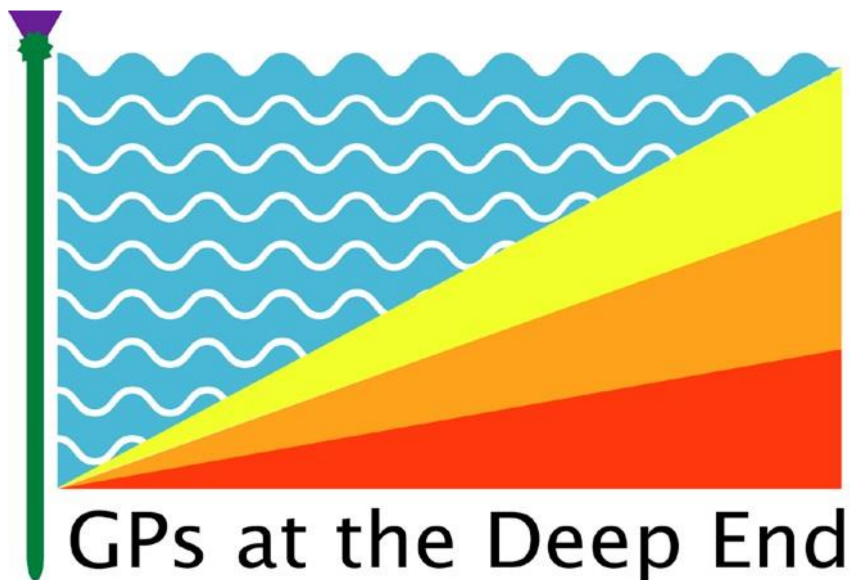


Current Concerns :

A Deep End Conference Report

42 General Practitioners and colleagues involved in Deep End projects met on 28th September 2017 to hear presentations on the Govan SHIP Project, the Link Worker Programme and the GP Pioneer Scheme. Roundtable discussion followed the presentations, addressing three issues in particular: changing skill-mix, GP recruitment and retention, and how to scale up the experience and findings of the Deep End Projects. The contents of the discussions are noted in this report.

October 2017

SUMMARY

42 general practitioners and colleagues met at Govan Health Centre on 28th September 2017 to share learning from three substantial GP-led Deep End projects, and to discuss challenges ahead. Most of the GPs present had been involved in one of the three GP-led projects, or had experience of practice-attached pharmacists.

The Politics of General Practice

- There is uncertainty about the Scottish Government's commitment to addressing the inverse care law, the content, acceptability and prospects of the new Scottish GP contract and the extent to which Integrated Joint Boards will allocate additional primary care funding to general practice i.e. generalist clinical care.
- GPs are poorly represented on Health and Social Care Partnerships (HSCPs) and Integrated Joint Boards (IJBs) The implications of this in terms of influence over policy and resource allocation are poorly understood.
- There is concern that HSCPs may not follow through on Government priorities. They should be held accountable for promises/commitments made.
- GP clusters should encourage sharing of learning and peer support (thereby reducing unwarranted variation and improving quality of care) and engaging practices in more democratic decision-making.
- Transparency in GP remuneration has always been an issue: There is no real penalty for not providing a good service; yet practices are penalised financially for seeking to employ staff, and take time out, in order to drive clinical improvement.
- For any proposed fundamental changes to service planning and implementation there should be a GP Impact Assessment statement to consider the effects of such changes on GP workload, continuity and coordination of care, and population coverage.

The Realities of General Practice

- Protected time for GPs to think, innovate, and work on service developments has been a 'key ingredient' of successful Deep End projects and would make GP work considerably more attractive to future generations.
- The Deep End Project has been successful at providing an inspiring voice, showing that GPs can improve and innovate in services from the ground up. This is particularly important when most other voices are very negative about general practice. This should be built on.
- Autonomy, mastery and purpose are the 'key ingredients' of work satisfaction and professional drive
- The drivers of increasing skill mix relate to increasing demands on general practice and challenges with GP recruitment and retention.

