

# GENERAL PRACTITIONERS AT THE DEEP END

## INTERNATIONAL BULLETIN NO 3

*If we don't create the future, the present extends itself*

Toni Morrison, Song of Solomon



A red camelia which finally blossomed, after twenty years without a flower, in Partick, Glasgow

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## INTRODUCTION

Graham Watt

Welcome to the third Deep End International Bulletin. Despite Covid-19, colleagues have contributed a rich collection of experiences and views based on activity before and during the pandemic.

Liz Walton from the Yorkshire/Humber Deep End group has written a fascinating piece based on her sabbatical at the University of Western Sydney with Professor Jenny Reath and colleagues. (Page 4) I first met Prof Reath in 2012 at a conference I had the good fortune to plan and organise as a satellite meeting of the International Society of Hypertension (ISH) in Sydney Australia. (1)

Hosted by Norman Swan, a medical student friend at Aberdeen during the mid-1970s who became Australia's leading medical broadcaster (now with iconic status on the basis of his daily Coronacasts on ABC radio), the meeting took the form of a one day symposium on *Bridging the Gaps in Cardiovascular Care*, but by design and the choice of speakers from Australia, Belgium, India, South Africa, the United States, United Kingdom and Uruguay, the symposium was also about primary care.

It was one of the first opportunities to present the Deep End Project to an international meeting. Of all the presentations on the programme, the most similar to mine was given by Professor Alex Brown, an Aboriginal medical doctor and researcher, who was working at the time in Alice Springs, before moving to lead Aboriginal health research at the South Australia Health and Medical Research Institute (SAHMRI).

There was a striking similarity between marginal groups in different health systems, be they aboriginal communities in Australia or deprived communities in post-industrial Scotland, in terms of premature mortality, reduced healthy life expectancy, under-resourcing of health care relative to need, and difficulties of engagement, not only with patients but also practitioners. (1)

Liz's experience of visiting the Aboriginal health service reminds us of this connection. There are now several other Deep End activities in Australia, including the continuing activity of the Canberra Group, as described by Joo-Inn Chew and Sue Baglow. (Page 14)

Several Deep End groups in the UK and Ireland had been looking forward to the visit of Liz Sturgiss from Monash University in May, as a further opportunity to build Australian links, but for obvious reasons that had to be postponed. The training conference on *Wellness on the Margins*, planned for Dublin in March, was also postponed and has yet to be re-scheduled.

Also attending the 2012 conference in Sydney as a speaker was the ubiquitous and peripatetic Jan De Maeseneer from Ghent in Belgium. He continues to prompt and support the Deep End movement. For example, he suggested the Deep End session at last November's conference of the European Forum for Primary Care (See our [Newsletter No 2](#)). He also suggested the visit of Belgian primary care colleagues to Glasgow in March 2020, reported in this issue by Jessica

Fraeyman and colleagues. (Page 9) It is always interesting “to see ourselves as others see us”. Thankfully, a good time was had by all.



The Belgian primary care delegation with Scottish Deep End colleagues. Profs Graham Watt and Jan De Maeseneer are in the front row, adding 2.4 years to the average age of the party.

Following their initial note in the last newsletter, it is especially pleasing to include the progress of Deep End colleagues in the North East & North Cumbria, adding a seventh Deep End logo to our collection. (Page 12)

There are also reports from Patrick O'Donnell and colleagues in Ireland (Page 16) and Chad Hockey in North West London. (Page 18) Gary Bloch in Toronto and Richard Ayres in Plymouth have both promised Deep End Reports for Newsletter No 4. We hope to hear more soon from Deep End stirrings in Derby and Nottingham.

From the Scottish Deep End Project, there is the executive summary of *Deep End Report 36: General Practice in the Time of Covid-19*, commenting not only on experiences during the pandemic but also the implications for “normality” once it returns. (Page 21)

Finally, there are two contributions from the very impressive Yorkshire and Humber Deep End Group, showing the range, strength and vibrancy of their programme. (Page 23)

Watch out for Deep End International Newsletter No 4 in December 2020.

