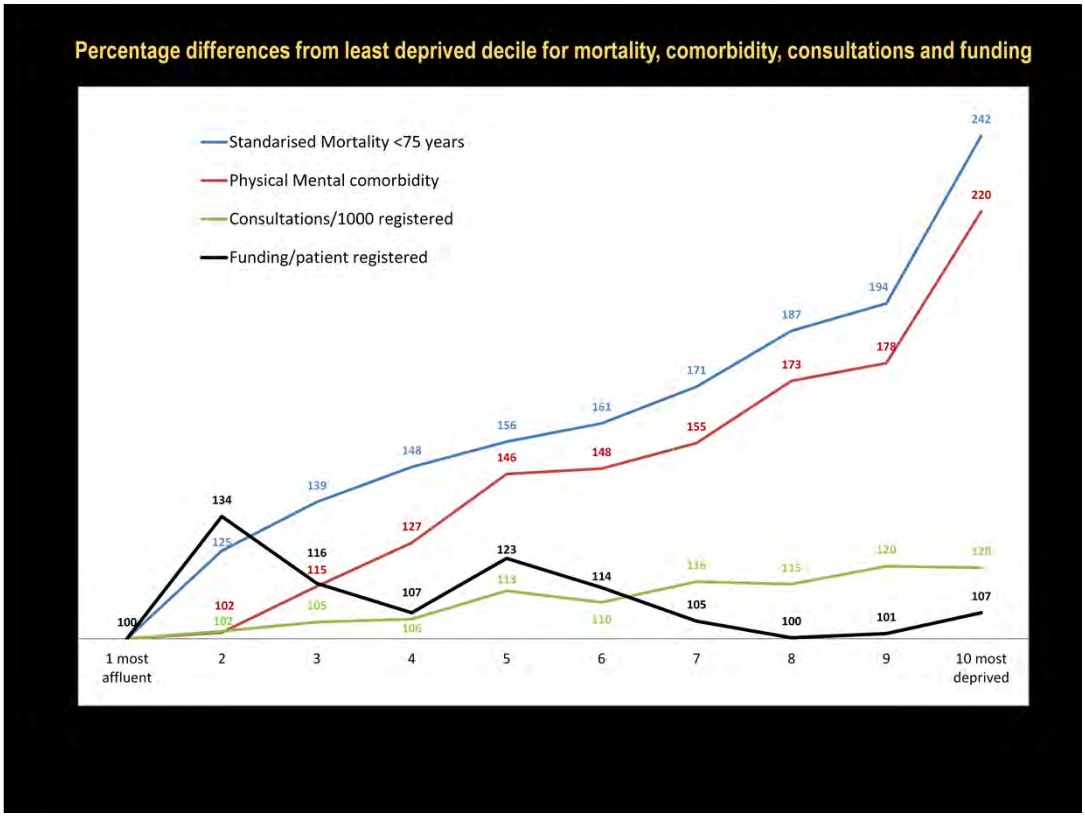


SLIDE 14

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?”

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.

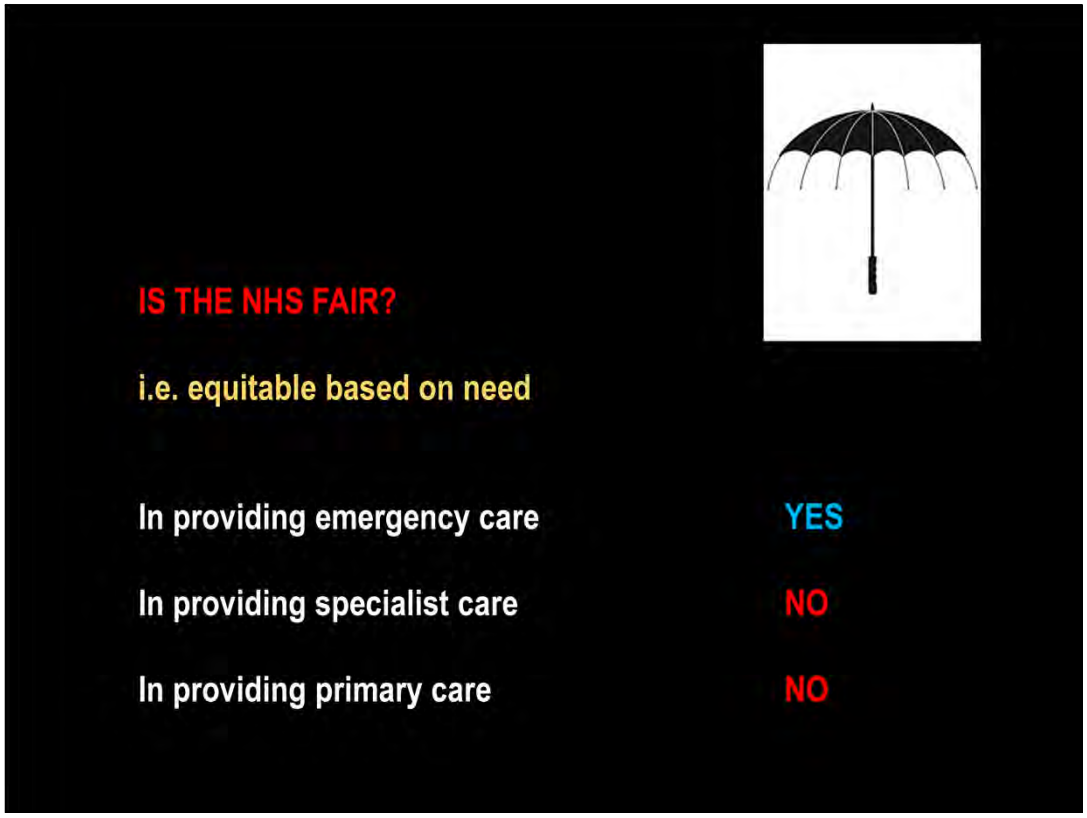


SLIDE 16

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.

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.



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.

The Herald

FOUNDED ON MONDAY JANUARY 27, 1783

Give care services more resources

GPs at the Deep End

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 fail in its attempts to narrow health inequalities.

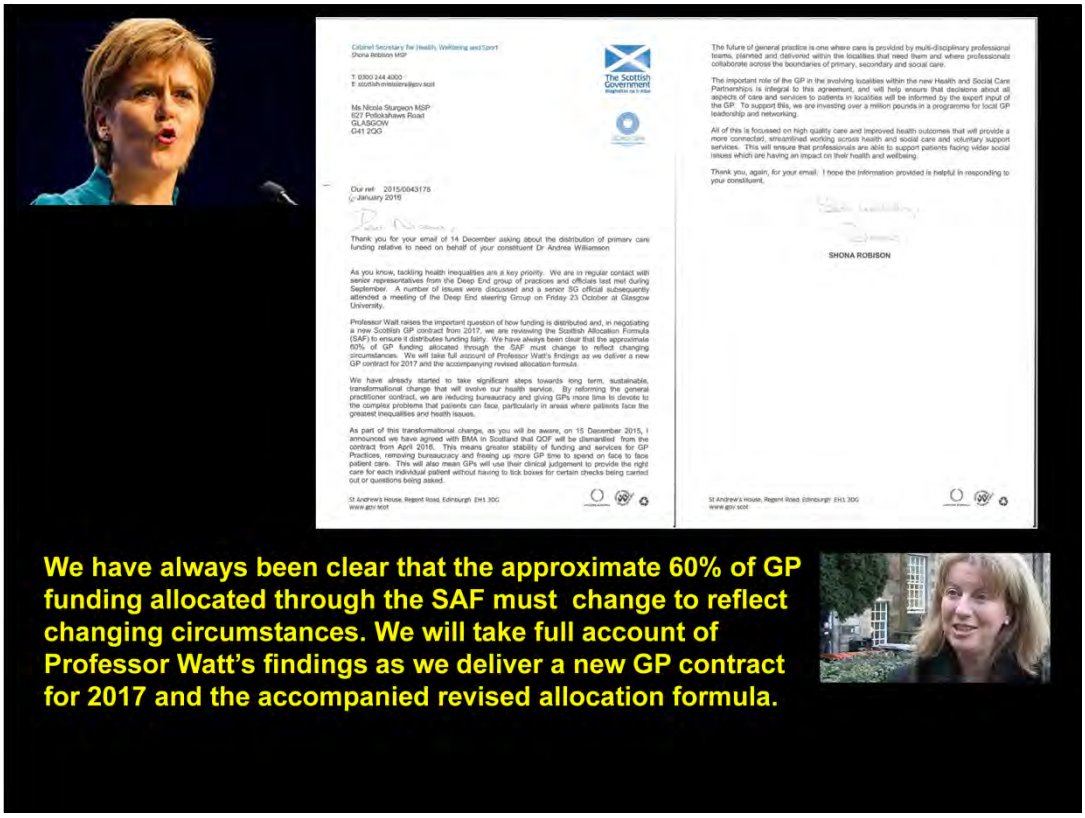
Longer consultations are needed to work with patients on their problems, to take a preventive approach and to instigate links to other services.

