GENERAL PRACTITIONERS AT THE DEEP END

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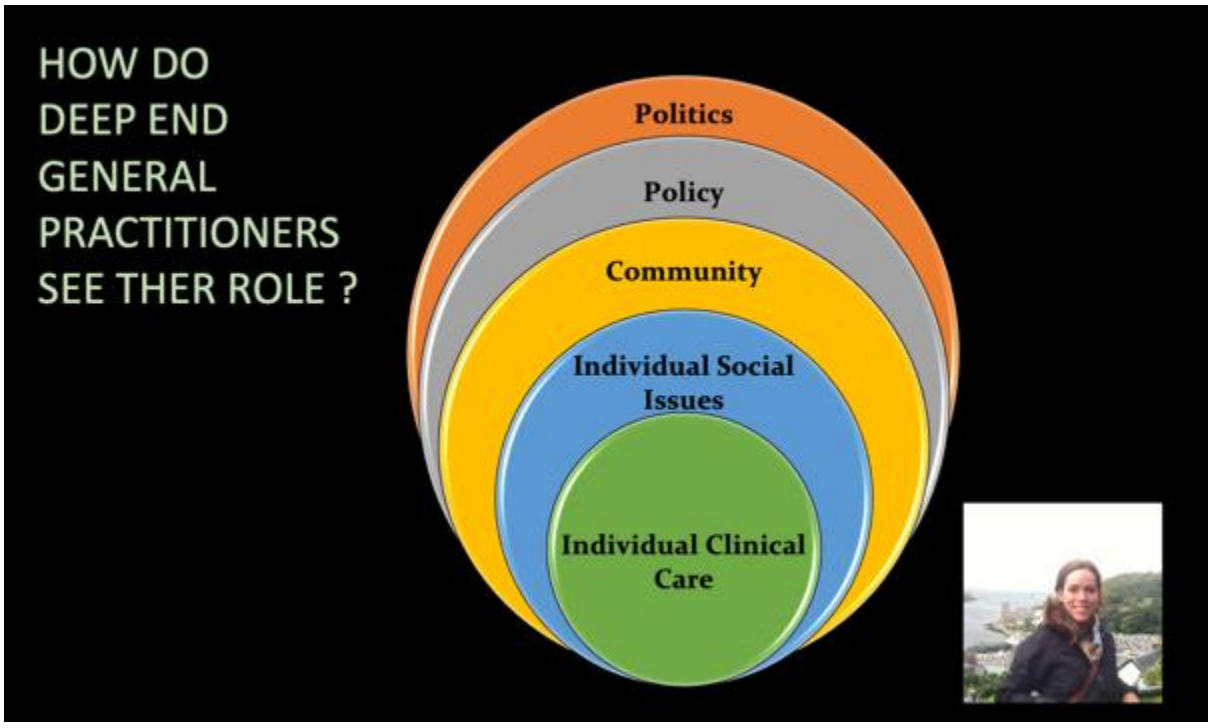
I have always wondered why somebody doesn't do something about that. Then I realized I WAS somebody.

Lily Tomlin



In her contribution to *The Exceptional Potential of General Practice*, Breannon Babbel interviewed GPs working in deprived areas in Glasgow. All saw their role in clinical consultations. Some saw no further than that, while others tuned in to patient's social situations, viewed the local community as a resource, saw the social and political determinants of poor health being played out in front of them, and wanted to do something about it. This edition of the Bulletin features several examples of such activism, from the past and from abroad.

The 27th of February marked the 50th anniversary of Julian Tudor Hart's Lancet paper on the Inverse Care Law, so there is an opportunity to comment on that and why the author wasn't especially proud of the paper. We also comment on JTH's less well known community activism, as an introduction to other articles on the topic, including two appreciations of the late Jack Geiger, who is not well known in the UK but should be. In the words of Lily Tomlin he WAS somebody.

Chris Gourlay reflects on the expansion of community link workers in Scotland and the implications for system change.

In view of current concerns about GP recruitment and retention, we include data updates on these issues from Dublin and Glasgow, before an account of the Trailblazer Scheme in England.

There is a note of the second Deep End International Zoom meeting plus reports from the Scottish and Irish Deep End Projects, and a news item about Deep End stirrings in NE London.

Finally, there is news of recently published books authored by James Matheson, Katy Gardner and colleagues.

ADVOCACY SUCCESSES

Advocacy is not only what you say but also what you do. Long experience shows that advocacy is not a sprint but a marathon requiring perseverance and the ability to overcome disappointment.

Deep End Ireland has been successful in attracting dedicated funding from the Irish Government for general practices serving very deprived areas.

Deep End Scotland has been successful in working with partners to secure Government funding for 150 financial advisors to be embedded in Deep End practices. The rollout of community link workers to all Deep End practices is also being completed

Deep End Canberra has seen the opening of a second Opioid Treatment Service in Canberra after a long period of advocacy from the Deep End Group along with other groups.

The next Deep End International Bulletin in December 2021 will include updates on these developments. Hoping also to report new Deep End developments in Wales, the East of England and Denmark.

Graham Watt graham.watt@glasgow.ac.uk **June 2021**

CONTENTS

50 YEARS OF THE INVERSE CARE LAW

On 27th February this year, The Lancet ran a series of articles (see pages 6 and 7) marking 50 years since the first publication of its most cited article – Julian Tudor Hart's paper on the Inverse Care Law – observing that the availability of good medical care tended to vary inversely with the need for it in the population served, especially when market forces hold sway.

It was not an anniversary he would have been keen to celebrate. It was his 5th publication, with over 150 papers and several books to follow, many of which he deemed more important. The big idea that fuelled his life's work was that a general practitioner, working on a defined front on the war against misery and disease, could improve the health of a local population. Further, he believed that by working together, and with their communities, primary care teams could sow the seeds of a better society. His politics frightened conservatives but essentially were simple - anyone contributing a skill to society was an ally; people who lived by owning things were not.

The title was catchy, drawing on Isaac Newton's Inverse Square Law, but while Newton's law had precise and predictable properties, the gravitational pull between two objects varying inversely with the square of the distance between them, the Inverse Care Law was a loose amalgam of several things, none with mathematical properties.

He was very clear that while *"Medical services are not the main determinant of mortality or morbidity …. that is no excuse for the failure to match the greatest need with the highest standards of care".*

In 1971, just over 20 years into the NHS, he was concerned about the re-entry of the market into UK health care. As night follows day this is a prescription for inequity and inequality. Asked how long the NHS would last, Aneurin Bevan replied, "for as long as people are prepared to fight for it", implying not one single effort such as the 1948 battle over the introduction of the NHS but a sustained defence campaign, more like maintaining a Dutch dyke, keeping the tides of market interest at bay. As NHS England, but not NHS Scotland, steadily succumbs to US corporates, to market encroachment and privatisation by stealth, Bevan's advice has never been more relevant.

There was another important theme. Notwithstanding universal access free at the point of use, for which the NHS is famous, if the distribution of health care resources is not commensurate with need, inequity and inequality will result, as some groups get the benefits of effective needs-based care while others don't. Julian argued that that this wasn't just about resource distribution. It was also about the preferences of the medical profession, as indicated by the content of medical education, the undervaluing (actually disparagement) of general practice and the career choices and geographical choices of doctors. The challenges were cultural as well as political.

Tudor Hart was unusual as a commentator on health inequalities in that, unlike most other writers on the subject, who have little or no connection with policy or practice, he could do something about it in his own small community.

He had worked in the MRC Epidemiology Unit in South Wales whose community studies with very high response rates had demonstrated the usually asymptomatic nature of very high blood pressure. The VA trial of blood pressure lowering had shown that strokes could be prevented. Echoing Brecht's dictum, "the figures compel us", Julian became the first doctor in the world to measure the blood pressures of all his patients.

Famously, the last man to take part, Charlie Dixon, only agreed to take part if everyone else had taken part first. He had the highest blood pressure in the village and was asymptomatic with a diastolic of 170. He would have been dead in 2 years but lived another 25.

The key to population blood pressure control was what Julian called the "measurement of omission", highlighting not what he had done but what he hadn't done, which required an information system with a denominator. He began by screening his records, not his patients, to identify what needed to be done. Of course, all that is a lot easier now

He could then address the rule of halves, the tendency in health care for things not to be done, or to be done poorly or incompletely.

Taking full advantage of the 1966 GP contract, he both employed and empowered his nursing and reception staff to help him provide high quality medicine and care for their local community.

In his book *A New Kind of Doctor,* he described a 42 year old man, invalided out of the steel industry with a leg fracture, who was hypertensive, hypercholesterolaemic, diabetic, obese, with an alcohol problem. 25 years later, he could write

Overall the story is a success … For the staff at our health centre it was a steady unglamorous slog through a total of 310 consultations. For me it was about 41 hours of work with the patient, initially face to face, gradually shifting to side by side. Professionally, the most satisfying and exciting things have been the events that have not happened : no strokes, no coronary heart attacks, no complications of diabetes, no kidney failure with dialysis or transplant. This is the real stuff of primary medical care.

After 25 years, he could report in the BMJ that premature mortality was 30% lower in his village than in a neighbouring village, the only evidence we have of what a GP working in, with and for a community, can achieve in a lifetime of practice, partly by delivering evidence-based medicine (less available then than it is now) but also by the delivery of

unconditional, personalised continuity of care, whatever problem or combination of problems a patient might have.

He had put his big idea into effect, reversing the inverse care law in one of the most deprived communities in South Wales. The story is one of the foundation stones of general practice and must not be forgotten.

