THE SCOTTISH DEEP END PROJECT TEN YEARS ON

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Ten years on from the first conference of General Practitioners at the Deep End, it is timely to reflect on what has been achieved and what the future holds.

The first step was to engage with front line general practitioners working in the 100 most deprived communities in Scotland, capturing their experience, views and aspirations at a series of conferences and round table discussions, all of which were summarised and posted on the Deep End website in short and long forms. A synthesis of consistent points resulted in the Deep End manifesto.

A series of mostly Scottish Government-funded projects gave practical expression to the manifesto, learning by trial and error to develop ways of using protected GP time, multidisciplinary team meetings, attached workers (social workers, community link workers, financial advisors, alcohol nurses) and young GP Pioneer Fellows. An educational curriculum was established and followed to address the learning needs of general practitioners working in very deprived areas.

The collective voice of Deep End general practitioners was used for advocacy on public health issues such as austerity, welfare benefit changes, child poverty and alcohol pricing but mainly, although with little success, on the continued operation of the inverse care law. A parallel series of research studies not only described the consequences of the inverse care law within consultations (greater morbidity and complexity, less time, poorer outcomes) but also the cost-effectiveness of providing additional consultation time for selected patients with complex problems (the Care Plus Study).

Papers in the British Journal of General Practice, plus conference presentations and invited talks spread the message and shared the experience, resulting in similar Deep End Projects, so far in Ireland, Yorkshire/Humber, Greater Manchester, Plymouth and Canberra. The initial Scottish project has become a movement based on similar experience and common cause in many locations. A book entitled *The Exceptional Potential of General Practice,* with 55 contributors from 11 countries (including 44 general practitioners) was published and launched at a conference in Glasgow in February 2019, which also celebrated the memory and example of Julian Tudor Hart with practical accounts of his continuing influence.

A consistent underlying theme and affirmation has been the importance of the work of clinical generalists, providing unconditional personalised continuity of care for patients, whatever problem or combination of problems they present. This is true of general practice in all areas but is especially important in very deprived areas, at the bottom of the health and health care slopes, where there is a greater prevalence of premature

physical, psychological and social problems, often in combination. Exclusionary criteria in service provision and lower levels of patient knowledge, confidence and agency challenge practitioners to be “the worried doctor” anticipating and trying to prevent complications.

It is axiomatic that clinical generalists must be competent across a broad range of topics, many of which are not covered in conventional GP training, but competence in consultations, while essential, is only the beginning of four building programmes, all requiring GP initiative, leadership and learning.

The first programme uses serial encounters with patients to transfer knowledge and skills, building patient’s confidence and agency in coping and living well with their conditions, and resulting over time in a practice compendium of patient narratives. Many patients need little help from doctors but the sixth of patients who account for 50% of consultations usually need more.

Consultations provide the main starting and turning points of clinical care. Patients might have a clinical issue managed exclusively by their GP but often solutions need to be linked to other skills and services within the primary health care team, with specialist community-based services, with secondary care and with community resources for health. The skill of an experienced GP is to know when the former is insufficient to provide the best outcome for the patient.

With intrinsic features of contact, coverage, continuity, coordination, long term relationships and trust, general practices are the natural hubs of local health systems and so, the second building programme involves the time and effort required to develop and maintain this wide range of productive partnerships. Link workers are an important addition to the general practice team, not only signposting and helping patients to relevant services but also as complements to the generalist function.

The relative autonomy of individual general practices is a huge potential strength and opportunity for local initiative and leadership, but is also a recipe for variation, inefficiency and inequity. The third building programme develops collegiality and solidarity, based on shared learning between colleagues addressing similar challenges in different places, accountable not only upwards to sources of funding and downwards to patients and local communities but also horizontally to colleagues in other practices.

The fourth building programme is developing the career pathways and opportunities required to attract, support and retain general practitioners who are enthused and energised not only by their clinical work but also the collegiate challenge of realising the exceptional potential of general practice.