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, Possil and Springburn; Susan Langridge, GP, PossilPark Health Centre; Stewart Mercer, Professor of Primary Care Research, University of Glasgow; Catriona Morton, GP, Craigmillar Health Centre; Anna Mullin, GP, Govan Health Centre; Jim O'Neill, GP, Lightburn Medical Centre; Euan Paterson, GP, Govan Health Centre; Petra Sembala, GP, Keppoch 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.



SLIDE 20

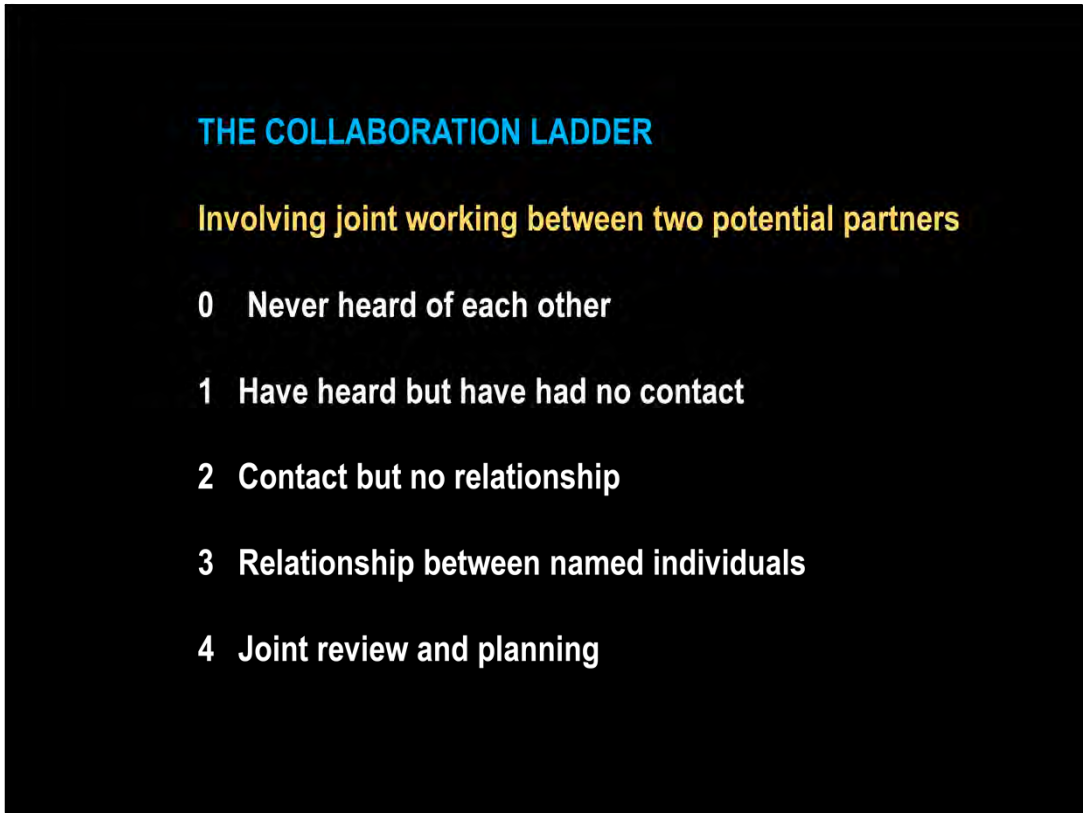
Our First Minister Nicola Sturgeon and Cabinet Secretary for Health Shona Robison have both said they expect the needs of deprived areas to be addressed via the GP contract. We shall see.

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

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.



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.

SLIDE 24

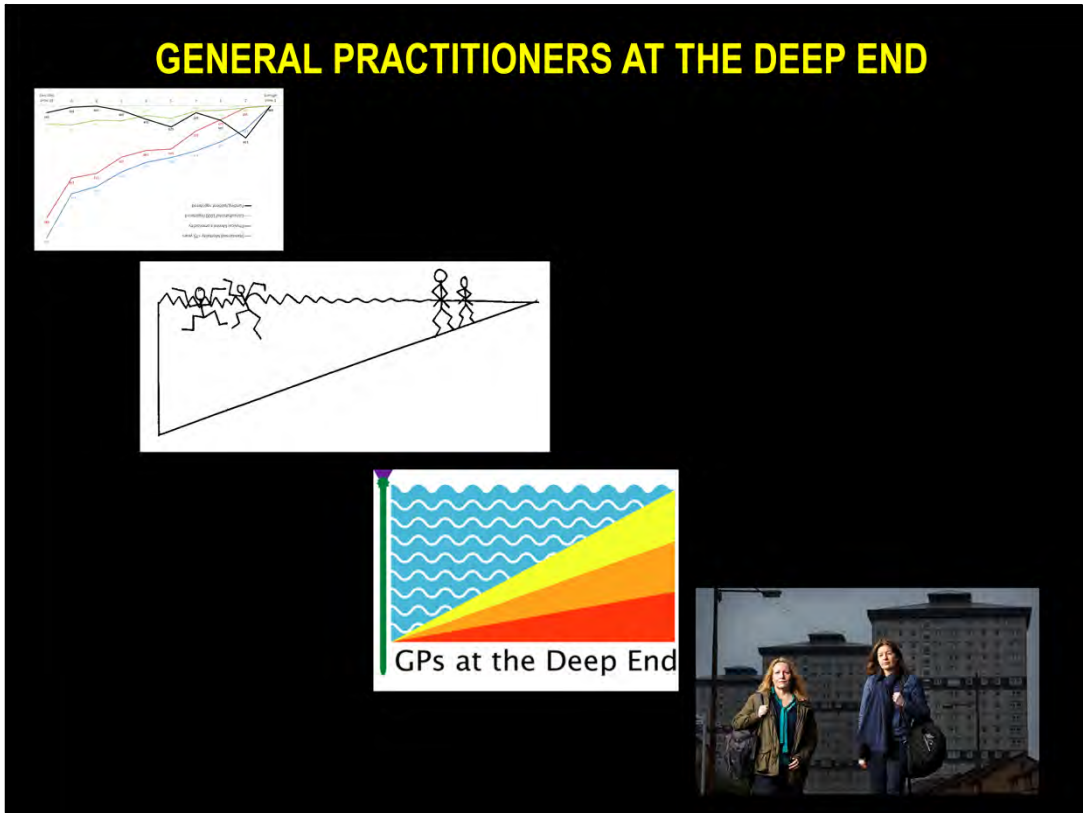
Local health systems can be resource poor but people rich – think of Cuba, or resource rich and people poor – think of the US. Who knows how our local health systems measure up on this scale?

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.

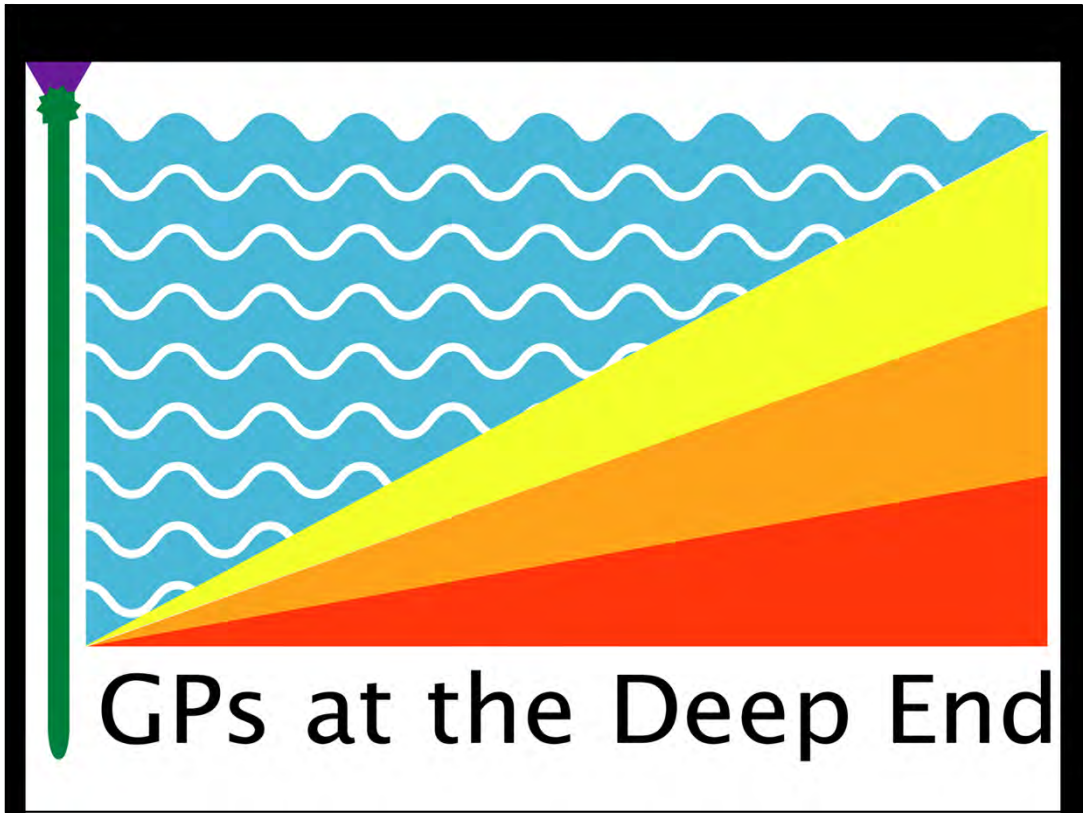
SLIDE 26

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.