- In whatever form it takes, skill mix does not negate the need for GPs and will likely change GP work rather than reduce it significantly.
- One consequence of a wider skill mix team taking on certain tasks – including simpler or more guideline-driven ones – is that GPs end up doing more and more complex tasks.
- If someone else is doing the “easier” stuff then patients may not come back to GPs to discuss more difficult/complex issues. Relationships – knowing patients within their context – are the silver bullets of general practice. We cannot lose this.
- Managing uncertainty and risk are key concerns related to skill mix. Additional training and support will be required for any new members of staff taking on new decision-making roles.
- Any new scheme/team member needs to be introduced flexibly, responsive to local needs, with a bottom-up approach. GPs should be involved from the outset.
- Colleagues who say “That’s not my job” should be asked “Whose job is it?” so that it is clear who is dealing with the problem.

The Future of General Practice

- Medical schools have a crucial role to play in making GP careers more attractive, by increasing exposure to high quality GP placements and by ending the negativity towards general practice in the ‘hidden curriculum’.
- Increasing GP exposure during Foundation Years would help improve mutual understanding and respect between GPs and hospital colleagues.
- Better support and more flexibility for early career (‘First 5’) as well as late career (‘Last 5’) GPs would help GP recruitment and retention.
- The rise of the portfolio GP reflects the fact that younger GPs are creating their own protected time.
- While acknowledging causes of current negativity about general practice, all of the above should feature positive examples of GP-led service development, as exemplified by Deep End projects and their involvement of young practitioners.
- Generalist clinical care needs to be supported and promoted as the solution to health care fragmentation, pressure on emergency services and static inequalities in health, especially concerning patients with complex multimorbidity.
- SGHD and IJB s must demonstrate that they understand and support the importance and development of generalist clinical care.

Note

Powerpoint presentations and pre-circulated material summarising the past, present and future of the Deep End Project (Deep End Report 32) can be accessed via the Conferences and Events section of the Deep End website (www.gla.ac.uk/deepend).

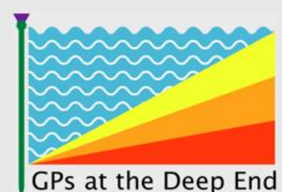
ABBREVIATIONS

AHP	Allied health professional
ANP	Advanced nurse practitioner
BJGP	British Journal of General Practice
CLP	Community Links Practitioner
CMHT	Community Mental Health Team
DN	District Nurse
GP	General Practitioner
HCP	Health Care professional
HSCP	Health and Social Care Partnership
IJB	Integrated Joint Board
MDT	Multi-Disciplinary Team
OOH	Out of Hours
RCGP	Royal College of General Practitioners
SAF	Scottish Allocation Formula
SHIP	Social and Health Integration Project
SG	Scottish Government
SSC	Student Selected Component
UTI	Urinary tract infection

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

Full report available at www.gla.ac.uk/deepend

Contact for further information deependGP@gmail.com



INTRODUCTION

- There are significant challenges across Scotland in recruiting new GPs and in retaining more experienced GPs as a result of pressures on and within practices, the perceived unattractiveness of GP careers, and increasing numbers taking early retirement.
- There are particular challenges due to greater medical and social complexity in areas of socio-economic deprivation
- Patients in deprived areas have poorer health; consultations are shorter than in affluent areas and patient enablement is lower; GPs report higher levels of stress.
- A higher proportion of GPs in deprived areas are approaching retirement age.
- Deep End projects have sought to improve patient care and improve working conditions for Deep End GPs, by providing additional clinical capacity (addressing the inverse care law), providing protected GP time and linking more effectively with other parts of the health and social care service (e.g. Govan SHIP), or with community resources for health and wellbeing (e.g. Links Worker)
- The way forward remains unclear according to the GPs at the roundtable discussions: 'It is difficult to make plans when we don't know what [GP contract] we will have'

UNCERTAINTIES

Uncertainty surrounds several issues.