Note: This article is taken from a keynote address on *The Exceptional and Equitable Potential of Family Practice* by Professor Graham Watt to the Annual Leaders Forum of the College of Family Practice of Canada on 28th May 2021. The full text and powerpoint slides are available at https://www.gla.ac.uk/media/Media_794990_smxx.pdf

THREE OF THE FIVE LANCET ARTICLES MARKING THE 50TH ANNIVERSARY OF THE INVERSE CARE LAW ON 27TH FEBRUARY 2021

50 years of the inverse care law

"The availability of good medical care tends to vary with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced."

These understated opening lines of Julian Tudor Hart's paper, The Inverse Care Law, are as relevant now (50 years to the day since publication) as in 1971. The paper is one

managed by private providers too. With populations that are living longer and with more chronic conditions, families—rather than the state—bear much of the cost of long-term care. Public funding for long-term care is more means tested (based on both income and wealth) than needs tested. However, that the inverse care law continues to be seen even with integrated universal health-care systems suggests that there are other

The inverse care law and the potential of primary care in deprived areas

The inverse care law, whereby health care favours more assertive interests and in doing so compounds the disadvantage of patients and communities with the poorest health,[1] exists in most health systems. 50 years after Julian Tudor Hart's landmark paper in which he first described the inverse care law in England and Wales,[1] it is still going strong.[2,3] In *The Lancet*, Richard Cookson and colleagues[4] provide a global re-examination of the inverse care law.

Tudor Hart's main target was the role of commerce

health needs to discuss, especially related to psychosocial issues.[11] These consultations generally involve lower patient expectations of shared decision making, poorer health outcomes, and greater stress among health professionals than in wealthier areas.[11,12] Patients who are socioeconomically disadvantaged generally make more use of emergency health services but less use of specialist and preventive care.[13] COVID-19 is compounding these issues through social gradients in incidence and case-fatality rate, the mounting backlog of non-COVID-19-

The art of medicine

Julian Tudor Hart: medical pioneer and social advocate

Julian Tudor Hart is seen variously as a researcher, an expert on high blood pressure, an epidemiologist, scientist, writer, political commentator, and social advocate. But at heart he was always a practising family doctor. Few physicians manage to be expert in so many fields and none while also looking after the primary care needs of some 2100 people, which Tudor Hart did at Glyncorrwg, a former colliery village in south Wales, UK. His dedication to general practice meant his work was relevant and valued by fellow general practitioners (GPs). Tudor Hart's big idea was that for research training under Archie Cochrane, a pioneer of chronic disease epidemiology and advocate of randomised controlled trials at the Medical Research Council (MRC) Epidemiology Unit near Cardiff. Tudor Hart found the work at the MRC Unit frustrating, however, observing many patients with unmet clinical needs which as a researcher he could do nothing about. So, he left, exchanging "a life of facts for the facts of life", and moved to a single-handed general practice in Glyncorrwg, West Glamorgan. Shortly afterwards, he made the most important decision of his

COMMUNITY ACTIVISM AT GLYNCORRWG

On a January night in 1981 my future wife and I were asleep upstairs at 18 Norton Terrace, a row of miners' houses in Glyncorrwg, South Wales, when we were awakened by a loud engine noise overhead. "Sounds like a helicopter", I said, and went back to sleep.

Meanwhile, a young Glyncorrwg woman was going into labour, her case complicated by the fact that the village was marooned, the only access road lying under several feet of snow, something that happens in that part of the world about once in 50 years.

Car partly submerged in snow, Glyncorrwg, 1981

While we slept, the community midwife had woken up half of the village, summoning them to the local rugby pitch where, holding torches to the night sky, they formed a large circle in which the helicopter could land. Next day, the successful live birth at Neath General Hospital, 12 miles away, became the only Glyncorrwg birth ever to be reported on the front page of the London *Times*. As the doctor on call, the midwife had correctly assessed that I had little to contribute to what needed to be done.

The village doctor, Julian Tudor Hart, leaned of this a few days later on his return from a speaking visit to Cuba. On his desk was another invitation, this time to a US National Institutes of Health (NIH) conference on Community Oriented Primary Care (COPC) in West Virginia. Generously, he suggested that I go instead, which almost certainly wasn't what the hosts wanted but was a great opportunity for me.

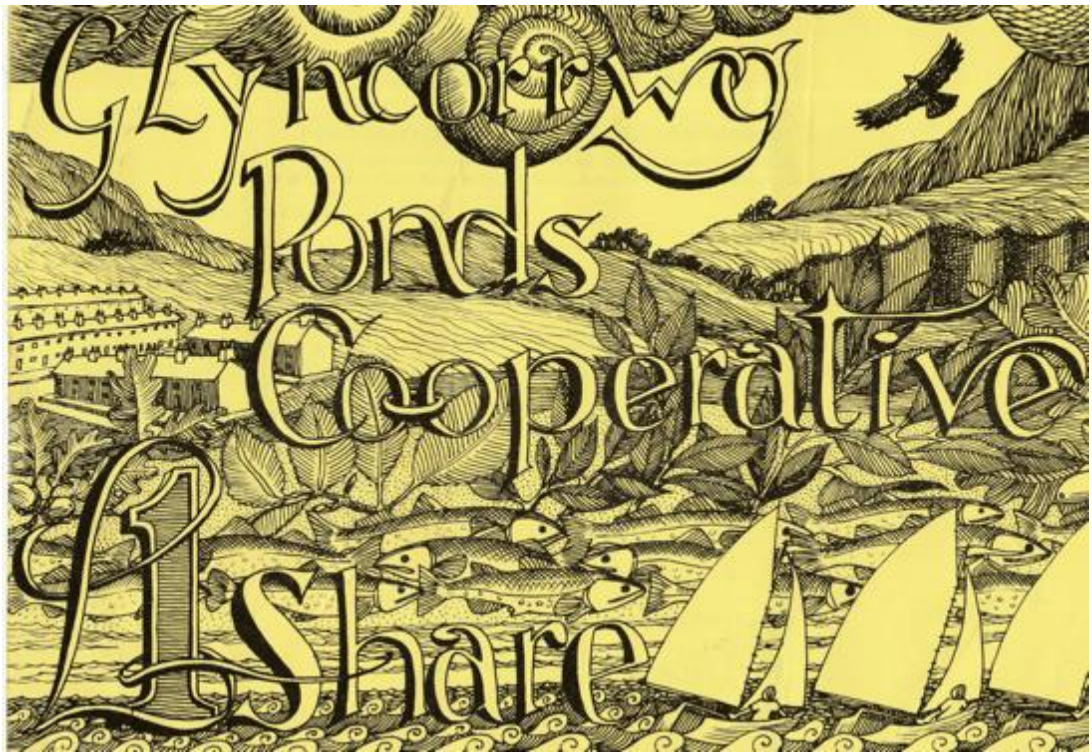
The two main things I learned were first, the diversity of the US population and second, whatever one thought of mainstream US health care, the margins were alive with imaginative, progressive projects, most of whose leaders were at the conference.

Leading this group was the late H. Jack Geiger, who died on 28th December 2020 at the age of 95. With permission from the Millbank Memorial Fund, it's a pleasure to include in this Bulletin two short commentaries on H. Jack Geiger's life and work.

This edition also recalls the pioneering work of Dr Cyril Taylor in Liverpool, as covered in Katy Gardner and Susanna Graham-Jones' new book *A radical practice in Liverpool– the rise, fall and rise of Princes Park Health Centre.*

Julian Tudor Hart was also a community activist. On the hillside opposite Glyncorrwg's single access road was a ten foot wall, about a hundred yards long and part of the embankment supporting the old colliery railway. When a TV crew visited the health centre to interview Julian, he would go out the night before to whitewash the wall with MINERS SAY NO TO THATCHER in huge lettering. The TV crews never failed to capture this message, as part of their background footage.

A colleague wrote recently, *"What very few people say in quoting Julian, alongside his clinical care delivery and College and lecturing commitments, is how much of a local community activist he was. He thought it came in the same bundle of care. The enormous time he gave to getting the Miners Museum off the ground, which finally didn't get planning permission for access reasons, but did get established in Afan Argoed, was all his idea. Then the ponds/biking centre was his idea and now is one of the favourite mountain bike centres in the country with attached cafes, bike repairs and B/B outlets all of which contribute to the economy albeit a small amount but helps with the wellbeing of the community more than pills. Now houses fly off the market as soon as the boards go up - the farm on the forestry road which was a dump has gone for £500,000 recently with just one field, but to be developed as a glamping Centre."*



A £1 share certificate for the Glyncorrwg Ponds Co-operative

The examples of Julian Tudor Hart in South Wales, Cyril Taylor in Liverpool and H. Jack Geiger in many places in the United States show that Deep End initiatives are not new. What is new is the connectivity between such practices, sharing learning, building solidarity and speaking with a stronger voice.

Graham Watt

A CITY MAINTAINS H. JACK GEIGER'S COMMITMENT TO COMMUNITY

In Central Falls, Rhode Island — the city with the highest COVID-19 infection rate in the state — 20 city residents regularly walk the streets decked out in bright orange hoodies, orange watch caps, and face shields; passing out masks; explaining the benefits of vaccination; and encouraging to sign up for vaccinations. These Health Ambassadors for the city are doing this work because of H. Jack Geiger, MD, and how he thought about health, health care, and health services. Community and health as well as community and health services, are as inextricably intertwined, Dr. Geiger knew, as dancer and dance. Health is of, by, and for each community. Health therefore flows from relationships and is not a commodity. And health services promote democracy by giving everyone a more equal place at the table, helping to address the health impacts of centuries of institutional racism while providing the residents of underserved communities with jobs, new professions, and new agency over their lives.