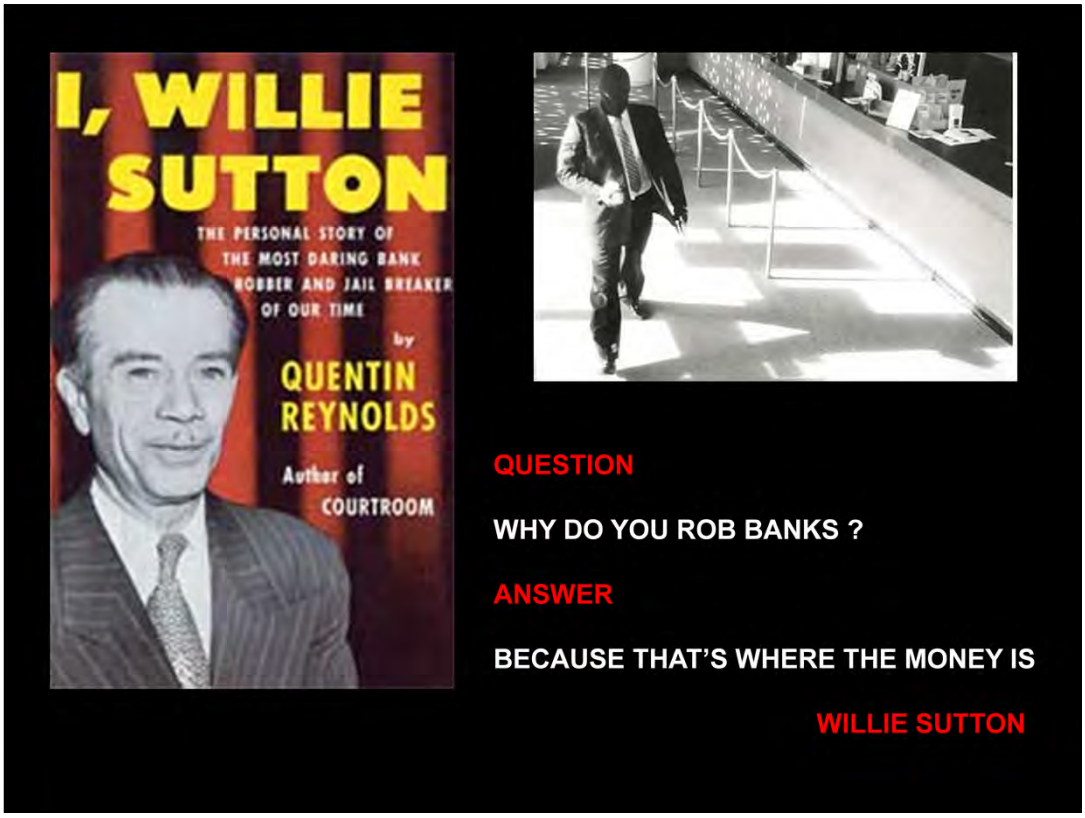
SLIDE 27

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.

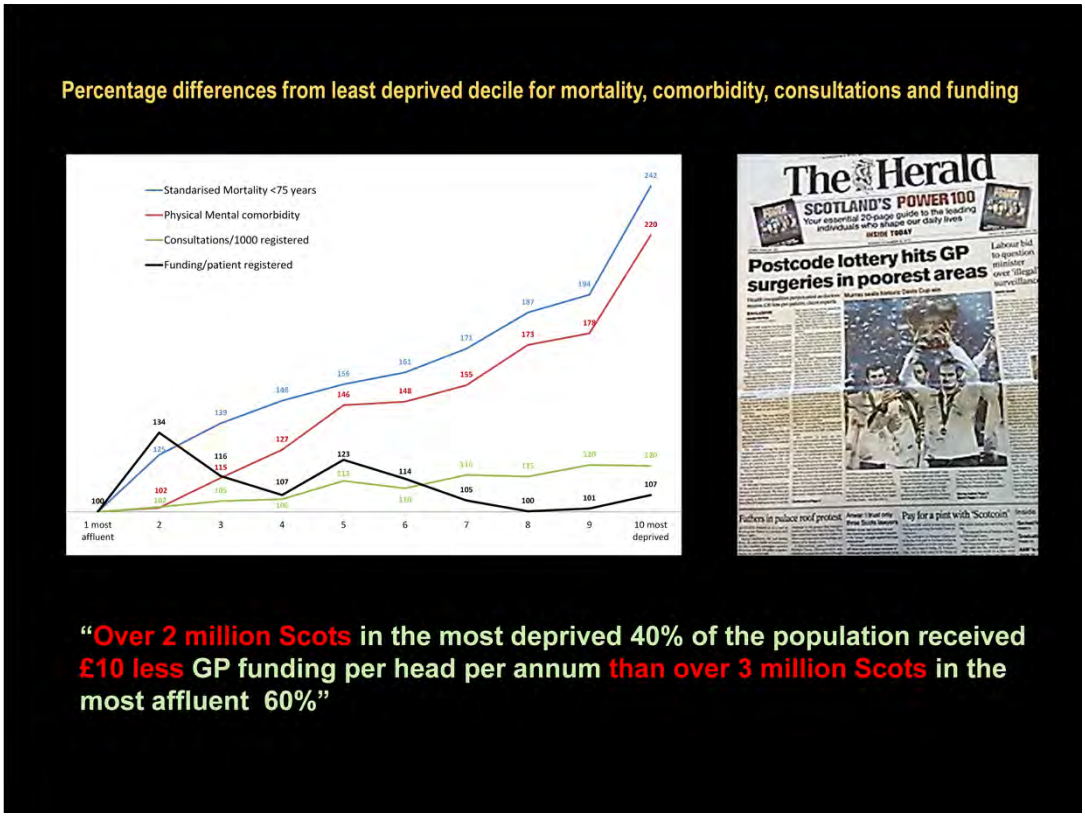


SLIDE 29

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.

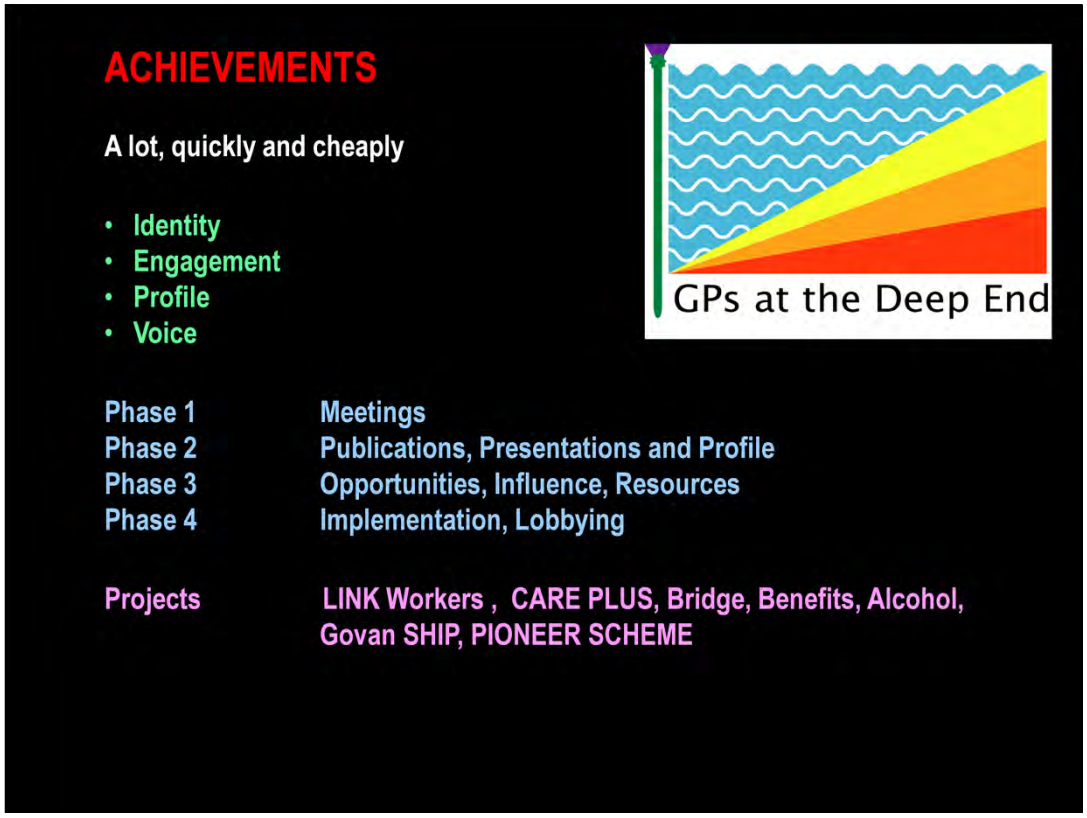
SLIDE 30

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.