Inverse Care Law

Nicola Sturgeon, the First Minister has made statements in the Scottish Parliament committing the Scottish Government to addressing the needs of patients and practices in very deprived areas via the new Scottish GP contract

Nicola Sturgeon – First Minister's Questions, 3rd December 2015:

"One of the ways in which the Scottish Government is tackling health inequalities is by reforming the general practitioner contract, to reduce bureaucracy and give GPs more time to devote to the complex problems that patients can face, particularly in areas where patients face the greatest inequalities and health issues. Further changes will be made to the 2017 contract, which will include a review of the Scottish resource allocation formula, to ensure that GP surgeries in the areas of most need receive funding that is proportionate to the needs in their areas".

"I welcome these findings [inverse care law paper in BJGP], which we will take fully into account in delivering a new GP contract for 2017 and the accompanying revised allocation formula. The resource allocation formula has been in place since 2004 and has undergone some revisions and changes since then. The new GP contract, on which we are in the early

stages of negotiation and which will take effect in 2017, gives us a good opportunity to revise the allocation formula to ensure that it reflects the varying needs of GP practices in different local communities.

Shona Robison, Cabinet Secretary for Health and Sport made similar comments in a letter to the First Minister on 6th January 2016:

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

In October 2017 it is not clear whether, how and to what extent these commitments will be honoured.

Additional resources for general practice

Despite the rhetoric of shifting resource from secondary to primary care (e.g. the Scottish Government's 2020 Vision), the 'facts on the ground' tell a different story. Sustainability is no longer an issue confined to Deep End Projects but now concerns general practice as a whole. Additional funding for primary care has been announced, but without clarification of the proportion to be spent on the generalist functions of general practice. By delegating responsibility for spending the additional funds to Integrated Joint Boards, it is possible that funds will be diverted to specialist community health services which unlike general practice have already received substantial new funding in the last decade.

Integration and cluster working

"From 2017 onwards it's expected that GP practices and GP clusters will have oversight and direct involvement in improving the quality of all health & social care services"

GP clusters at present have no commissioning powers. There is no appetite for this currently but this may be revisited if learning from the Deep End projects is scaled up to a national level.

SUMMARIES OF ROUNDTABLE DISCUSSIONS

Bullet points from the five roundtable discussions, each lasting one hour, are collated below, grouped by three main discussion topics:

- Skill mix,
- Challenges to GP recruitment and retention,
- Scaling up and exit plans.

SKILL-MIX

- The drivers of increasing skill mix relate to increasing demands on general practice and challenges with GP recruitment and retention (see section 2).
- In whatever form it takes, skill mix does not negate the need for GPs and will likely change GP work rather than reduce it significantly.
- One consequence of a wider skill mix team taking on certain tasks – including simpler or more guideline-driven ones – is that GPs end up doing more and more complex tasks. Furthermore, GP time is needed to support other team members (much like consultants in secondary care clinical teams). That has a time and 'burnout' cost.
- If someone else is doing the "easier" stuff then patients may not come back to GPs to discuss more difficult/complex issues. Relationships – knowing patients within their context – are the silver bullets of general practice. We cannot lose this.
- There are several practical questions related to skill mix:
  - As additional staff will be HSCP employees, where will they be located and who will fund the space?
  - What does 'top of licence' mean in practice? And what about 'bottom of licence'? There are issues with protocol-driven work – "that's not my job" often means that things come back to GP, creating more work.
  - What supports are available to allied health professionals (AHPs), such as advanced nurse practitioners (ANPs)? These roles can be isolated and lonely.
- There is work to be done to communicate changes to patients, and educate how to navigate the new system (e.g. information in waiting rooms, triage). This may be more difficult in Deep End patient populations.
- Relationships are key but it takes time for new staff to 'bed in'.
- Any new scheme/team member needs to be introduced flexibly, responsive to local needs, with a bottom-up approach i.e. get AHPs on board rather than telling them what to do, recruit people who *want* to work to the top of their licence. In Lothian the HSCPs have allowed practices to tailor their additional primary care resource, by choosing what they need (e.g. pharmacist versus physio).
  - The health board employs them for 6 months and after that, if the practice wishes to keep them, they then contribute 50% of salary costs
  - Paramedics have also been trained to see acutely unwell patients at the practice, but also on home visits (mixed views on the success of this)