When Dr. Geiger came to Mound Bayou, Miss., to co-found the new Tufts Delta Health Center and began working with Dr. John Hatch, a social worker and community organizer, and Dr. Andrew James, the first Black sanitarian to work in Mississippi, they focused on hiring local people whenever possible. They demonstrated that environment, employment, and self-determination are critical factors in helping communities become and stay healthy. It's a lesson we've tried to put to use in Central Falls.

Central Falls is Rhode Island's smallest, poorest, most densely populated, and most Latinx city. Twenty thousand people live on 1.3 square miles in old wood frame triple-deckers. It is a city without much open land and with many undocumented residents, but it is also a city with unbridled grit and determination. It entered bankruptcy in 2011 but emerged in 2013 with a new mayor and city council. Many young people who had grown up in the city returned after college to give back to their communities. Known as the Comeback City, Central Falls has been innovating for years, finding its way to better education, better health care, a better economy, and a better future.

COVID-19 found opportunity to spread when working people living in poverty in Central Falls had to go out to work every day and come home to families living in densely

packed houses. Dr. Geiger knew that medical care alone is never enough. For Dr. Geiger, a "community health center …[is] an instrument of social change" allowing for "intervention in the social, biological, and physical environments" using the tools of "community organization and community empowerment."[1] He understood that health outcomes don't improve without community organization, and that health care alone is insufficient to protect and improve the public's health.

Central Falls is the home of the first Neighborhood Health Station in the United States, which is a single clinical enterprise designed to provide primary medical, dental, behavioral health care and other services to the entire population of the city. In fact, community development focused on health is now a whole-city enterprise in Central Falls, inspired by Dr. Geiger's example. Thanks to the vision of an engaged mayor, James Diossa, his visionary successor, Maria Rivera, and a supportive city council, the city took the notion of community-based primary care and transformed it, so the city government, and not just the health center, has become the locus of community organization and empowerment. The city uses its Parks and Recreation Department to engage people in physical activity. It studies data from its Emergency Medical Services to find opportunities to better deploy primary care and to address the needs of its most vulnerable people using a team of health care and social service workers, an expanded version of the health care teams that Dr. Geiger developed.

When COVID-19 struck city residents, about half of who had no access to primary care, the city stepped to the plate, and organized isolation, testing, and family support, by and for people who lived in the city and were most impacted by the spread of COVID-19. Now, it is the city that has organized a vast immunization program, and Central Falls is on track to becoming one of the most effectively immunized places in the United States if vaccine supply holds out.

In addition to understanding the transformative power of people from different communities working together to build a more just society, how health care in general and primary care in particular can help us address dignity and community, and to calling upon the moral responsibility of health care leaders, Dr. Geiger had a vision of the critical nature and integrity of communities themselves. His ability to recognize communities as central to health, and to strengthen communities so they could nurture all of us, lives on in Central Falls and in thousands of communities across the nation and the world. Dr. Geiger's vision, his courage, and his commitment to community lives on and brings dignity to health care and health care workers as we struggle together to keep the nation and its democracy intact.

Michael Fine

[1]Ward, TJ. Geiger HJ. *Out in the Rural: A Mississippi Health Center and Its War on Poverty*. New York: Oxford University Press; 2017.

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H. JACK GEIGER AND THE POWER OF HEALTH CARE TO TRANSFORM LIVES AND COMMUNITIES

The death of H. Jack Geiger, MD, on December 28 of last year at the age of 95 should not go unnoticed.

Journalist, physician, and relentless advocate for civil rights and social justice, Dr Geiger pioneered the development of the nation's community health centers, which now serve 1 in 13 people in the country. He helped start two organizations that won Nobel Peace Prizes and inspired two generations of clinical leaders focused on the capacity of health care to transform lives and communities.

Dr Geiger's work sprang from three central tenets that those of us involved in any aspect of health care would be wise to keep in mind at this fragile point in our country's history.

The transformative power of being with people who are different

Dr Geiger's childhood in New York City was marked by a stream of Jewish family members fleeing Nazi Germany, who brought with them a different culture and stories of persecution.

Too young for college when he graduated from high school at 14, Dr Geiger worked as a copy boy for *The New York Times* and started exploring the city, discovering jazz music and its culture. Showing up in 1940 with his suitcase at the Harlem doorstep of actor Canada Lee after seeing him on Broadway, 15-year-old Geiger was drawn into the world of the Harlem Renaissance, absorbing the anger, alienation, and community of black

authors, musicians, and artists like Langston Hughes, Paul Robeson, and Adam Clayton Powell.

The effect was lifelong. Deeply moved by this exposure to a long history of injustice, including the treatment of black soldiers prior to World War II, Dr Geiger spent his early college years at the University of Wisconsin organizing the school's chapter of the Congress on Racial Equality. He served in World War II in the Merchant Marines because it was the only fully integrated branch of military service. After the war, in premedical studies at the University of Chicago, he organized a 1,000 person strike against the treatment of black patients and candidates for medical school — an effort that got him black-balled by the American Medical Association from admission to medical school for five years.

No matter — the deal was sealed. Dr Geiger's regular and repeated willingness to be with and listen to people very different than this Jewish kid from New York had convinced him of the common dignity of all and the fundamental injustice that occurred when that dignity was denied.

Health care as a strategy to address racism and build dignity and community

Trained as a physician in a typical medical sciences curriculum, Dr Geiger then spent his fourth year at Case Western Reserve University's Medical School helping to set up clinics among Zulu people in what is now South Africa. There he discovered that the organization and provision of medical care could be a way not just to treat illness but to build health. By focusing on the social factors that cause poor health and integrating patients and community members into the delivery and oversight of health care services, the delivery of health care could help restore human dignity and build community.

Focusing on the concept of the social determinants of health long before it became fashionable among consultants and health systems, the practice of what became known as community-oriented primary care was a response to the environmental factors and health inequities resulting from inequities of power. As Dr Geiger put it in his characteristically blunt terms, "There is just no point in treating rat bites — and ignoring the rats. . . . To equip a concentration camp with a medical center is not only futile — it is an expression of the deepest moral cynicism."

After working in the civil rights movement in the 1960s, Dr Geiger took advantage of the Johnson's administration's Office of Economic Opportunity to obtain federal grants to start the first two community health centers in the country. In these demonstration projects in poor urban (Boston) and rural (Mound Bayou, Miss.) settings, he deployed lessons from South Africa. Besides increasing access to high-quality medical care, he and his colleagues developed programs in housing, jobs, and food, and gave patients oversight authority over the center operations. The Mound Bayou and Columbia Point,

Mass., health centers were the progenitors of the more than 1,400 federally qualified health centers now serving over 28 million mostly low-income people.

Dr Geiger's fundamental strategy was simple and remarkably aspirational. Health care is not a commodity service to be advertised on billboards and during football games. Nor is it an investment opportunity alongside other uses of capital. Given that all of us have experienced both illness and health, access to decent health care is a matter of social solidarity and, he said, the delivery of "health services, which have sanction from the larger society and salience to the communities they serve, have the capacity to attack the root causes of ill health through community development and the social change it engenders."

The moral responsibility of health care leaders

Dr Geiger's work did not stop with community health centers. Recognizing the particular moral authority of physicians in our society and their responsibility to call attention to the causes of ill health, he co-founded Physicians for Social Responsibility (PSR) in 1961 to address a catastrophe to the health of the planet – the possibility of a nuclear war. In the midst of heightening Cold War tensions, with science and statistics, PSR repeatedly laid bare the prevalent myth that a nuclear confrontation was survivable.

Twenty-five years later, Dr Geiger returned to his international health roots and helped found Physicians for Human Rights (PHR), calling public attention to human rights abuses by various governments and their consequences for societal health. Both PSR (for nuclear disarmament) and PHR (for land mine removal) were honored with Nobel Peace Prizes.