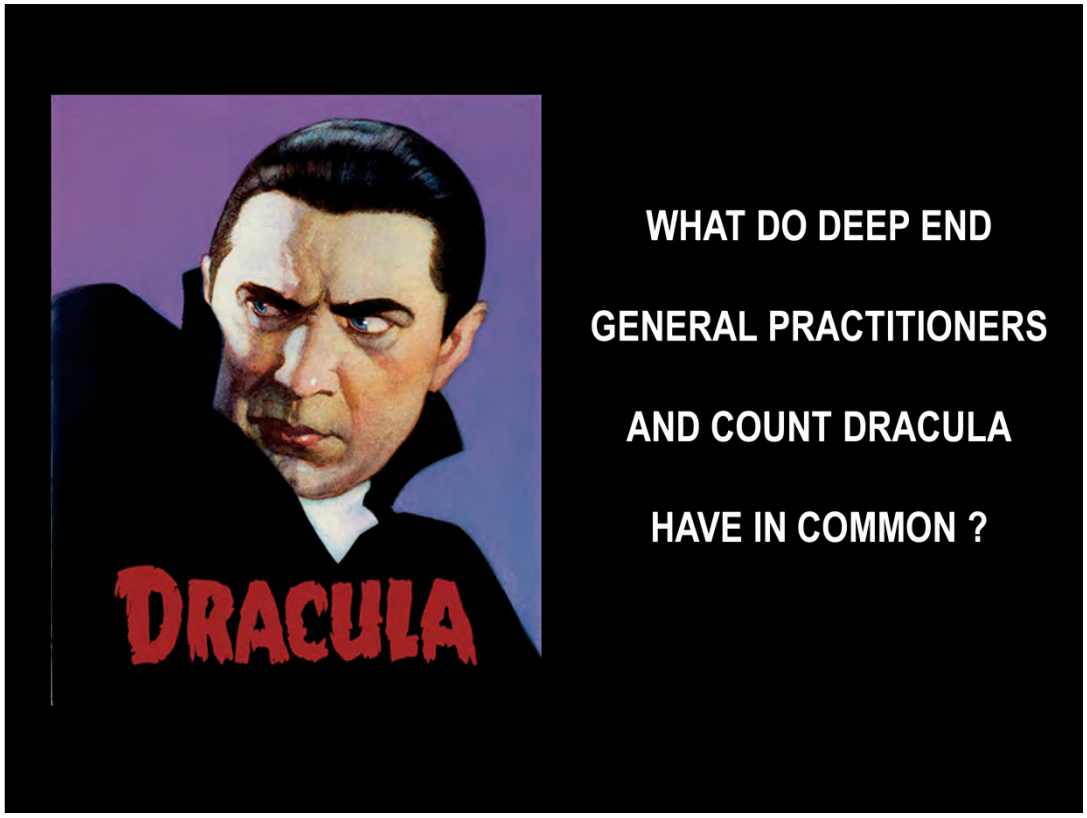
SLIDE 31

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 les GP funding per head per annum than over 3 million Scots, the most affluent 60%. That needs a pro rata funding formula.



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.

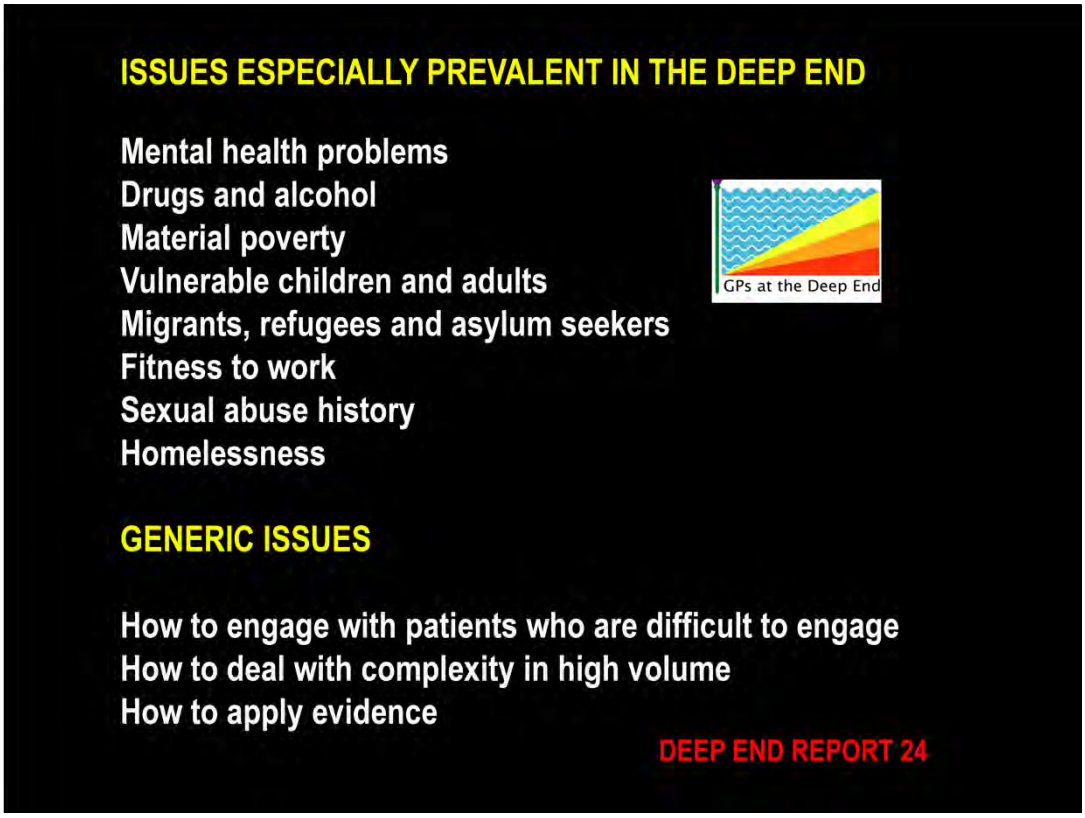


SLIDE 33

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.

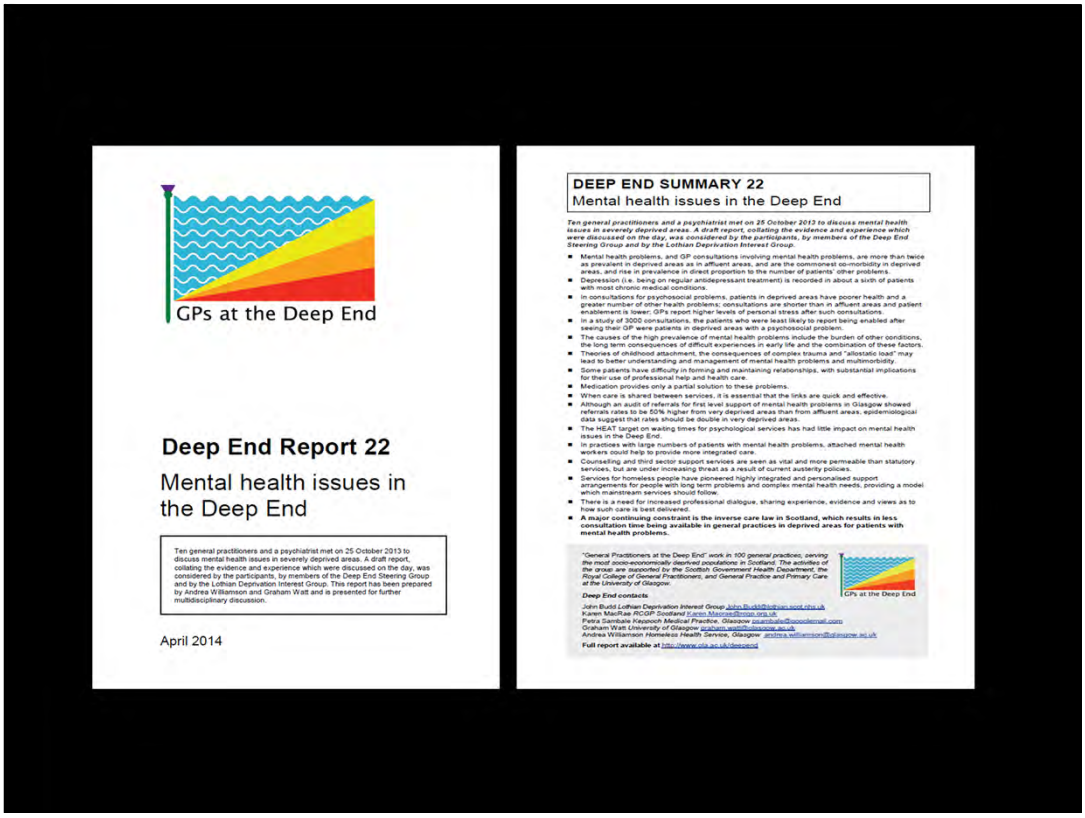
SLIDE 34

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.