Graham Watt. Bridging the gaps in cardiovascular care. British Journal of General Practice 2013; 63 (606): 44. DOI: <https://doi.org/10.3399/bjgp13X660904>

## AN AUSTRALIAN DEEP END SABBATICAL:

### DIPPING A TOE IN THE RED DUST...



**Dr Liz Walton**  
**GP at Evelyn Medical Centre**  
**and Chair of Sheffield Deep End Research Cluster (NIHR Funded)**

I looked into the eyes of a beautiful face, alone in the dark on a recent sabbatical to the University of Western Sydney. The face belonged to an Indigenous man whom I had never seen before. It was warm and his eyes drew me in. I wanted to find out why his face was being showcased in the Campbelltown Arts Centre in February 2020. I decided to drop into the gallery on my way home after visiting Dr Tim Senior at the impressive Tharawal Aboriginal Corporation Medical Centre, which is about an hour's train ride inland from the better-known parts of Sydney. You might remember hearing about Tharawal from Professor Marmot when he spoke so highly of their innovative service in his RCGP keynote lecture in 2019. (1)

Tharawal (2) is everything that a Deep End medical service should be. Run as a community corporation with Indigenous Elders at the heart and head of the service, it attracts the best primary and secondary care doctors to work alongside an impressive multidisciplinary team and allies from community services, which include dentists and a local Veggie Box distribution service. The building wraps you up in clinical excellence, empathy and practical help for a community where the statistics of health inequalities are predictably grim yet still incredibly shocking. The latest *Closing the Gap* report (3) was released during my visit and describes the infant mortality rate of Indigenous children as double that of non-Indigenous. There is a 7 to 8 year gap in life expectancy between Indigenous and non-Indigenous communities in Australia.

So, as I walked through the streets of Campbelltown to the Arts Centre, (4) racism and unfairness were on my mind. The eyes, which drew me into the powerful Vernon Ah Kee's exhibition, (5) were those of a man called Lex Wotton. Known as the 'tall man,' Wotton led the people of Palm Island, off the coast of Brisbane, to fight back against a police system that was murdering young black people in custody. Walking around the exhibition on my own was a powerful time for me to reflect on Deep End issues. The privilege of spending time with patients and colleagues from the University of Western Sydney, alongside the shame and guilt of

belonging to a white society which has abused its power. Ah Kee repeatedly summed up why we need the Deep End movement in his powerful exhibition entitled *If I was White*. One simply framed image stated “*If I was white I would be more likely to live longer*”. Tragically this is still blindingly obvious to those of us involved in Deep End work at home in the UK and overseas.



Vernon Ah Kee, Lex Wotton (profile), 2012, and tall man, 2011, installation view, Campbelltown Arts Centre, Australia 2020. Photo: Document Photography.

The words resonated even more for me after visiting Alice Springs and Uluru. We had enjoyed a trip to the red centre and our tour guide had respectfully introduced us to an Indigenous woman. Our guide explained that unlike in western culture where looking someone in the eyes is a sign of respect, here it is a sign of respect to look away. Eyes are important. Our gentle Indigenous host taught us about Aboriginal culture through drawing stories in the sand. Without speaking she slowly passed my ten-year-old son one of the men's hunting tools, similar to a boomerang, which she knew he'd be delighted with. Fresh from busy clinical work in the UK it took me a while to calm down and tune in, but once I did, this is one of the most special memories of our trip.

Later, I was lucky enough to join a lecture delivered by the University of Western Sydney's charismatic Professor of Aboriginal Torres Strait Islander Health, Aunty Kerrie Doyle. 'Aunty' is a term of respect for Elders. From her I learned, alongside a brilliantly diverse group of final year medical students, more of the history of the abuse suffered by Aboriginal people in Australia. Professor Aunty Kerrie described the trauma inflicted by characters such as Auber Octavius Neville, who is well known as 'Neville the Devil'. Despite his title of 'Chief Protector of



Vernon Ah Kee, *If I was white*, 2002, installation view, Campbelltown Arts Centre, Australia 2020. Photo: Document Photography

Aborigines' he led on the policy to take mixed ethnicity children away from their mothers and communities, with the abhorrent aim to 'breed out the colour'. Professor Auntie Kerrie described how this policy has affected every Aboriginal family in the country and has led to widespread intergenerational trauma. Trauma was taught and treated with as much respect at the University of Western Sydney as the more traditional medical school lecture topics of dermatology and emergency care, and I learned about how the creative arts can really help with physical and mental health. (6) Despite the long and relentless history of abuse of Aboriginal communities, the Indigenous people I was honoured to meet throughout the trip showed a humility and generosity which was at times painful to experience as a privileged white visitor from England.