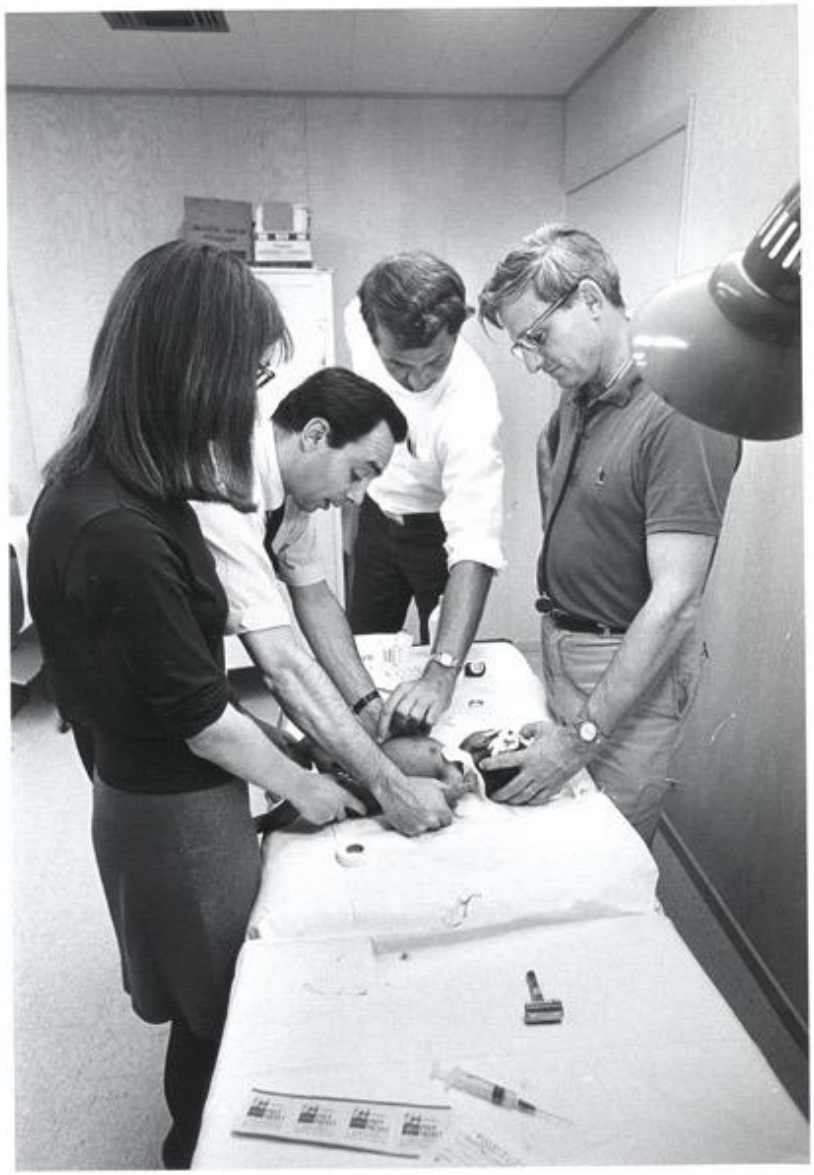
Leadership in health care is inherently moral, in Dr Geiger's view, and brings with it a responsibility to act. "I've been angry," he wrote, "seeing terribly burned children in Iraq after the first Gulf war, or interviewing torture victims in the West Bank, or listening to Newt Gingrich say ghetto kids should learn to be part-time janitors and clean toilets (in another country, they called that Bantu Education). So anger doesn't vanish, but is replaced by a determination to do something."

Dr Geiger's tenets are more relevant for our times than ever. In a period of social media–fueled polarization, made worse by the pandemic's isolation, we need to build personal habits of making in-person contact with people who think differently than we do. That is the beauty and the promise of universal institutions like libraries, public schools, and, yes, even elections.

In a time of increasing economic inequalities and awareness of the persistence of racism, we who work in health care have unique opportunities to build more just and equitable structures of health care access, financing, and governance that address the social factors that cause poor and inequitable health outcomes.

Finally, in a time of massive societal health care spending for diminishing life expectancy, health care leaders have a responsibility to think beyond the needs of their own organizations, institutions, or professions and use their authority and influence to communicate about the systemic challenges we face and in Dr Geiger's words, "to do something."

Christopher F. Koller
President, Millbank Memorial Fund



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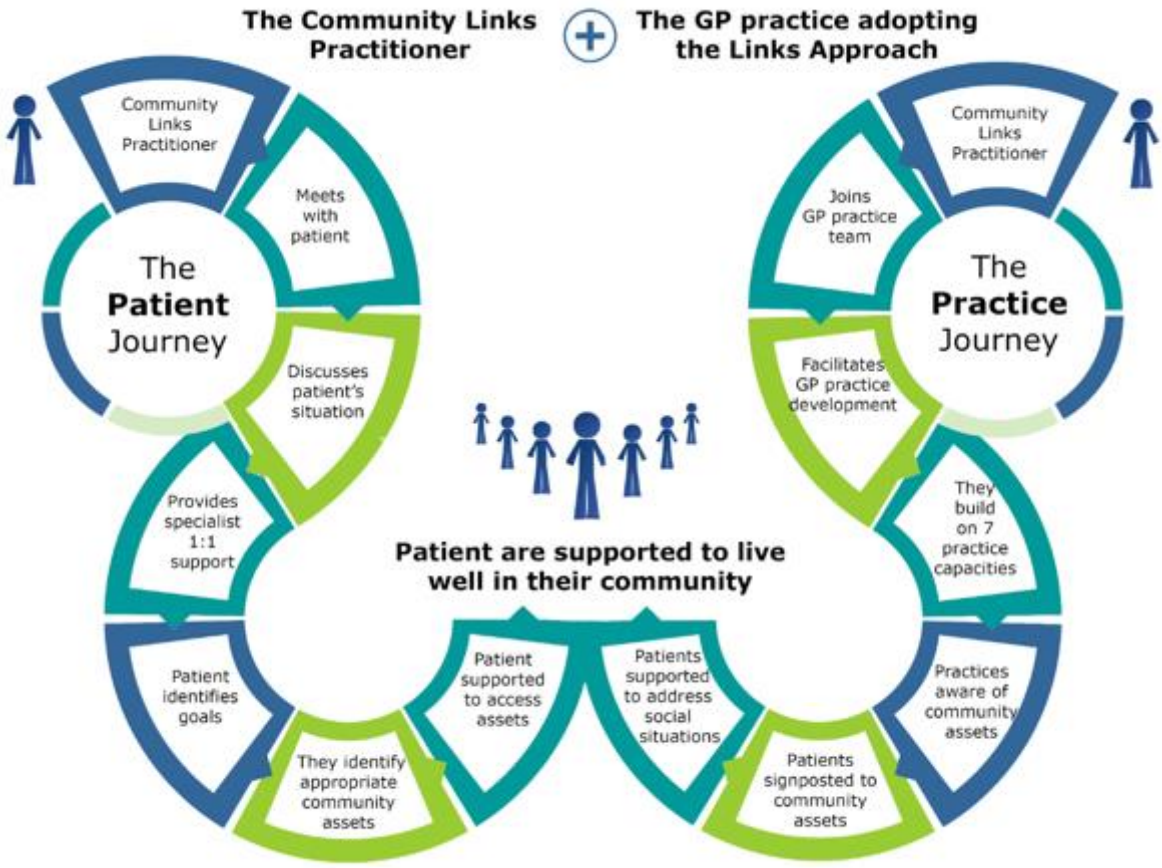
COMMUNITY LINK WORKERS – IMPLICATIONS FOR SYSTEM CHANGE



The Scottish Community Link Worker Programme

As progress is made in implementing the Scottish Government's target of installing 250 general practice-based Community Links Workers (CLW) to provide the support people living in our most deprived communities need, various challenges and opportunities arise.

This is natural in any endeavour concerned with managing growth in scaling up a model across settings. Our own programme, delivered by The Health and Social Care Alliance Scotland (the ALLIANCE) began in 2014 in seven Glasgow general practices. Currently we deliver a CLW service in over 40 practices in Glasgow City and will soon expand into West Dunbartonshire local authority area.

In recruiting, supporting and seeking to continually develop the growing CLW workforce, conscious evolution of management structures and support networks is crucial. To this end we have developed a Senior CLW role. Initially, individuals in these roles continue to deliver the CLW function to patients in their own practice whilst each holding line management responsibility for 6 to 8 CLWs, to whom they deliver supervisory and performance management sessions, as well as helping facilitate what are now sectoral

(one of for each of the three Glasgow City localities) peer support and intelligence sharing team meetings.

Training and development activity, such as 360º Feedback exercises, to enhance supervisory and leadership skills has been undertaken and this team report to the Programme Manager. Dynamic quality improvement is vital in this and tools like field note diaries and facilitated development days complement standard recording of details of cases/links journeys to allow us to keep various aspects of this development under review, including continual generation of learning around how sustainable it is for those in the senior roles to manage their own caseload in the practices where they deliver a frontline service themselves. Such evolution must of course be achieved within an environment of limited resources, in common with all tranches of healthcare.

Another longer standing and related challenge is to demonstrate impact. It is clear that profound benefits are felt by those the programme is intended to benefit. However, this is chiefly demonstrated through qualitative testimony from patients and staff in participating practices. 'Godsend' is a word used uncannily often by various people who've benefited from the CLW service in describing the support they've received.

"You're doing more than anyone to help me sort out my wellbeing. You've been a total Godsend"

Patient

"As a GP trainee new to the locality I was challenged by complex social issues I had not encountered previously. With complex social, financial and psychological issues the CLW is my first port of call for help. I can count on our CLW to deliver prompt advice, help and support across an impressive range of issues. I've had excellent feedback from many patients. They praise our CLW's industrious work ethic, availability and friendliness. I genuinely believe patients have benefitted greatly"

Trainee GP

Demonstrating impact using harder outcome measures is notoriously challenging, as it is in most real world work that operates in the social realm whilst also crossing the whole social-physical-mental spectrum of health outcomes. This is recognised by the team who worked on the independent evaluation study of our programme in the paper wherein they coin the term 'middle ground research', a concept aimed at progressing thought in how we may begin to meet this challenge. Whilst tools do exist that could conceivably measure relevant outcomes, not least validated self-report questionnaires on Self-efficacy and Self-determination, the feasibility of adequately applying these to the populations of interest is a massive question that remains.

In exploring whether such measures can be applied through routinely collected data, it would be useful for delivery organisations to develop collaborations with academic

colleagues and others. Judicious implementation of the most feasible and useful outcomes measures could prove crucial in supporting the long-term sustainability of the CLW workforce. In this a balance must be struck and care must always be taken not to overburden frontline staff with recording duties. It is important to guard against use of what could be perceived as somewhat tokenistic measures – Is there really value in having patients complete a simple likert scale on patient satisfaction before handing this to a CLW, to whom this rating of satisfaction pertains?