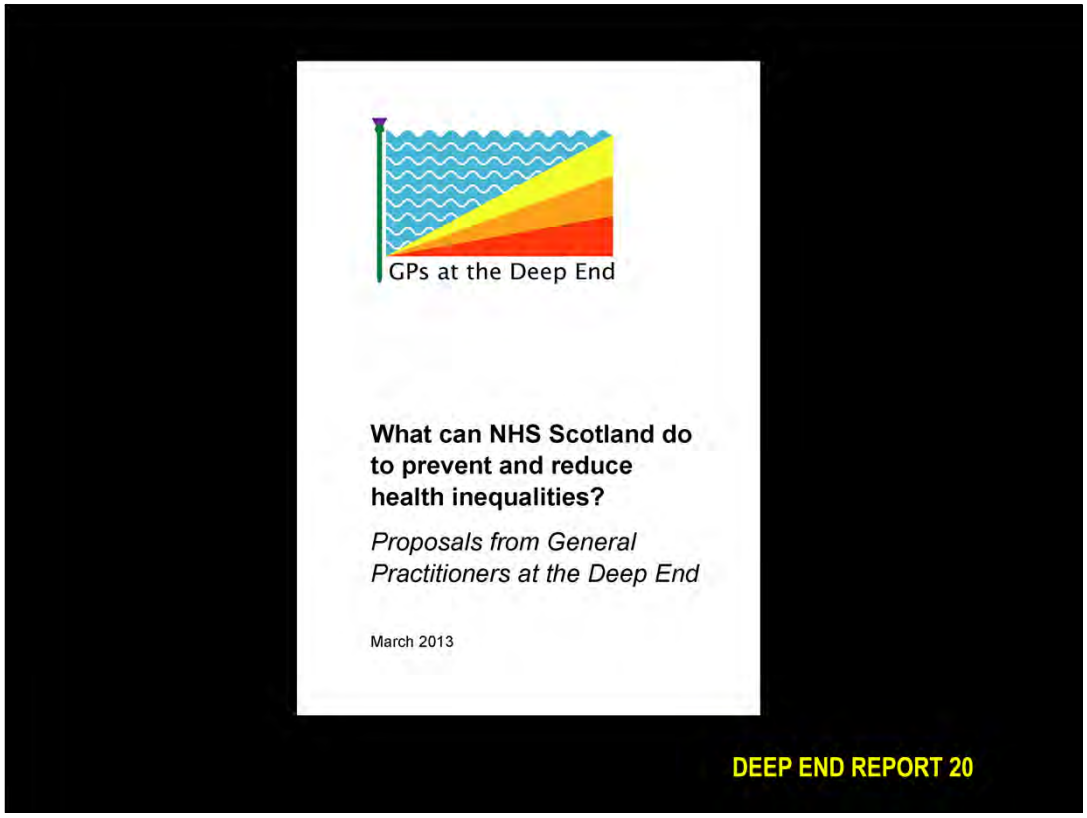
SLIDE 35

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.



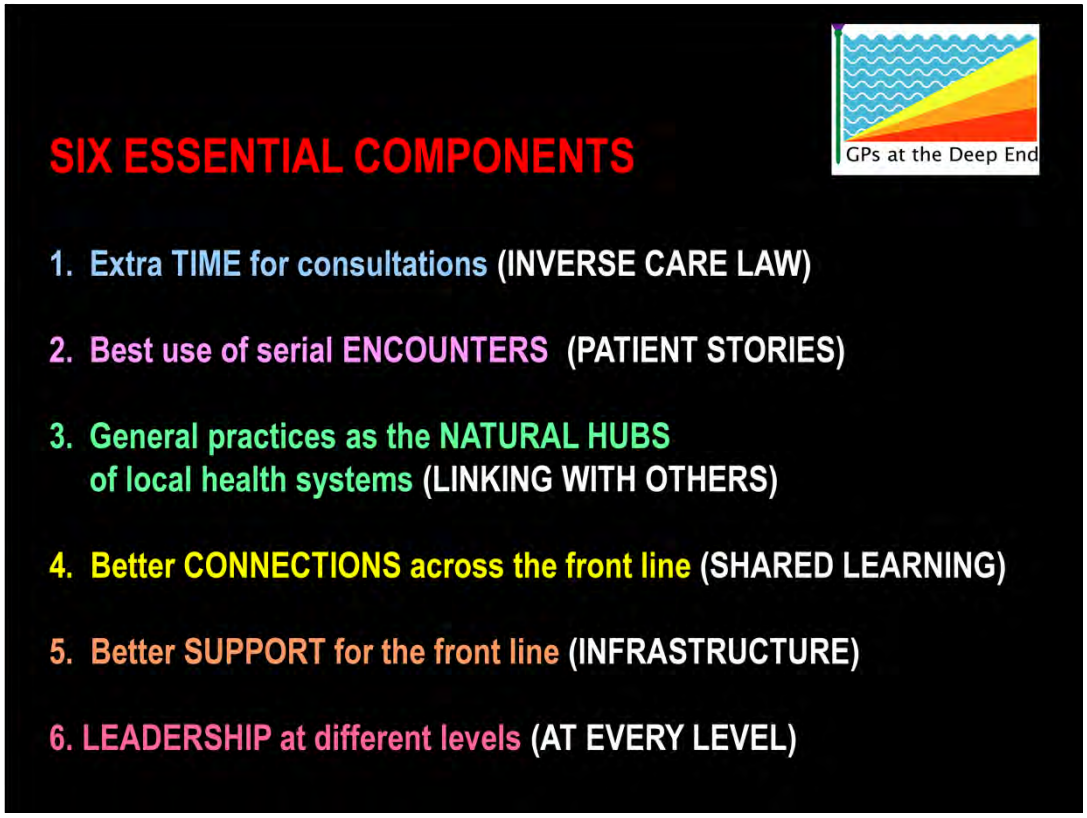
SLIDE 36

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.