- Managing uncertainty and risk are key concerns related to skill mix. Decision makers (other than GPs) are disappearing from the front line – e.g. senior district nurses (DNs) triaging from base rather than seeing patients and more junior staff therefore not being exposed to making decisions. Who will do this when senior DNs leave/retire? Requires training and support
- There is scope for making better use of receptionists and administrators – e.g. for triaging – with appropriate training and remuneration.

Examples of good practice – *what works?*

- **Pharmacists –** bring knowledge and liaison with secondary care pharmacists. Role varies though generally felt to be of value. At one practice an attached pharmacist (for 6 sessions/week) had made a significant difference to GP workload, with benefits including:
    - Freeing GPs up to do other more appropriate tasks.
    - Allowing pharmacists to do medication reconciliation and polypharmacy reviews, which they often do better than GPs.
- **Advanced Nurse Practitioner (ANP) –** role in OOH complements GP working; they work autonomously, manage risk, diagnose, treat and discharge patients. They are a good example of managing undifferentiated care but require a lot of training and supervision.
- **Govan SHIP –** experience of both social care workers and social workers attached to practices was also generally positive. One of the initial barriers to implementing change was that the social workers saw the project as "extra work" but it was explained to be a better, more efficient way of working. Understanding the interpretation of thresholds in working practices has been informative.
- **Links Workers** – embedded (not just co-located) within practices and working very much with a team ethos.
- **Pioneer scheme –** encourages leadership from fellows and experienced GPs. Ideals of a three-year rolling scheme for the pioneer scheme and links workers. Keeping the locus of control in GP practice.
- **Specialist community based services** e.g. for diabetes. In Dundee, consultant geriatricians have moved into the community and follow the patient's journey to secondary care and back.
- **Optimise/enhance existing skills and tools e.g.**
    - Admin staff for simple Docman® tasks (e.g. smear alerts and file cervical screening results) and to free up GP time;
    - Triage directly to physiotherapy /podiatry etc.
    - MJog® text reminders and online access frees up reception
- More strategic and efficient use of IT / social media
- Recruitment of retainers, salaried GPs, ANPs, HCPs from 2y care frontline

What does not work so well? ('casualties')

- **District nurses** – GPs understood the rationale for geographical teams and agile working but issues experienced in practice were common to all GPs. The new 'single point of contact' cannot beat face-to-face communication, and the nuance of discussing patients both groups know in the context of a longstanding relationship is lost. There are many complex issues that cannot be explained over the phone, particularly if using an answering machine. Officially all practices have a named DN aligned to them, but that is very different from being attached to the practice, the difference was felt to be important. It was felt that DN should be given protected time to attend practice meetings.
- **Midwives –** GPs have been taken out of the loop with midwives but still see patients, and often patients are advised to see us. Problems arise when GPs are not in that communication loop anymore, more fragmentation. No feedback process. Simple clinical problems (e.g. anaemia, UTI) should be managed and treated by midwives if diagnosed during an antenatal clinic attendance.
- **School nurses –** Most schools don't have school nurses, which is a problem in terms of liaising with education. Do we need to liaise with guidance staff instead? This is one area where we could work better together. The two universal child care professionals (i.e. health visitors and teachers) who often know complex families well are based in health and education respectively and constitute the majority of the 'Named Person' for child welfare as outlined in the Children and Young People (Scotland) Act 2014.
- **Improving process**
- Poor communication (causing clinician and patient frustration)
- Shroud of anonymity (affecting patient journey and accountability)
- 'Them' and 'Us' mentalities (CMHT and Addictions access discussed). Lack of transparency on responsibility of the lead agency
- Police propping up CMHT

What could be achieved in the short and long term?