As CLW rollout in most areas is being achieved through procurement models, the urgency to rate 'quality' is an aspect we must continually be wary of. GPs at the Deep End are right to warn against the danger of market-based models being the predominant mode used to develop healthcare initiatives, particularly those aimed at reducing inequality, as discussed in depth at the recent Deep End conference: 50 years of the inverse care law (See https://youtu.be/0ToeoBZF8N4). Are such models themselves subject to evaluation, if not, should they be?

In evolution of the CLW model to date, some success has been attained in fostering the understanding that general practice-based links work serving socioeconomically deprived communities goes far beyond simply social prescribing and signposting, as outlined in our Links Worker Roles paper.

As the CLW workforce grows and develops and increasing professional networks and stakeholder agencies seek to help shape this development, we must continue to demonstrate this, along with the importance of delivery models remaining universally accessible and highly flexible, if we are to retain the capacity to provide the often multifaceted support demanded by those who are intended to benefit. In demonstrating impact and seeking to ensure the long-term sustainability of CLW roles and programmes, resource must be devoted to ensuring that those at the frontline, both patients and frontline staff, are able to bring their experience to influence and help shape this growth in order to guard against over professionalisation and help maintain the crucial trust in CLWs that has to date been built among practice populations. It is no small challenge.

Chris Gourley
Links Worker Learning and Evaluation Officer
The Health and Social Care Alliance Scotland

NOTES ON GP RECRUITMENT AND RETENTION

In this section we focus on Deep End experience of attracting and retaining young GPs for careers serving very deprived communities, starting with anecdotes from Dublin and Glasgow before a fuller description of the Trailblazer Scheme in England.

The North Dublin City GP Training Scheme

In The *Exceptional Potential of General Practice,* published in 2019, Austin O'Carroll described the North Dublin City GP Training Scheme. In a follow-up study of 37 doctors who had experienced the scheme, 35 were working full-time or part-time in practices serving deprived populations or marginalised groups.

The Scottish Deep End GP Pioneer Scheme

In 2021 David Blane followed-up 12 doctors who had been GP Fellows as part of the Deep End Pioneer Scheme in Glasgow.

- 1 GP partner in Deep End practice
- 6 salaried in Deep End practices
- 2 locuming in Deep End practices
- 1 doing Higher research degree
- 1 on maternity leave
- 1 doing occupational health

The Govan Ship Project

One of the key features of the Govan Ship Project in Glasgow was the employment of 2 newly qualified full-time locum GPs to release time of the existing GP Principals so that they could have one session of protected time per week to focus on the most complex, multi-morbid patients. Each locum GP worked across 2 of the 4 participating practices which all had similar numbers of patients and GP Principals, making allocation a relatively straightforward process. In addition to providing the necessary backfill for the experienced GP Principals, the GP locums were also integrated into the SHIP project and, for example, became active contributors to the monthly structured multi-disciplinary team meetings.

The locum GPs were employed on a one year contract on a salaried basis. There were some 20 existing GP Principals in total, participating in the project over the 4 practices in Govan Health Centre and, over the lifetime of the project, 5 newly qualified GP locums were employed. Although retention was not one of the anticipated outcomes of the Govan SHIP Project, the project did have a subsequent very positive effect on GP recruitment and retention.

During the lifetime of the project, several GP Principals retired, all in their 60's and all having deferred their initial retirement date due to the increased job satisfaction they were enjoying as a result of the new way of working. When they did retire they were all replaced by the 5 newly qualified locum GPs who transitioned seamlessly into partnership, filling these vacancies without the need for formal advertising. As a result, Govan Health Centre, with its four typical Deep End practices, has no current GP vacancies, contrary to national experience.

In terms of transitioning into partnership, the locums commented that working across 2 neighbouring Deep End Practices helped them to develop a broader understanding of what it was like to work as a GP in a Deep End Practice, noting that it was beyond the protected environment of training but still with a layer of support from senior colleagues. They commented that it helped to ensure that they were retained in a Deep End environment whereas, if they had elected to locum or take up a salaried post in a less challenging environment, it may have reduced their appetite to take a partnership in a Deep End practice. They commented positively on the enhanced working relationships with other members of the MDT, which were maintained into partnership.

Finally, they commented positively on the ability to have continuity of care for patients with whom they had formed relationships during the one year post, which were then maintained and developed as to they moved seamlessly into partnership. As a result of their experience, they have become firm advocates of the traditional form of GP partnership and found this transitional year, at the end of training, a whole heartedly positive experience, which they strongly recommend, for formal incorporation as a post qualification feature.

The participating practices have also become strong advocates of this approach, given the ease with which experienced GP Principals were retained and the ease with which recruitment was achieved, which again, to reiterate, is very much against the national trend.

John Montgomery

THE TRAILBLAZER SCHEME

The Trailblazer scheme is a Health Educational England funded post-CCT fellowship programme. The scheme started in Yorkshire in 2018 and supports newly-qualified GPs to work in areas of socioeconomic deprivation. The scheme is modelled on the Deep End Pioneer Scheme that started in Glasgow in 2016. The aim is to help early career GPs build confidence, experience and skills working in these challenging and rewarding areas. The Trailblazer fellows have one day per week of paid release time for education,

action learning sets, coaching, and personal and professional development alongside their clinical work as a GP. The scheme is offered to practices in areas of deprivation with the aim that those GPs on the scheme would be helped to be recruited and retained working at the Deep End.

Bevan Health Care Visit

Since the scheme starting in 2018, 25 GPs have taken up roles as GP fellows in Yorkshire and Humber. Feedback at the end of the 2019/2020 scheme showed that 100% of GPs were certain they wanted to stay working in an area of deprivation compared to just 66% at the start of the scheme. 77% of GPs wanted to stay in their current practice compared to 22% at the start of the year. All GPs felt that the scheme supported them in their clinical work as a GP and all would recommend the scheme to a colleague.

'It was refreshing to have the room and space to breathe, to think and to think well... I really valued meeting with my peers, learning and growing together and from each other '

Trailblazer GP 2019/20

A survey on the impact of being involved in the scheme found that 89% of practices felt that participation in the scheme boosted both recruitment and retention and 63% felt that the practice population benefitted from it's participation through quality improvement projects led by their fellow. The same survey assessed the ongoing impact on former

fellows and found that 92% of respondents were still working in the same practices they were employed at whilst on the scheme. Up to some 16 months post being on the scheme, fellows were reporting: more confidence assuming leadership positions (25%); more confidence generally (21%); feeling encouraged and equipped to lead on practice population initiatives (21%); invigorated learning in health inequalities (17%); and increased clinical acumen (17%)

Project 6 Visit, September 2019

There were a few new developments in the scheme in 2020. First, due to success of the scheme locally in Yorkshire and Humber over 2018-2020 the scheme was launched in other areas of England in the Autumn of 2020. Excitingly, there are now Trailblazer GP schemes in Yorkshire and Humber, East and West Midlands, Devon and East of England with 51 GP fellows being supported in areas of deprivation. A further 8 fellows from Plymouth are expected to be on board in the near future.

Second, much of the learning was moved online due to the current pandemic. Despite being unable to meet in person, the educational programme and support has successfully continued virtually. Running the educational programme virtually has allowed us to create a national learning space for GPs to meet once per month to learn, network and support each other across England. These online sessions and resources allow GPs to share learning outside of their local pockets of experience and practice. The online resource sits alongside small groups of local GPs who have more regular education and professional development sessions together online and hopefully in person in the near future. Already GPs have been creating common-interest groups to try and solve particular issues and common frustrations with working in areas of

deprivation e.g. improving access to care. The group's energy and enthusiasm for working in deprived areas is truly inspiring.

British Red Cross Visit 2020

Moving forward, we are looking forward to hosting the first post-CCT Trailblazer conference later in the year. We are delighted that further funding has been approved to fund the 2021/22 scheme which will be the fourth cohort in Yorkshire and Humber to experience and benefit from the rich and lasting rewards of the scheme. Furthermore, we will be in a position to continue with our support to other areas of the UK to run the Trailblazer scheme and to continue to run the national element of the educational programme.

Dr Rachel Steen,

Dr J Duodu

Professor Dominic Patterson

DEEP END ZOOM MEETING NO 2

27 colleagues from Scotland (4), Ireland (3), England (14), Belgium (1), Australia (2), Canada (1) and the United States (1) took part in a 90 minute zoom discussion on 28th January 2021.

There was a special welcome for Gary Bloch in Toronto, Jan De Maeseneer in Ghent, John Frey in New Mexico and Peter Tait and Liz Sturgiss in Canberra (for whom the session started at 6.30 am).

A brief summary of the discussion is shown below.

News

Stewart Mercer, John Patterson, John Robson, Susan Smith, Liz Walton and Graham Watt have written a Comment article, entitled "The Inverse Care Law and the Potential of Primary Care in Deprived Areas" which will appear in The Lancet in late February on the 50th anniversary of the original publication of the Inverse Care Law (See pp 6-7)

The 29-minute BBC film The Good Doctor, based on the career of Julian Tudor Hart, is available as a digital copy for use in teaching and education. For details contact graham.watt@glasgow.ac.uk.

Covid-19

There was a general discussion about colleagues' experiences of the Covid-19 pandemic and in particular their involvement in vaccination programmes. In Australia where the pandemic has been contained more successfully than in the UK, as a result of

earlier and stricter lockdown combined with severe travel restrictions, GPs have no involvement in vaccination, the work being coordinated and carried out by colleagues in public health.