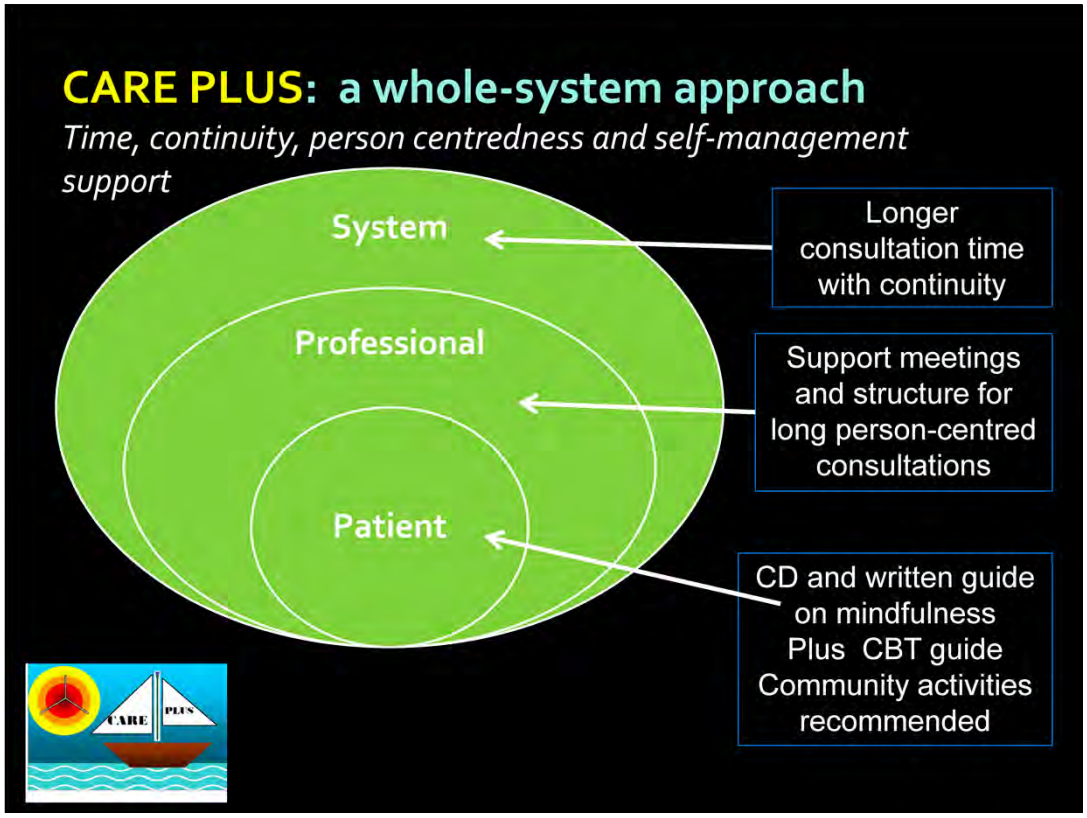
SLIDE 37

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



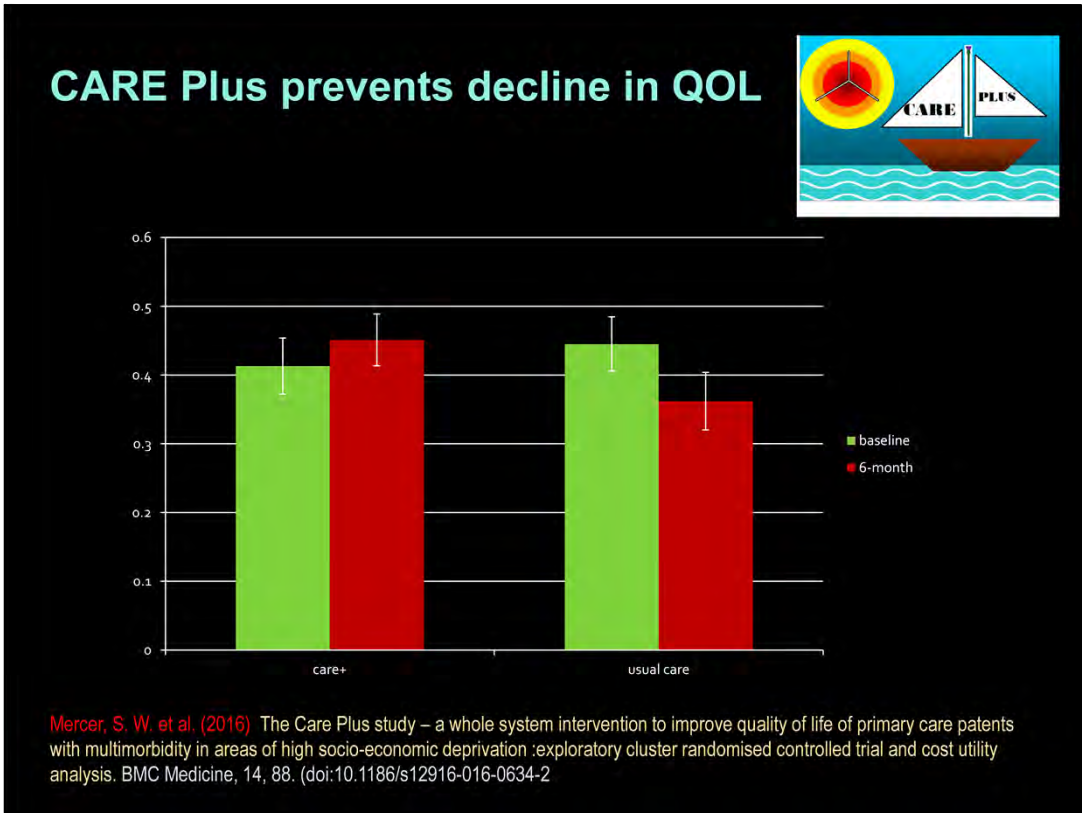
SLIDE 38

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.



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.



SLIDE 40

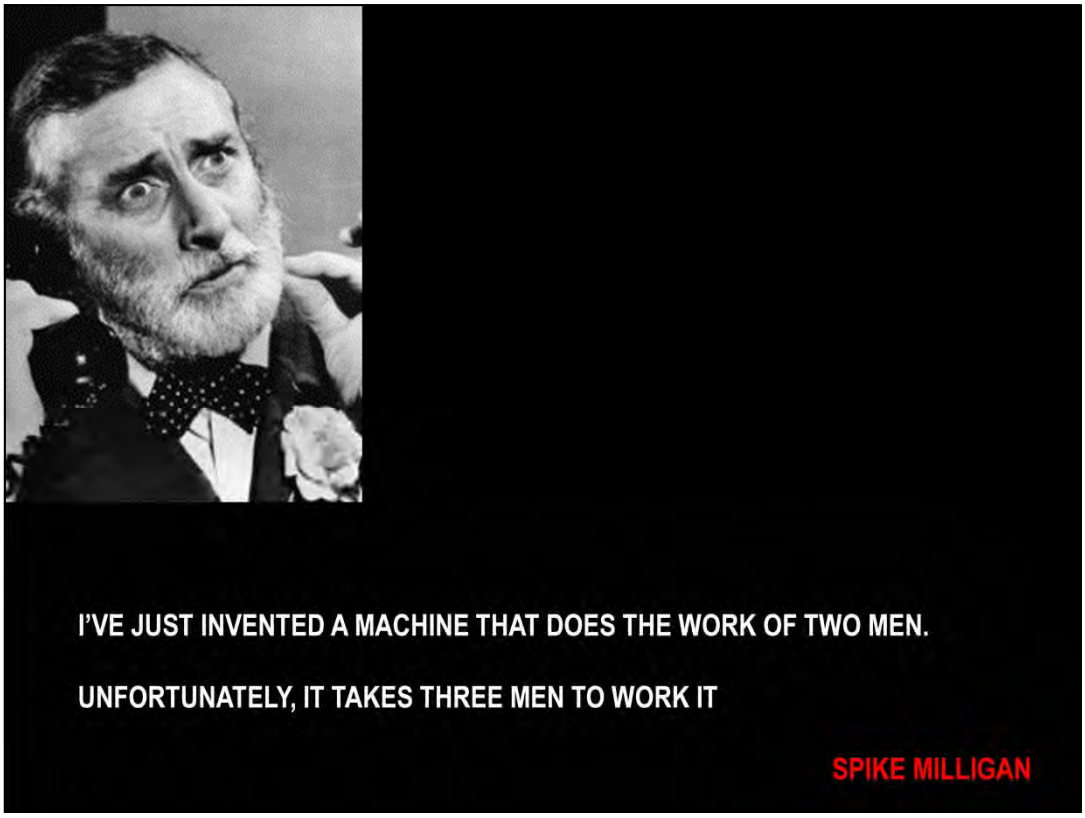
After 6 months and a year, Quality of Life was higher in the intervention group, on the left, not so much because it improved in this group, but because it got worse in those not getting the intervention, on the right. The intervention slowed decline. That's a crucial observation.

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.

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.

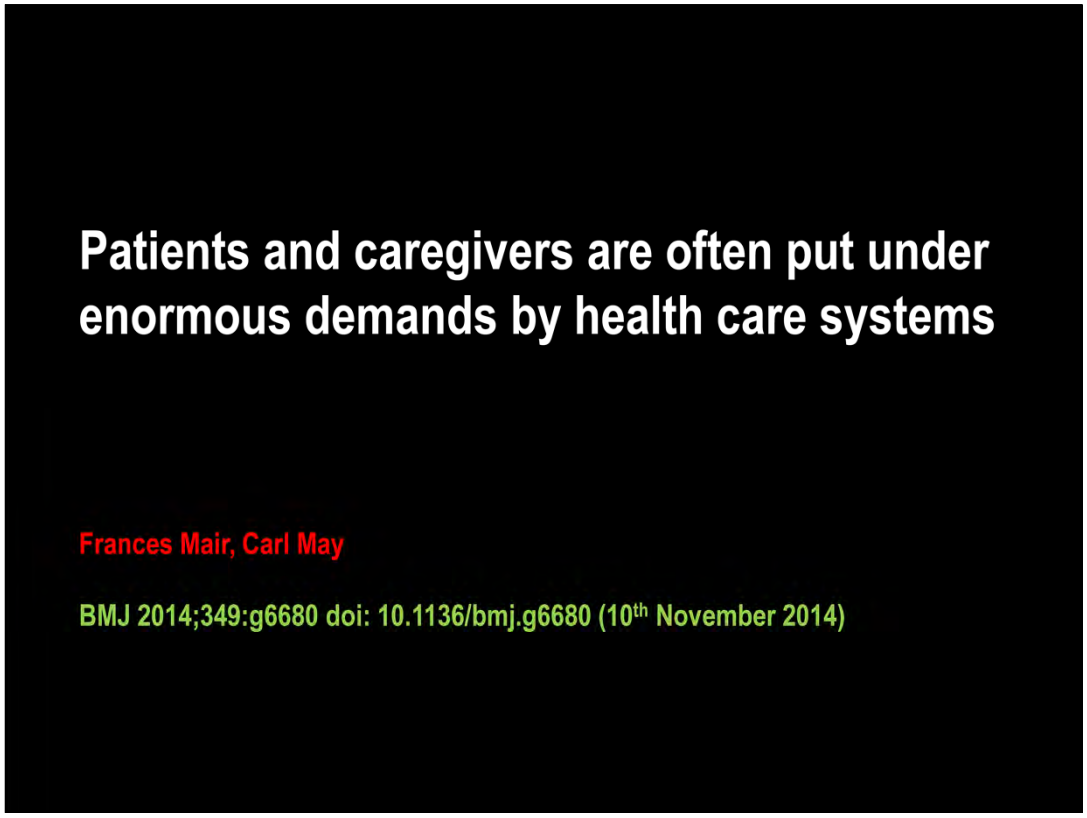


SLIDE 43

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.