*"If I was White I would be less likely to spend time behind bars"* is another quote from Vernon Ah Kee's exhibition, which I sadly witnessed at first hand when visiting several prisons around Sydney. The idea for my 'Deep End' sabbatical was triggered when listening to Professor Penny Abbott's award-winning work on the medical homelessness of female prisoners, (7) which she presented at the UK Society for Academic Primary Care (SAPC) conference, a world away, at the Barbican in 2018. She kindly introduced me to the Justice System in New South Wales where there are vastly disproportionate numbers of incarcerated Aboriginal people. (8) This is especially evident for children in youth custody where they make up 50% of the prison population, yet make up only 3.9% of the New South Wales general population. I can only assume that the intergenerational trauma inflicted on Aboriginal communities has led to this very sad situation. I learnt that the children resident at the 'Juvie's' had often not committed a crime but were victims of family breakdowns and had nowhere else to go.

However, I witnessed the best again of Deep End practice within the justice system of New South Wales. For example, when I visited a women's prison and sat in with the Indigenous health nurses (a bespoke service to offer Aboriginal women extra help with chronic disease) there was a very tender moment of one of the nurses looking into the eyes of a prisoner who had a squint and offering her help. The unexpected kindness led the woman to weep gently. I was also privileged to watch the first time a plaster cast of a heavily pregnant woman's belly was made within the Justice System. This has become a right of passage for Aboriginal women after a very clever midwife realised it was a way to attract women to their ante-natal appointments. The women receive the hardened cast to decorate at a later date with beautiful Aboriginal designs. We chatted quietly as the cast was taken and I asked how the prisoners were coping with the heat. It was the time of the overwhelming bushfires and we had just experienced temperatures in the high 40's. The quietly spoken pregnant woman told me that other prisoners had donated their fans to her as the temperatures rocketed up to 50 degrees Celsius in their accommodation. I can't imagine how they are coping now during the coronavirus pandemic and lockdown. Many seemed to be incarcerated for insignificant issues and appeared to be much more victims than perpetrators of serious crime.

Alongside sitting in with generous colleagues from Refugee Health and a Women's Health centre I was welcomed to join colleagues at the University of Western Sydney where Professor Jenny Reath leads a team who are passionate about primary care medicine and research. They have created a course and ethos where Indigenous students are welcomed and supported in a curriculum with Deep End issues at its core. The medical students' ethnicity is

representative of the general population, which seems to be sadly unique to this medical school. The contribution that students make to rural Aboriginal communities, where students all undertake a placement, is recognised every year by Professor Aunty Kerrie with a large canvas covered in colourful students' handprints. This is then hung on the walls in recognition of their good work and as a reminder that they will always belong to this special institution. I am so grateful to Jenny and all the team at Western Sydney University for making me so welcome and my short time with them so fruitful.



Final Year Medical Students Hand Prints from Western Sydney University (2019) Reproduced with kind permission from Professor Aunty Kerrie Doyle, Professor Aboriginal Torres Strait Islander Health, School of Medicine, Western Sydney University. Rivers and water are highlighted between the hand-prints.

The threat of Coronavirus was looming during my sabbatical but I never expected my eyes to be the most important part of my consultations over the top of PPE masks. Getting back into the new rhythms of UK General Practice, the warmth and experiences I had in Australia feel a long time ago. However, I have some beautiful tangible gifts from new friends and colleagues which are giving me great comfort at this challenging time. More important, I have the experiences of a sabbatical where I was so lucky to experience a little of the Australian red dust. I have learned so much from the trip and especially from the Indigenous people and

health communities I was fortunate to visit: humility, humour, community, family and story-telling ....all of these lessons have helped me through the challenging past few months.

#### Funding

I was awarded £810 from the BMA Claire Wand Fund and the remainder of the costs of the sabbatical were self funded.

#### References and Links

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## BELGIAN VISIT TO THE DEEP END IN GLASGOW

Jessica Fraeyman

On Tuesday the 2<sup>nd</sup> of March 2020 we took the train with a group of health care workers from Belgian Community Health Centers for a 3-day visit to Glasgow and the GPs at the Deep End, coordinated by the Academic Lead for the Deep End Group, Dr David Blane. We take the opportunity in this Bulletin to share some of our experiences.