Priority for those aged 80 and above discriminates against people with shortened life expectancy (a person aged 70 in a deprived area may have less life left than an 80 year-old in an affluent area). Several colleagues in the UK had made progress in getting vaccines for homeless patients on the basis of their shortened life expectancy, sometimes by taking a local initiative rather than waiting for policy approval.

In general, the pandemic and the challenges of leaving it behind provide an opportunity for general practice and primary care to demonstrate their strengths, based on knowledge of patients and community-based relationships.

Advocacy

Irish colleagues were congratulated on recent success in getting additional funding for general practices in deprived areas, the first time that this has been achieved. Although starting from a low base and with strings attached (the need to show what has been done with the funding) this has been an important advance.

Reflecting on the advocacy required to achieve this result, it had involved persistent and consistent effort, drawing not only on information and research evidence but also the testimony of practising GPs. It had been helpful to work independently, outside established institutions, including professional organisations, with their tendency to the status quo.

Scottish experience was similar, although leading mostly to specific activities (e.g. link workers, financial advisors, integrated care, GP fellowships, alcohol nurses) rather than general funding. Most of these initiatives could be tracked over many years of persistent activity, via many small steps, all in a general direction but often progressing via “knight’s moves” and serendipitous connections and opportunities. A key factor was readiness, in terms of ideas, proposals and potential participants.

Research

Research evidence provides an important underpinning for Deep End advocacy. Colleagues in Sheffield were congratulated on obtaining funding for a dedicated research network based on general practices in deprived areas – the only Deep End Project to have achieved this.

In Scotland, research in Deep End practices has been based on trusted relationships with an informal network of practices. Similarly, the impressive results of the Clinical Effectiveness Group (CEG) at QMUL in East London (topping national QOF league

tables for many indicators despite high levels of socioeconomic deprivation) have been based on long term relationships with local practices.

Community engagement

Dan Hopewell described the pioneering work at Bromley-by-Bow (BBB) involving community engagement, partnership and leadership, in many ways the inspiration of the new National Academy of Social Prescribing. BBB is way ahead of most general practices and has had a huge number of visitors, including Government Ministers (although BBB colleagues have always emphasised that their work has depended on local initiative rather than Government support).

Not everyone was happy with "social prescribing" as a term, given its similarity to "medical prescribing". In Scotland (See page 16), the community link worker function includes an element of social prescribing but also adds to the generalist function, via on-to-one engagement with patients, helping to sort out their problems, especially their engagement with a multiplicity of daunting, fragmented services and agencies.

Next generation

Many Deep End Projects are engaging with the next generation of leaders in general practice and primary care, with activities involving medical students, GP trainees and young GPs (See pages 19-23).

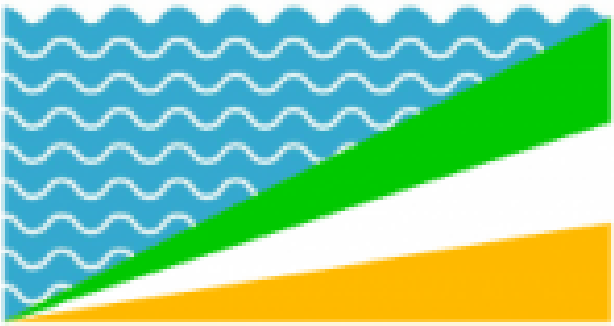
London

Lili Risi and Chad Hockey described their complementary activities in NE and NW London, with the intention of linking up to provide pan-London coordination of Deep End activity.

Looking ahead

Many topics were raised briefly which merited further discussion, either as zoom meetings or as part of a face to face Deep End conference when lockdown comes to an end.

REPORT FROM THE IRISH DEEP END PROJECT



GPs in Deep End Ireland as elsewhere have come through one of the most challenging years due to the Covid-19 pandemic. Recent months have been particularly difficult as we try and ensure equitable COVID-19 vaccination for our patients. The mass vaccination centres in Ireland are delivering vaccines to age cohorts but those in more medically vulnerable groups are being vaccinated by their GPs, if they have the capacity to do so. This has led to considerable extra workload, particularly as we are using mRNA vaccines for this group as these require particular handling, storage and delivery in batches in vaccine clinics meaning less time for the essential routine GP work we all do. We are now emerging from one of the longest and toughest lockdowns in Europe and all our COVID-19 indicators are really improving. Unsurprisingly, we are all beginning to see the impacts of the pandemic on mental health and on delayed presentations and diagnoses.

The pandemic has had a profound impact on an already stretched system for assessing vulnerable children with developmental delay and mental health problems. We have formed a working group and are linking in with the national Disability and CAMHS Clinical Leads to try and ensure resources are directed to where they are most needed, so that we can ‘re-build better’.

On a positive note, we were successful in securing HSE funding for a GP Fellow for 12 months, who will be based half-time in three Deep End practices in rotation and half-time in the Department of General Practice in RCSI in Dublin. This presents a fantastic opportunity for us to reflect on our work and consider the impact of the GP Urban Deprived Grant that was introduced last year. The initial reports suggest Deep End practices are using the grant to employ practice based link workers, CBT therapists and provide more GP time to deal with vulnerable patients. We are also looking forward to the final results from our link worker trial, which managed to recruit just over 200 patients despite the pandemic. The process evaluation will provide rich data on the experience of practice based link workers supporting patients with multimorbidity in Deep End practices.

Finally, we are collating a resource on our website on Health Inequalities and COVID-19 and please send on any papers or studies you have completed or are aware of. Resource document available here: http://deepend.ie/covid-19-evidence-update/

Susan Smith

REPORT FROM THE SCOTTISH DEEP END PROJECT

GPs at the Deep End

It is an exciting but daunting time to be taking on the role of Chair of the Scottish Deep End Project. Dr Anne Mullin handed me the reins in January 2021, as the country was in the middle of the Covid19 pandemic's second wave, which shone a spotlight on the stark realities of life for so many of our patients affected by health inequalities. Amongst the loss and sadness of the pandemic, it has felt like there has been a 'compassion window' of professional, political and societal insight into the lives of our most marginalized citizens… and a desire to do better by them. I want to make the most of that opportunity.

I had just completed my three-year tenure as Chair of the RCGP in Scotland, during which time I had prioritised raising awareness of health inequalities, and the potential role that general practice can play in mitigating this. My approach had been to focus on

building inter-professional relationships and forging alliances where possible, recognising that success is more likely when collaboration occurs, and I had found that it is easier to be a critical friend when needed, if you are not already considered a foe.

What do I see as the challenges ahead in this role and for the Deep End project?

Despite having worked as a GP in areas of deprivation for many years, I have only recently had the capacity and opportunity to become more involved in the work of the Deep End project, and so I am on a steep learning curve, but fortunate to be surrounded and supported by experienced, passionate and inspiring clinicians. During the first few busy months, we have hosted a round table discussion on Covid vaccination deployment to marginalised groups (report and recommendations here), and an online conference marking fifty years of the Inverse Care Law (See https://youtu.be/0ToeoBZF8N4).

One of the many achievements of the Deep End project has been the forging of a professional identity, a community of practice and a support network for colleagues. I have always been proud to call myself a 'Deep End' GP, but general practice can sometimes be a divided profession, fuelled by competing interests vying for ever smaller slices of the NHS pie. Urban can be pitted against rural and deprived pitted against ageing affluent.

Although we cannot escape the fact that there are specific and significant challenges for general practice teams working in areas of blanket deprivation, I believe that we need to find ways to unite the profession in a collective desire to ensure that the NHS is at its best where it is needed the most. For the profession to support this 'proportionate universalism', with resource targeted according to need, we need higher funding for general practice overall. It is unrealistic and divisive to argue for more equitable slices of a pie that is already too small to feed everyone.

I have welcomed the shift in emphasis within the Scottish Deep End project, from a focus on 'Deep End practices" to a focus on "Deep End patients." This recognises that, to a greater or lesser extent, there are patients with poor health outcomes driven by socio-economic circumstances in every practice across our country. This should enable a more collective 'buy-in' from the wider profession, and a shift away from the perception of Inclusion Health as a special interest topic to one that is a core part of every NHS GP's work.

The Deep End project was created in 2009 by the coming-together of GPs working in areas of deprivation, but the landscape of general practice has changed a lot since then. With far more of an emphasis on care being delivered by multidisciplinary teams, it is