- Some cautious optimism that GP clusters will help with sharing learning and peer support (therefore reducing unwarranted variation and improving quality of care) and engaging practices in more democratic decision-making
- There is a need for better training of ANPs, HCAs, admin staff
- Better call handling by all staff
- Protecting time for service development (SHIP, Deep End GP Pioneer Scheme)
- Encourage higher health literacy in all service users and providers
- Better working lives for all clinicians and staff (CLP / leadership)
- Direct community engagement and education on the challenges to the health service

CHALLENGES TO GP RECRUITMENT AND RETENTION

Medical schools

- GPs can be our own worst enemy when discouraging junior doctors and medical students into primary care - “too much moaning and whining and no control over workload.” While this is unhelpful, it is true that GP work has increased in intensity and complexity, and is thus very stressful, if not properly supported.
- Some secondary care colleagues do not really know or understand what we do in the community and these misconceptions can be passed onto medical students on hospital placements.
- There should be more exposure to general practice during medical school, though this is starting to improve (e.g. additional time in Year 3 at University of Glasgow).
- There is a need for medical students to be more exposed to general practice but we need to be wary of the “hidden curriculum” - when medical students attend practices/speak to GPs and are exposed to negative comments.
- There is a growing core of medical students and young GPs who are interested and engaged, and who want to work in deprived areas; we could do more to encourage that.
- Plan for introduction of broad based training – after foundation years, which would include 6 months in general practice.

Younger GPs (Recruitment)

- Poor publicity of GP as a career, not a trendy subject, concerns with financial risk and buying into premises, increasing workload, risk of losing all your efforts in bureaucracy, waiting in vain for paradigm shifts.
- New GPs are expected to do a lot and can be attracted to other countries where there is a better work/life balance (as opposed to more senior GPs who have absorbed and adapted to the changes and increased workload over their careers).
- Importance of mentorship for new (first 5 years) GPs as well as support for those prior to retirement (‘Last 5’).
- Seeing burnt out trainers/experienced GPs. The younger GPs explained that the disdain and negativity they often heard from older GPs was really draining and damaging.
- Gap of GP teaching/experience in foundation training.
- Social media - again portrayal of GPs vs secondary care.
- The Deep End has been successful at providing an inspiring voice, showing that GPs can improve and innovate in services from the ground up. This is particularly important when most other voices are very negative about general practice. This should be built on.

- Younger GPs also felt that more established GPs underestimated just how hard it was consulting lots of patients you don't know, or don't know well. There was a feeling that there should be more support for new GPs, that one year's training is not enough for the complexity GPs face. It was felt that mentoring could be really valuable and welcome.
- Greater flexibility, including the option of working sessions at one's own pace, would help.
- Recruitment/retention challenge in a nutshell: younger GPs know it's busy but don't know it's a good job; older GPs know it's a good job but it's too busy.

Experienced GPs (Retention)

- The intensity of GP workload has increased due to several factors: changing political sphere, workforce and patient population, complexity compounded with diminishing resources, lack of follow up from secondary care, more litigation.
- 9 clinical sessions are too much because sessions are stretched to accommodate increasing workload. GPs need 2y care model of admin time built into contracts. GPs are the only group who don't have specified admin time. Importance of having some "head space" in order to be able to work at one's best.
- Consultants are contracted by hours/wk; GPs by sessions - '6 sessions' may not sound full time but we are doing ourselves a disservice, as '6 sessions' involves considerably more work when adding in admin time, accessing this at home/coming in early/days off.
- The focus on sessions rather than hours worked also impedes wider understanding of GP workloads.
- Increased consultation length felt to be important.
- Supporting women with young families (this is a GP issue not just in deprived areas).
- Many mid-career GPs want to diversify, learn new skills.
- Practices that have benefited from extra time/Deep End projects have found it easier to recruit and retain GPs.
- Remember that "being a GP is a good job underneath all the crap"