The activities of the Deep End Project can be characterised, therefore, as follows:-

ACTIVITIES OF A DEEP END PROJECT

- Connecting with and giving voice to general practitioners serving very deprived communities
- Building a practice compendium of strong patient narratives especially for patients with complex multimorbidity
- Building the capacity of general practice as the hub of local health systems
- Working for greater consistency and commitment between general practices to reduce variation, inefficiency and inequity
- Lobbying locally and nationally for the additional time, staff and connections needed to address the inverse care law, comprising issues of horizontal and vertical inequity within health systems
- Using the collective knowledge and experience of Deep End practitioners to highlight the effects of social factors on the health and lives of patients
- Building collegiality between practitioners serving Deep End communities and patients, sharing experience, evidence, learning, views, activities and plans
- Encouraging and supporting the next generation of Deep End practitioners

Numerous discussions involving Deep End general practitioners has shown that their primary motivation is to improve the care provided for patients, especially when there is a clear gap between what they are able to do and what they could do with more time and resource. By improving care and outcomes for individual patients and delivering such care for all patients in a practice, population health can be improved and uses of emergency care reduced. Addressing health inequalities is a consequence of such care rather than its starting point. The collective experience and voice of practitioners can also highlight the importance of adverse factors on health operating outside health care, especially in early life.

Local ownership, initiative and leadership are essential but if general practice is not supported from the centre, with resources commensurate with need, with information systems to measure omission and monitor progress (e.g. the balance between routine and emergency care) with educational opportunities to share experience and learning, with research to establish what works and with career opportunities that attract, sustain and retain general practitioners, the exceptional potential of general practice will remain an aspiration, exemplified by small numbers of pioneering practitioners rather than the product of a vibrant, ubiquitous system.

As the Deep End project evolved, listening to front line general practitioners, capturing their experience and giving practical expression to their views via a range of projects, the

focus has changed from political lobbying, trying to influence the inverse care law via the Scottish GP contract, to developing the Deep End Project as a resistance movement, developing the collegiality of Deep End practice, encouraging the next generation of Deep End practitioners and harnessing the knowledge and experience of Deep End GPs who know their patients and communities well.

The attempt to have the inverse care law redressed via the GP contract was unsuccessful for several reasons : the lack of data on unmet need which could be incorporated in a resource distribution formula; opposition from other general practitioners who saw themselves as potential losers as a result of resource redistribution; and managerial and civil service scepticism regarding the GP contract as a way of funding service development.

Two other factors have had a bearing on the Scottish Deep End Project. First, the current manpower crisis in general practice did not begin in deprived areas (rural areas and some more affluent health board areas were more affected) but is set to become a problem in the Deep End as a result of the larger numbers of Deep End GPs approaching retirement.

Second, two thirds of Deep End patients (living in the 15% most deprived Scottish data zones) are registered with several hundred general practices serving pockets of deprivation, compared with the one third registered with Deep End practices serving areas of blanket deprivation. It follows that focusing on Deep End practices instead of Deep End patients was unnecessarily exclusive in two ways, missing the majority of Deep End patients and dividing general practice into two camps. This divide is not helpful to general practice at a time when the whole profession needs to develop a shared perspective on the many challenges to health and social care provision.

In view of these considerations two new approaches have been adopted, broadening the focus from Deep End practices to Deep End patients (while retaining a practice focus for Deep End projects) and addressing the inverse care law by being more successful in recruiting and retaining GPs in Deep End practices.

Activities of Deep End General Practitioners

These may be considered at different levels involving activities with patients, within practices, and with other practices locally and further afield.

1. Within consultations

- Acquiring the knowledge, skills and contacts necessary to address prevalent problems in Deep End general practice
- Engaging with patients who are difficult to engage, with empathy as a precondition of enablement and ambition for what might be achieved
- Building strong patient narratives based on continuity and increasing patient knowledge, confidence and agency
- Using cumulative knowledge of patients to target the best use of GP protected time

2. Within practices

- Maintaining the morale, well-being and function of the practice team
- Developing local arrangements for integrated care based on the needs of individual patients
- Developing the use of multidisciplinary team meetings
- Adding to practice capacity with new roles for nurses, pharmacists, administrative and other staff
- Adding to practice capacity via colleagues embedded within the practice (e.g. link workers, social care workers, financial advisors, alcohol nurses, mental health workers)
- Initiating and evaluating service developments within the practice

3. Within the local health system

- Developing productive partnerships with other general practices via geographical and non-geographical local GP clusters
- Developing productive partnerships with other community-based health and social care services, aiming for referral options that are quick, local and familiar to patients
- Developing productive partnerships with community resources for healthy living
- Developing productive partnerships with hospital-based services including A&E.