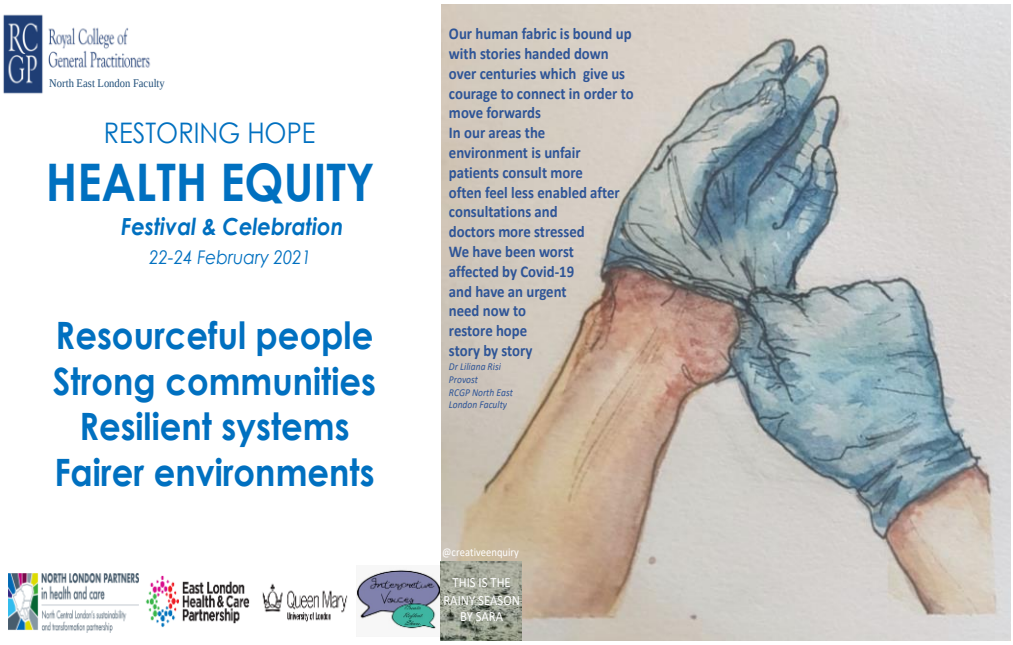
important that we build our alliances with colleagues in nursing, pharmacy and the allied health professions. There has been particular interest from practice nurse leaders who wish to become more involved in the work of the Deep End and this is to be welcomed. As always, the challenge will be in balancing the needs of a group that has flourished with its own professional identity and 'safe space' to discuss the everyday challenges of working as a GP, with a group that wishes to widen membership to better embrace these new models of care. These new models, when they work well, offer different perspectives, resilience, and better patient care. Interprofessional training, teaching and learning is the way of the future and I am excited about the proposals for a new Fairhealth Fellowship that supports this in Scotland.

One of the most significant challenges will be continuing to make the case for more sustainable funding mechanisms for general practice in areas of deprivation. This is essential if we wish to address the persisting Inverse Care Law. Simply put, in current times, this translates into, "not enough time to deal with the complex issues presented", despite the exceptional potential of general practice to address these needs. The projects of the Scottish Deep End have been successful and inspiring, but their wider roll out has often been slow and piecemeal. It is recognised that pilots with short-term funding are not a sustainable model. Despite early hopes, many feel that the GMS contract in Scotland is not a viable mechanism to address health inequalities. There is growing interest in a proposed National Enhanced Service for Inclusion Health, building on the existing evidence base of 'what works' in frontline settings, with appropriate and proportionate reporting mechanisms and financial governance. This feels like a promising way forward.

There is much work to do. All this work is set in the context of an exhausted general practice workforce, experiencing an exponential rise in workload and demand. The role of the Deep End project to advocate, for both our patients and our profession, has never been more important.

Carey Lunan
Chair, Scottish Deep End Project Steering Group

RESTORING HOPE, CONNECTIVITY, AND COURAGE FOR HEALTH EQUITY



Since its inception in September 2020 our Health Equity/Deep End leadership platform spanning the 13 Boroughs in our RCGP North East London Faculty, has grown by word of mouth to >65 people and now includes leaders from social prescribing, nursing, secondary care and commissioning, with a shared vision for fairer care. The communication remains on a phone WhatsApp platform as this still best serves the needs of the group in sharing information. The link with the North West London Deep End sessions, facilitated by GP Dr Chad Hockey, allows Deep End Learning themes to be disseminated widely through our platform and in a Faculty facilitated open access Reflective Forum titled 'Survive and Thrive in the Deep End' which follows on the evening after each of the sessions and signposts attendees to modules on the Fairhealth website.

There has been a similar parallel Faculty initiated and facilitated platform, called Greener Practice London, through scholarships in leadership for climate health equity, with a membership of >80 GPs spanning the whole of London. There is some overlap in membership between these two groups. The aim is to bring these grassroots leadership group together in the autumn.

In Feb 2021, we felt the burden of the pandemic taking its toll in our area worst affected by COVID-19 where race(ism) and place determine our health outcomes. Daily we are faced with an unfair environment, our patients consult more, often feel less enabled after consultations, and we as doctors are left more stressed. In collaboration with our local NHS Partners we felt an urgent need to restore hope story by story. Our human fabric is

bound up with stories handed down over centuries giving us courage to connect to move forwards.

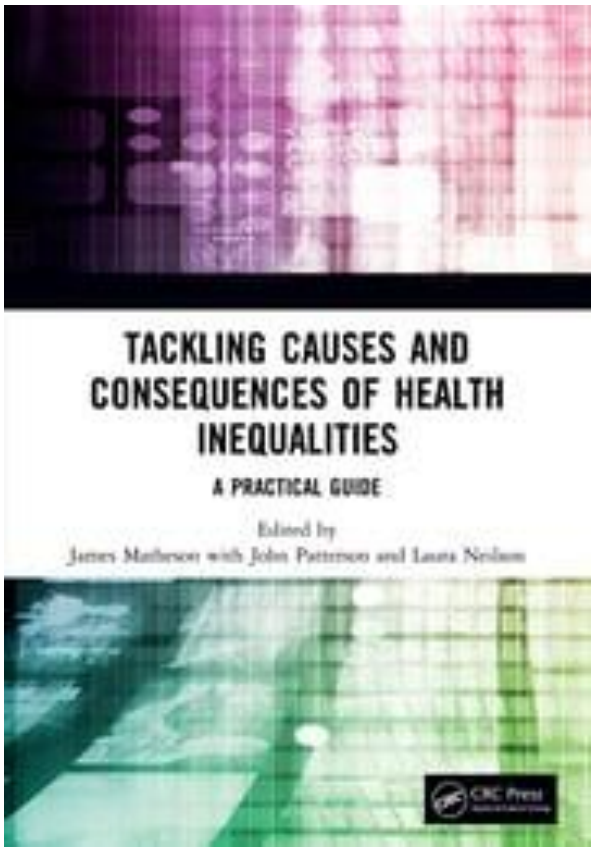
There was an overwhelming response, despite minimal lead in time for our virtual recorded Health Equity Restoring Hope Festival & Celebration in Feb 2021. The event spanned three evenings of reflection on Health Equity through stories featuring GPs, primary care teams, patients, medical students, social prescribing link workers, and community organisations which were filled with poetry and music. We are channelling the momentum from this event into a second Festival in September 2021 on 'Connectivity and courage for a fairer workforce in Marmot informed PCNs'.

Our main leadership task now is in facilitating conversations around integrating narratives for health equity. So, learning about trauma informed care is intrinsically linked to learning about chronic pain, opioid de-prescribing and the community as medicine. Social prescribing is about the wider determinants of health and reducing the carbon footprint of pharmaceuticals which is the main contributor of carbon in primary care and about choosing wisely which is fundamentally about consent and core to safeguarding which is about fairer environments, resourceful people, strong communities and resilient systems.

Integrating these narratives starts to address our Deep End reality and to inform commissioners and lead upwards so that we build Marmot Informed PCNs with a sustainable, healthy, creative workforce for the next decade and beyond.

Dr Liliana Risi
Provost RCGP NEL Faculty. Contact: LRISI@nhs.net

TACKLING CAUSES AND CONSEQUENCES OF HEALTH INEQUALITIES: A PRACTICAL GUIDE



Like many GPs starting practice in an area of socioeconomic disadvantage I found that, despite many (many) years of quality education and training, I still had a huge amount to learn if I was going to go any way to meeting the needs of my patients. From a clinical perspective, there was a huge amount of pathology but the social determinants of what made people unhealthy were staggeringly evident and frequently fell outside the remit of what traditional medical education would consider our sphere of influence as doctors. Looking around the United Kingdom, the realities of working in socioeconomically disadvantaged areas appeared to be poor outcomes for patients and high rates of burnout for GPs. There was also, however, a huge amount of hope that things could get better and a huge amount of passion from people working in our communities who seemed to be making that happen.