General issues

- Older GPs (e.g. in the "Last5" years) could be encouraged to stay on with a more flexible approach, e.g. additional peer support for things like revalidation, or reduced workload (e.g. 9 patients in morning surgery and no HVs or Docman®). This needs to be introduced BEFORE the decision is made to retire (i.e. pro-actively). What is the role of the RCGP in supporting recruitment and retention?
- Concerns were expressed that GPs are poorly represented on HSCPs and IJBs. The implications of this in terms of influence over power and resource are poorly understood but if the IJBs are pre-occupied with other matters and addressing budget constraints

out with general practice issues then general practice will not feature in the IJB agendas.

- Despite this, there is cautious optimism about GP clusters – communication between practices has improved, and there is a clearer line of democratic engagement. The extent to which cluster leads are engaging with GP sub-committee or IJBs is unclear, and requires additional support.
- For all that the pioneer scheme has achieved, it has only had a 10% investment (in additional clinical capacity)
- A GP from the Pioneer Scheme "couldn't have spoken to medical students 2 years ago" – would have been too negative
- Importance of learning from younger doctors - taking it back to practice.

GP funding

- Transparency has always been an issue in terms of GP salaries. If we want to deliver good care does this have to result in sacrificing our salary? Would a baseline salary with a cap be an option? How to make pay fairer, whilst keeping the autonomy we need is difficult.
- GP pay has never been based on what we actually do for patients i.e. how sick our patients are. Funding this way would mean an incentive for GPs to go looking for the unworried unwell, but something would need to give in order to have more time to do this.
- There is no real penalty for not providing a good service; yet practices are penalised financially for seeking to employ staff, and take time out, in order to drive clinical improvement.
- There is little incentive for new GPs to get involved in improving practices other than their own drive to do so. It was also felt that, given the increased demands of multimorbidity and social complexity in Deep End practices, practices that employ extra staff to manage this demand will lose out financially. If the long-term aim is to increase GP numbers in deprived areas this needs to be recognised and workload remunerated appropriately.

SCALING UP AND EXIT PLANS

Accountability

- The SG and HSCP should be accountable to stakeholders, including GPs, other primary care service providers, and patients.
- Concern that HSCPs may not follow through on Government priorities and have to be held accountable for promises/commitments made.
- It is difficult to plan when we don't know what money will be available
- We should focus on lobbying IJBs and using knowledge already learned
- How can you provide equitable funding when practices are so different in their take home money and there is little transparency?
- The softer information, e.g. management of the practice, gets overlooked in funding.
- Government-funded Deep End projects coming to an end. Need for GP input in the next stage of roll out, working with the HSCPs e.g. Links workers. GPs are the signposts for these projects. Sustaining protected time in the pioneer scheme in the short term still needs to be addressed. Ideal - continuation of protected time for leadership/quality improvement.

Sustainability

- In terms of sustainability, despite rhetoric of shifting resource from secondary to primary care (e.g. Scottish Government's 2020 Vision), the 'facts on the ground' tell a different story.
- The different ways practices in which manage demand was discussed with one practice only allowing same day appointments to avoid any "backlog". This has apparently reduced the number of appointments and associated work they need to do.
- Consider local and national infrastructure: Educate all those invested in health or social care in clinical, managerial or political roles, local neighbourhood social care 'clusters'
- Sustainability is key but many projects (e.g. attached alcohol workers) only had short term (e.g. 1 year) funding – there is a danger of 'pilotitis'.
- If the SG took over GP premises this would provide considerable relief to some practices.
- Need to invest in staff and public health:
    - It has already been shown with smoking but needs to be done with obesity.
    - There is a patient dependence/expectation on medication e.g. escalating diabetes medication rather than focusing on weight loss.
    - There is also a GP dependence on prescribing sometimes as easier/faster and also often waiting lists are so long that we feel we have to do something to help our patients e.g. prescribing in mental health problems while awaiting psychotherapy.
    - Increase social prescribing e.g. in access to sport, healthy eating.
- Acknowledging the impact on admin staff, more work.