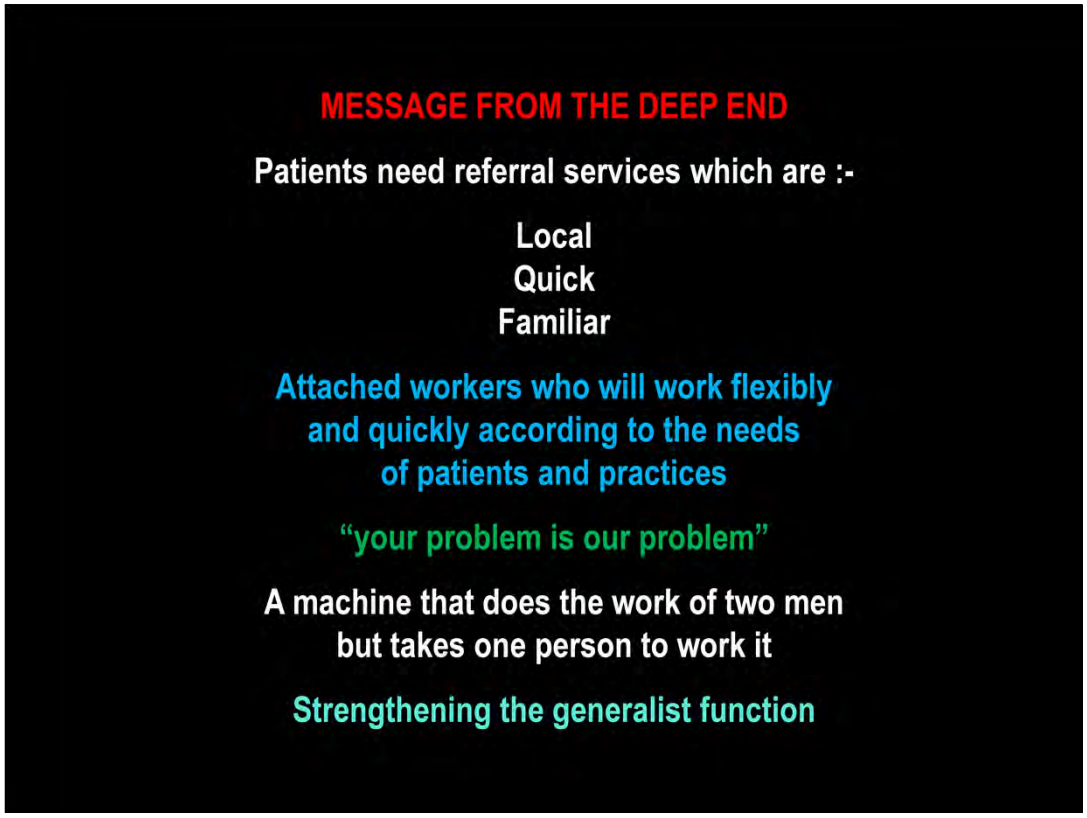


SLIDE 45

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.

SLIDE 46

For some patients, healthcare is like a pinball machine



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”.

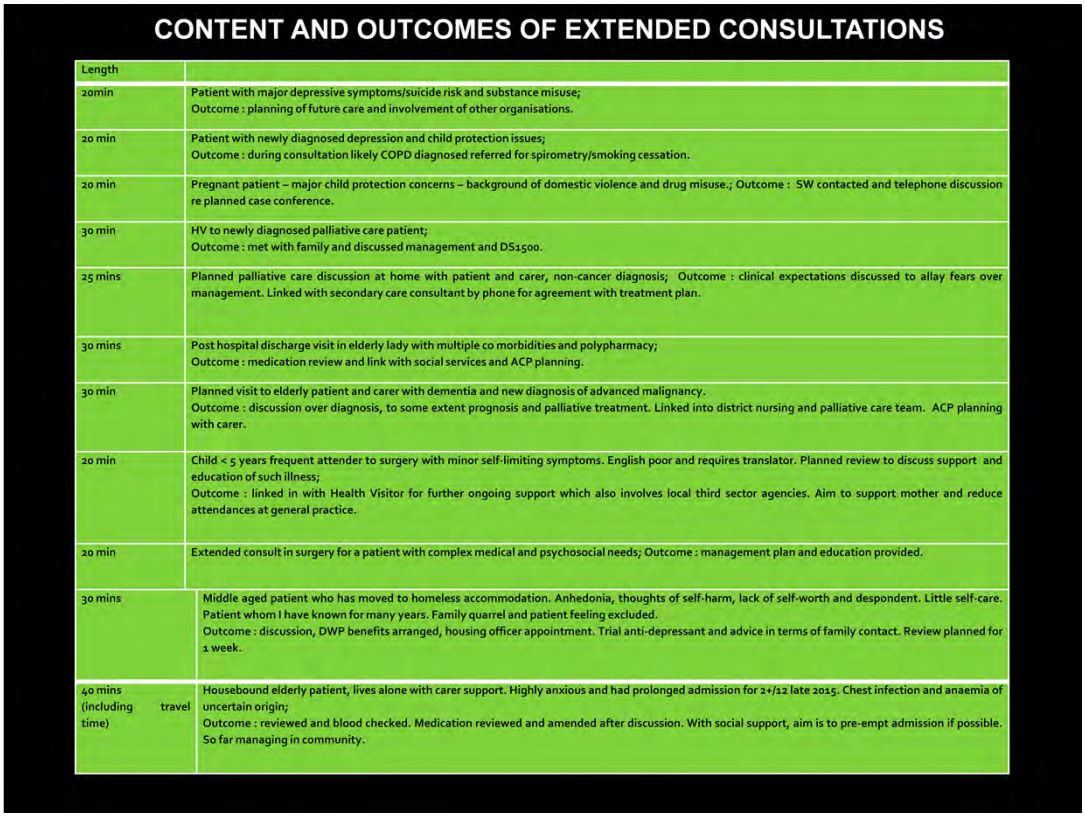
The health care equivalent of machines that do the work of two men, but need only one person to work them, are small local teams of doctors and nurses, working as generalists, unconditionally, knowing their patients well.

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.

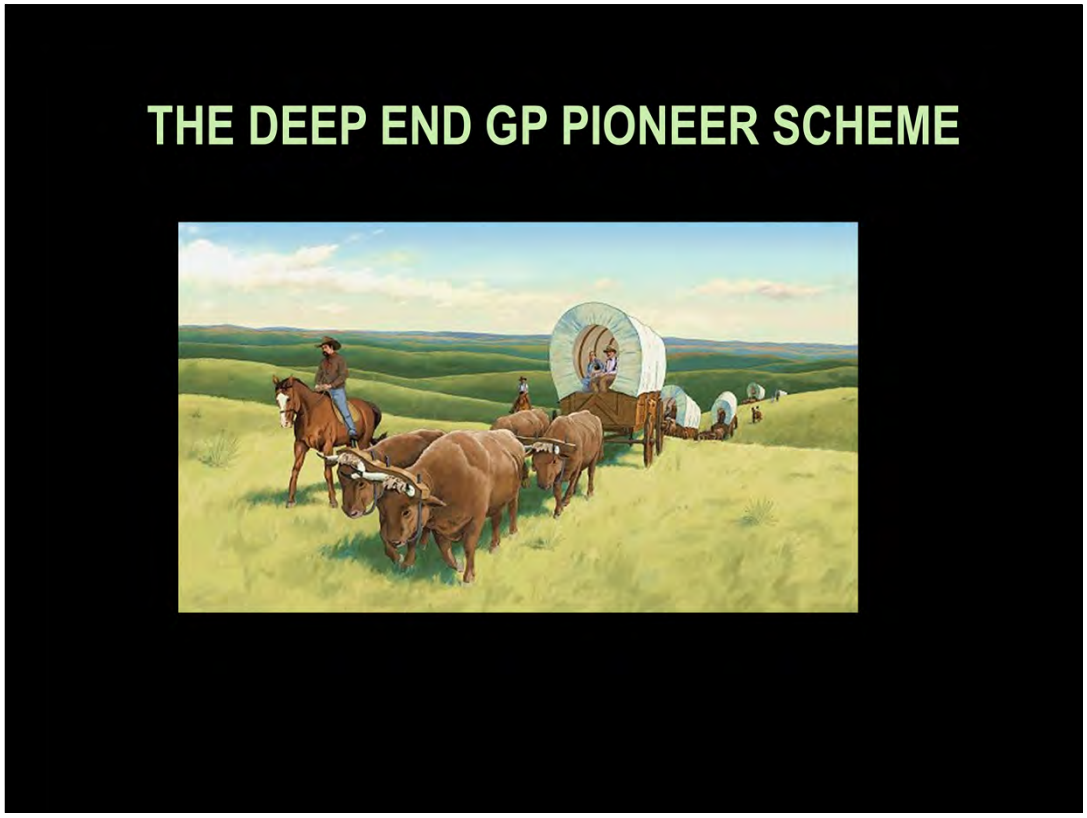
SLIDE 49

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.