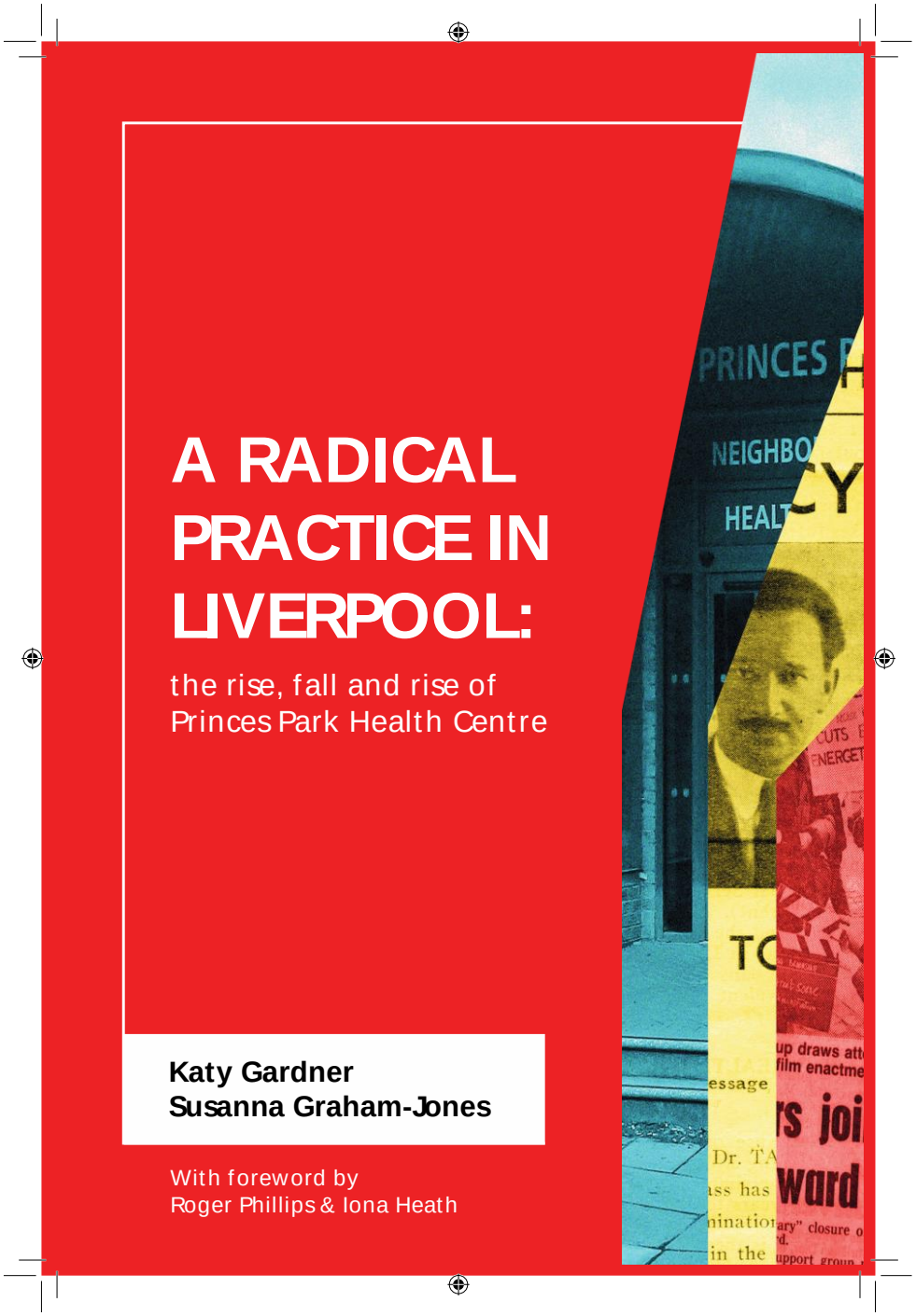
As many others before me did, I learned from my (generally) tolerant and supportive patients - about life and the problems in it, about health, illness and what mattered most to them – and from some amazingly dedicated and wise colleagues – about how to

support patients in changing the trajectories of their lives. But that was a steep learning curve and fraught with plenty of self-doubt and "opportunities for improvement" along the way. The knowledge we gain at the start and throughout our medical careers is hard-won and sometimes at the expense of patient, practitioner or both so it felt important to find a way to short-cut this process and pass on the knowledge and skills of those established in work in Deep End practices and with people experiencing marginalisation and exclusion. In this way we hoped to benefit both our patients and the people looking after them.

Although there was a growing literature on health inequalities and how to influence them at the national and policy level and through "public health" interventions, there didn't seem to be a book available that covered what we, in primary care, needed to know and do to address inequities through our practice. (Little did we know that, at the very same time, a little further North, The Exceptional Potential of General Practice was taking shape – it is an exceptional read and if you're working in a Deep End practice and haven't read it, by the way, you really should). A team formed from the Shared Health Foundation and Hope Citadel Healthcare community interest companies to draw together the expertise of our contacts, mentors and inspirations and to edit the results into a manageable form. The book is long, with a lot of chapters. You can see what's in it here: https://www.routledge.com/Tackling-Causes-and-Consequences-of-Health-Inequalities-A-Practical-Guide/Matheson-Patterson-Neilson/p/book/9781138499867# It should be longer and include more chapters. Every time we thought we had a fairly comprehensive contents list we thought of something else that should be in there (I still do). It won't (as I just noticed is promised on the publisher's website) "demonstrate approaches that can be applied in every situation of inequality" but it will give readers, newly-qualified and longer in the tooth, a load of useful information and perspectives on providing compassionate, holistic and effective care for and alongside people who have the odds of life stacked against them and to enjoy happy, healthy and lengthy careers doing so. The money from it goes towards providing more copies of the book so I can say, relatively guilt-free, that it's worth a read.

James Matheson
GP and one of the editorial team

‘A RADICAL PRACTICE IN LIVERPOOL…’
A LIVERPOOL DEEP END-TYPE PRACTICE, 20 YEARS EARLIER ? -



Princes Park Health Centre (PPHC) opened in Toxteth, Liverpool in 1977, the brainchild of Dr Cyril Taylor, friend and comrade of Dr Julian Tudor Hart. Susanna Graham-Jones and I worked there. Our book tells the story of this pioneering and radical practice over 40 years (1977-2017). It draws on memories from patients, staff and local residents, and reflects the vicissitudes of the NHS and its so-called ‘reforms’.

Cyril Taylor started out as a single-handed GP in 1950. He campaigned to establish a health centre in Toxteth which would provide health and social care under one roof, collaborating with local people and organisations. Julian Tudor Hart coined the term 'the Inverse Care Law' exactly 50 years ago. As GPs at the Deep End know, disadvantaged inner cities, as well as poverty-stricken rural areas, still struggle to attract medical staff and funding for health care. Cyril and his successors set out to challenge the Inverse Care Law, not simply by providing excellent medical care but by embracing social justice and an anti-racist agenda. In Cyril's words, 'To be a community-orientated doctor means involvement in all aspects of the community's health care needs, including health education, screening and prevention. It also means forming an alliance with the community to resist forces - political, social, environmental - which make for ill health.'

Susanna and I attended the GPs at the Deep End conference in Glasgow in 2019 and were inspired. To quote from our book: *'The centrality of the doctor-patient relationship as a key contributor to tackling health inequalities remains at the forefront of the Deep End agenda (Watt, 2019). For some rather envious former PPHC GPs, the success of the Deep End project is further proof that primary care teams working in deprived areas, with their backs to the wall, must be properly funded and supported to enable reflective practice and to allow them to enjoy their working lives. The principles embodied in this project provide hope and inspiration for GPs working in practices like PPHC.'*

Toxteth, Liverpool 8, was a vibrant but tough place to live and work in, even before the 1981 Toxteth riots, provoked by poverty, racist policing and discrimination. After surviving the riots, the practice team fought Thatcherism tooth and nail, campaigning alongside, and in partnership with, community organisations, women's health services, mental health projects and neighbourhood health workers. The health centre hosted open days, community arts festivals and exercise-for-health projects. The team took a proactive approach, identifying issues affecting patients and addressing them in partnership with local academic departments and organisations. The Family Health Project, for example, trialled and successfully evaluated a health advocacy outreach service for homeless patients.

PPHC was a hive of activity for over 3 decades, a magnet for young idealistic doctors in training, and a centre for community-based research. The population of Liverpool 8 greatly diversified over these decades, setting new challenges for social and health care. One initiative at Princes Park was the implementation of self-report ethnicity monitoring in 1988, when computerisation of medical records began. Later the practice identified and investigated Vitamin D deficiency in the local Somali community.

In the late 1980s PPHC was part of the Association of General Practice in Urban Deprived Areas (AGUDA). This informal networking organisation energised like-minded GPs across the country, but, with no funding or succession planning, it ran out of steam within a few years. In Liverpool, despite our efforts, research funding was time limited, GPs were time-

poor, and only a few of our projects became widely implemented and 'mainstreamed'. In contrast with the Deep End project's consistent support from the University of Glasgow, our links with the University of Liverpool's Medical School and Department of Public Health, and with the Liverpool School of Tropical Medicine, were related to particular projects rather than constituting sustainable support systems.

The 'fall': despite being a beacon of inner-city good practice, PPHC struggled to recruit new GPs in the 1990s, as GP partners' income had always been lower than average. As a result, the partners opted to change to a new model. In 1998 they became salaried doctors, working for a community health trust. This seemed to work well at first, but there were unforeseen consequences. The practice lost autonomy as the NHS landscape changed, coming under management by one new trust after another. As one GP commented, 'I don't think [the managers] ever really understood primary health care'.

In 2012 the practice was put out to tender and was taken over by a GP business which did not appear to share the PPHC values. A succession of locum GPs meant there was little continuity of care. This resulted in several years of misery before the Care Quality Commission, alerted by whistle-blowing patients, put the practice into 'special measures'. Fortunately, a local multi-practice organisation, which recognised PPHC's mission in Toxteth, agreed to take the practice into its portfolio in 2017.

And now? Optimistic former Princes Park GP Dr Michael Ejuoneatse commented, 'I think the NHS is increasingly revisiting the values that were once prioritised at Princes Park Health Centre.' Here's hoping.

Watt, G (ed.). 2019. The Exceptional Potential of General Practice: Making a Difference in Primary Care (Boca Raton: CRC Press)

Katy Gardner and Susanna Graham-Jones

A RADICAL PRACTICE IN LIVERPOOL– THE RISE, FALL AND RISE OF PRINCES PARK HEALTH CENTRE
By Katy Gardner and Susanna Graham-Jones
ISBN: 978-1-910580-56-1

Published by Writing on the Wall, Liverpool. £9.99 for the paperback; e-book £5.99.
Available from the News from Nowhere bookshop at 96 Bold Street, Liverpool L1 4HY
using the following link: A Radical Practice in Liverpool: The Rise, Fall and Rise of Princes Park Health Centre by Katy Gardner and Susanna Graham-Jones - News From Nowhere Radical & Community Bookshop, Liverpool

THE DEEP END LOGO POSTER

This poster has been produced in a limited edition with copies sent to every Deep End Project. A few unframed copies remain from this first print run. If anyone has a good suggestion for where the poster might be displayed and liable to attract attention, please contact graham.watt@glasgow.ac.uk.