4. Collegiate learning

- Sharing experience, views, activities and plans with others
- Developing a shared language and knowledge base to describe the work of unconditional, personalised continuity of care for patients with complex multimorbidity, including physical, psychological and social problems

- Developing a shared language and knowledge base to describe the tasks of leadership for primary care development
- Contributing to shared learning via CPD activities
- Contributing to a shared website with reports of service developments and educational activities
- Taking part in research and evaluation studies to establish better ways of working
- Using and developing information systems to assess progress
- Involving younger GPs in practice development

The Govan SHIP incorporates all these activities. It has been evaluated and the findings have been widely disseminated. The key learning is that when experienced GPs are given adequate resource within a robust framework of financial governance they are able to redesign the delivery of health care and adapt local systems within a relatively short time. As a way of reducing GP demand and addressing unmet complex needs within a supported and holistic GP and primary health care system the SHIP provides a template for such an approach that could be adapted throughout Scotland. It also supports many elements of the new Scottish GP contract including enhanced multidisciplinary teams, developing the roles of aligned and embedded practice staff to strengthen the extended primary health and social care team and supporting a GP profession that can adapt and survive the challenges of providing community-oriented health care in the future.

Activities of the Deep End Steering Group

The steering group provides identity, profile, voice, initiative, coordination and continuity for the activities of General Practitioners at the Deep End.

Identity

- The Deep End “brand”
- Logo
- Website

Profile

- Providing a coherent presentation of Deep End experience and views, communicated via Deep End reports and presentations at conferences and meetings
- Contributing to Government consultations on behalf of General Practitioners at the Deep End
- Contributing to national campaigns (e.g. the Child Poverty Action Group) where a Deep End perspective is appropriate and adds to the common cause of different organisations

Voice

- Advocacy at local and national level for measures to address vertical inequity in health care (i.e. unmet need, poorly coordinated care) via measures proven in Deep End projects including longer consultations, GP protected time, embedded workers, multidisciplinary teams etc
- Advocacy to highlight the resource needs of general practices serving areas of concentrated deprivation.
- Using the collective knowledge and experience of general practitioners and practice teams to highlight and comment on social issues affecting the health and lives of patients

Coordination

- Channelling of requests for Deep End input to the most appropriate Deep End general practitioner
- Responding to opportunities for project funding, based on Deep End proposals and the ready availability of practices to participate

Continuity

- The collective memory of the steering group makes it possible to share and build on the work and findings of the Deep End Projects
- Persisting with advocacy for measures to address the inverse care law
- Maintaining contact with Deep End general practices so that new GPs are aware of Deep End activities.

SPECIFIC ROLES

Membership and meetings of the Deep End steering group are open to any interested general practitioner. Within the steering group a range of roles are carried out :-

- Preparing agendas, papers and notes of steering group meetings
- Compiling news of Deep End activities
- Chairing meetings of the steering group
- Acting as a point of contact and fielding enquiries and requests
- Representing General Practitioners at the Deep End
- Coordination of academic activities including educational sessions for Pioneer Fellows, medical students, young doctors, trainees and GPs at several career stages
- Coordination of the Deep End GP Pioneer Scheme
- Liaison with Deep End Projects in Ireland, England, Australia and elsewhere.
- Maintaining the Deep End website at Glasgow University
- Using social media to disseminate information about General Practitioners at the Deep End.

FUTURE ISSUES

- Keeping under review the relationship between the Deep End Project and Deep End general practitioners. Based on voluntary participation, the Deep End steering group is an egalitarian network in which all opinions and experiences matter and are welcome. The Project's authority depends on the extent to which its activities are true to the experience and views of frontline practitioners.
- Identifying current issues where there is a need to renew engagement with front line GPs, capturing their experience and views and following the successful example of this approach in the first years of the Scottish Deep End Project.
- Based on Govan SHIP and the Care Plus Study, campaigning for GP protected time to provide extended consultations for patients with complex multimorbidity
- Campaigning for all Deep End general practices to be included in the national rollout of community link workers (only 41 of 75 Deep End practices in the Glasgow City HSCP have been allocated a link worker)
- Based on the evaluation of the Parkhead and Carntyne projects, campaigning for financial advisors to be embedded in Deep End general practices
- Securing continued funding and expansion of the GP Pioneer Scheme as a model for GP recruitment, GP retention, service development and shared learning
- Preparing for opportunities to develop and evaluate new service developments including attached mental health workers and applications of new knowledge concerning adverse childhood events (ACEs)
- Disseminating findings from the Deep End Projects so that they may be applied to Deep End patients irrespective of the type of general practice in which they are registered.
- Sharing experience and views of different career pathways including salaried and partnership options.
- Considering with academic colleagues what types of research are most needed to support general practice and primary care in the Deep End.
- Considering which strategic partnerships need to be pursued
- Prioritising activities within the Deep End Project, anticipating what might be achieved in the next two years and how progress can be monitored

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