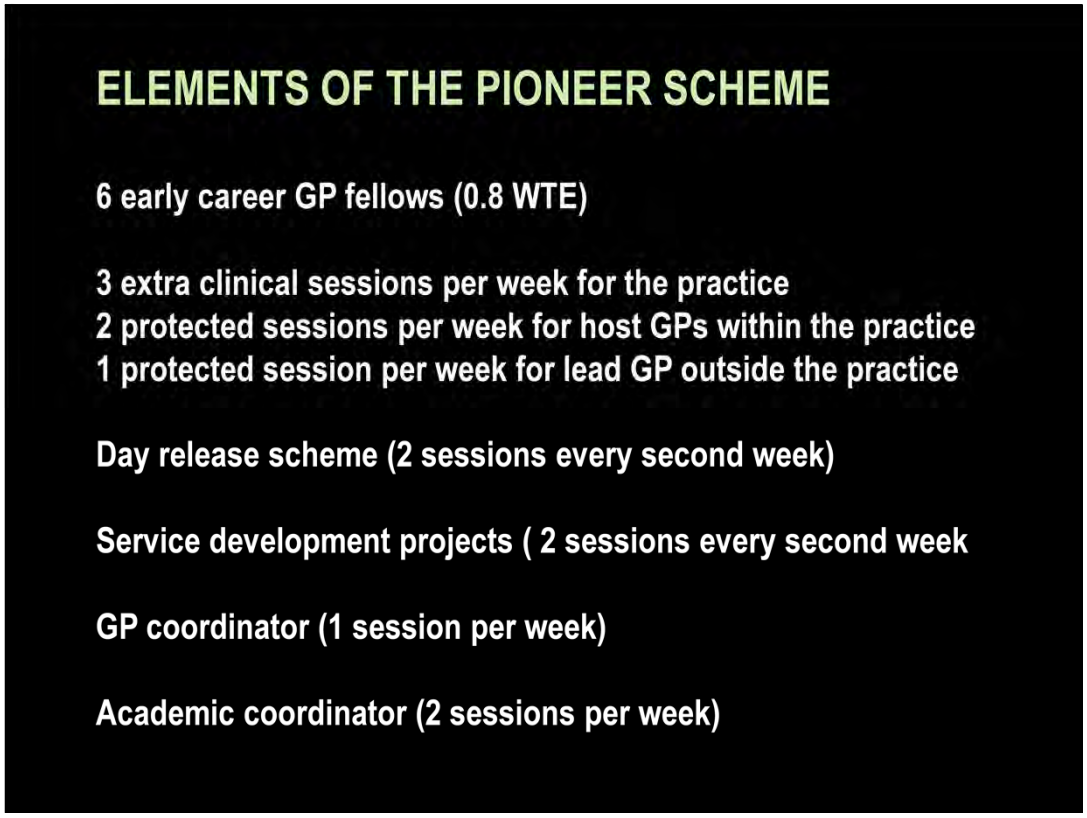
SLIDE 50

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.



SLIDE 51

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



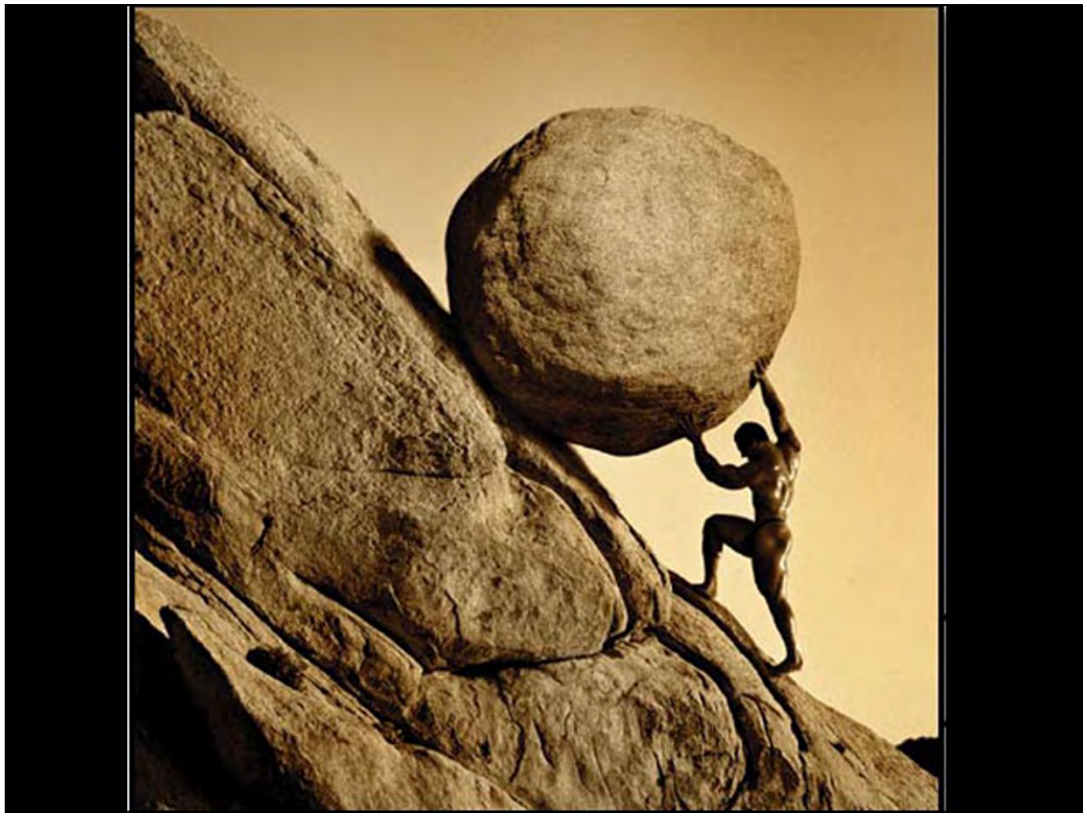
SLIDE 52

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.

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.

SLIDE 55

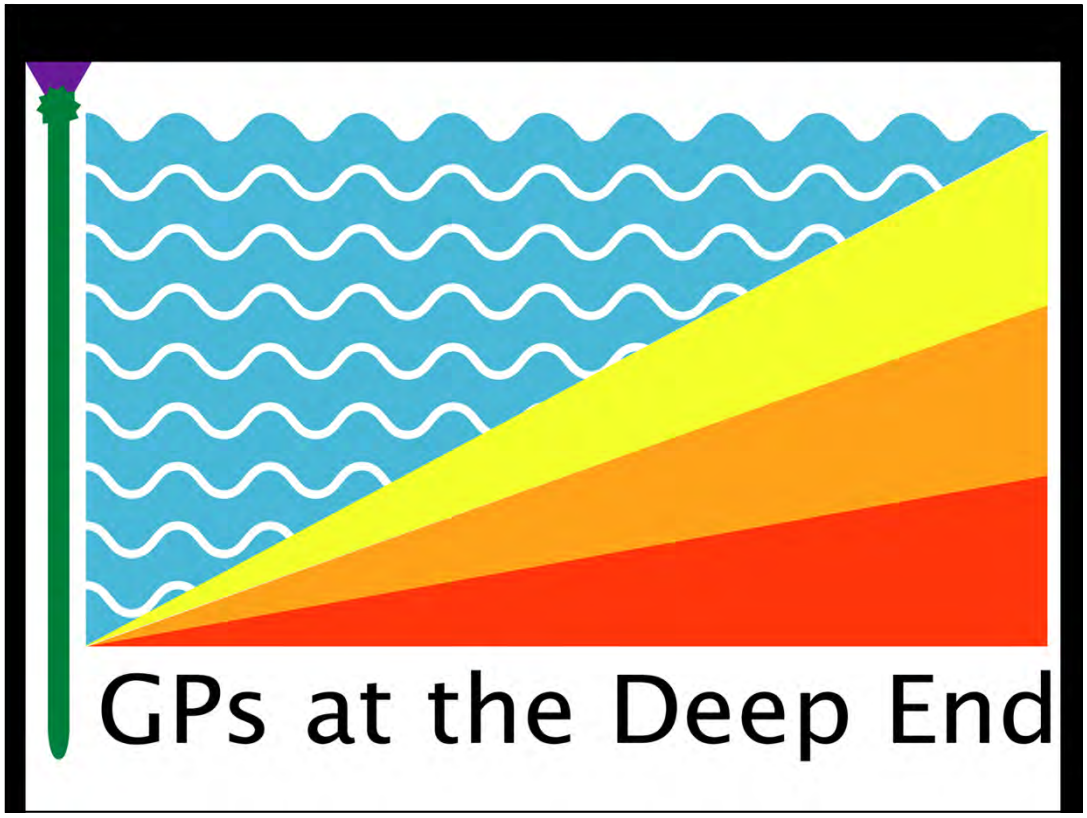
The three essential ingredients of professional satisfaction are autonomy (the ability to make decisions, to fashion the future), mastery (that's the feeling of being valued for what you do and doing it well) and purpose (the sense of having a clear shared direction). In a small way, the Deep End Project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

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.

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