- Autonomy, mastery and purpose are key ingredients to work satisfaction and professional drive. There was discussion of the sustainability of the GP partnership model. Moving to a salaried service may have some advantages, but would be significantly more expensive and may affect autonomy (e.g. hospital colleagues dictated to by management). The costs of salaried services that health boards have taken over are 2-3 times higher.

Sharing learning

- There was no consensus on how best to share learning, but a core group of committed and enthusiastic GPs are a powerful way to disseminate and share data/best practice.
- Engage and share learning with students early in medical school
- Using Trello website to share resources in clusters.
- Improving interface with secondary care, 3rd sector, support from NHS Scotland.
- Deep End GP website and twitter activity.
- Potential for an App or toolkit for SSC/junior doctors/those new to Deep End
- Need a national conversation about patient (and clinician) expectations and education for both in house and out of hours general practice.
- The key learning for all the projects was the importance of GPs having extra time to think and innovate; it shows what can be achieved when we have time, rather than firefighting most of the time.
- Need to get away from looking at how much these projects cost to how much added value they were giving. Without investing in GP protected time it will cost the NHS more, people will leave.
- The rise of the portfolio GP (and lack of new GPs willing to take on 10 sessions) reflects that younger GPs are creating their own protected time. It is likely that some of these GPs would consider doing more sessions if they were guaranteed protected time within them to plan service development, or do MDTs/longer consults, etc. This would also increase productivity.
- Project managers have played a key role in some of the successful Deep End projects. Strategic thinking and planning may not be GP strengths – there is valuable learning of having a skilled dedicated project worker to look at data and help support interventions and drive further required changes.

PARTICIPANTS

GP	Practice	List size	Deprivation ranking
Farah Ansari	Bridgeton HC	2060	47
Jean Beckley	Craigmillar MC	3257	40
David Blane	Pollokshaws MC	6219	119
John Budd	Homeless Health Service		
Ronnie Burns	Parkhead HC	3206	12
Niall Cameron	Govan HC	4766	28
Peter Cawston	Drumchapel HC	5126	45
Margaret Craig	Springburn HC	4093	11
Lynsay Crawford	Possilpark HC	3514	15
Margaret Ann Dale	Social Work		
Gillian Dames	Parkhead HC	4707	18
Emma Douglas	Crail MP	4260	38
Mal Duffy	Drumchapel HC	4433	8
Maria Duffy	Pollok HC	4866	43
Allison Bell	(Representing Richard Foggo, Scottish Government)		
John Goldie	Easterhouse HC	9534	4
Richard Groden	Clinical Director GG&C HB		
Susan Langridge	Possilpark HC	2165	27
Mairead McCallum	Lightburn MC	3475	25
Clare McCorkindale	Yoker MC	3974	93
Vince McGarry	Manager, Govan SHIP		
Ricky Milburn	Springburn HC	6623	46
Kirsteen Miller	Lightburn MC	3033	29
Brian Milmore	Govan HC	8712	75
Lindsey Morley	Pollok HC	4866	43
Debbie Morrison	Glenmill Medical Practice	6113	30
Catriona Morton	Craigmillar MC	8696	49
Anne Mullin	Govan HC	8712	75
Kerri Neylon	Dr Mair & Partners	5397	50
Deirdre O'Driscoll	Springburn HC	3000	30
Jim O'Neil	Lightburn MC	3117	37
Helen Richardson	NES Health Inequality Fellow		
Petra Sambale	Possilpark HC	3377	1
Andrea Williamson	Homeless Health and Resource Services, Glasgow		
Graham Watt	Glasgow University		
David Walker	Glasgow HSCP		
Kirsty Duncan	Academic Fellow		
Katie Fleming	GP Pioneer Fellow		
Marianne McCallum	GP Health Inequalities Fellow		
Noy Basu	GP Pioneer Fellow		
David McMahon	GP Pioneer Fellow		
Lisa Robins	GP Pioneer Fellow		