### **An (general manager of CHC):**

#### **Our timing to visit the Deep End practices couldn't have been better.**

*“Just before the borders closed, due to the Covid19 pandemic, we had the special opportunity to get an insight into the innovative, Scottish way of working, thanks to a program completely tailored to our questions. During the recent corona-weeks I often had to think back to this inspiring trip. We recently applied a number of things in our CHC: far-reaching triage by a receptionist, telephone consultations by the GPs, ... It was a great help to have seen some of these innovative practices just a week before in Glasgow...But the biggest added value of our visit was the shared values & vision, and on certain domains also a similar way of working. But at the same time it was different enough to make this trip a really fascinating experience and full of learning opportunities. I hope David and his colleagues will come to visit us soon, I think we can do a lot for each other ...”*

### **Jolin (GP): Active Tuesday**

Only 28% of the Belgian population aged 18 to 64 achieve the recommended amount of physical activity to have substantial health benefits<sup>1</sup>. Healthcare professionals are well placed to promote physical activity in patients as they are supposed to have the necessary education to do so and the healthcare system reaches a substantial number of people in need of lifestyle changes. These professionals need to be physically active themselves, not only for their own benefit, but also because of their position as role models. It has been shown that healthcare professionals' own lifestyle habits and interests can positively influence their counselling practices and attitudes<sup>2,3</sup>. Worksite health promotion activities in health care centers may thus be beneficial for healthcare workers as well as their patients.

### **Practice example:**



*“Apart from the scientific evidence it intuitively feels right to promote health in patients by teaching by example. I presume it my ethical responsibility to*

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<sup>1</sup> <https://www.gezondbelgie.be/nl/gezondheidstoestand/determinanten-van-gezondheid/fysieke-activiteit>

<sup>2</sup> Lobelo F, Duperly J, Frank E: Physical activity habits of doctors and medical students influence their counselling practices. *Br J Sports Med* 2009, 43(2):89-92.

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*comment on their (un)healthy lifestyles and find this easier to do when I feel healthy myself. For this reason, there is always a pitcher of tap water on my desk. Naturally I was immediately inspired by Garscadden Burn Medical Practice's 'Active Thursday' where all health care workers wear a sporty outfit on Thursday and do something active that day. I'm all in! Since I do not work Thursdays we will call it 'Active Tuesday'. I have it all worked out. I just need to convince my colleagues..."*

### **Jan (GP): Some lessons and reflections at the occasion of the 'Deep End' visit**



The basis of the Deep End Project is a wonderful group of committed General Practitioners, inspired by an ethical goal to achieve health equity, to put human rights into practice and to address the Inverse Care Law, tackling the Social Determinants of Health (SDH).

The analysis of SDH is translated in a response at practice level, looking at complexity, continuity, clinical competence, community, connectedness, cultural competence, cost-effectiveness, cohesion, context, communication, commitment...(all the C-words).

There is a kind of spontaneous evolution from a clinical GP-approach towards an approach integrating health and social care, care for individuals and public health, care for individuals and groups, and increasingly integrating interprofessional cooperation in the team. The focus on mental health is very clear, as is the preventive orientation (e.g. oral health).

The concept of COPC (Community-Oriented Primary Care) is not explicit, but very clear from the design of the interventions, with a strong emphasis on participatory processes, starting from every person's capabilities and focusing on increasing the resilience of the community.

The networking with community agents is impressive: in a society like the UK, charities are an asset to reach out to those most in need. But the practices do not rely only on charities: there is (successful) structural political action, that made "links-workers" available, to improve outreach from an eco-bio-psycho-social perspective to those most in need.

Attention is paid to the wellbeing of providers, a challenge when resources are constrained.

A smart investment in education to recruit professionals from the Deep End practices in a sustainable way, uses strategies like “early exposure”, specific training packages to acquire the skills needed to work with vulnerable people, creating groups of students trained in Deep End practices and installing a junior-senior apprenticeship.

Important lesson for Flemish practitioners in pre-Covid19 times: there are other ways of meeting with patients than the consultation, and subsidiarity creates a lot of unexplored opportunities.



**Isabelle (CHC manager): Be proud!**

*“The first thing I wanted to tell my team when I came back from the Deep End... ‘Be proud of what you are doing and make time to talk about it to those who are interested’!  
What impressed me most during the visit to the ‘Deep End projects’ was how proud the healthcare providers and volunteers are. They really believe in what they are doing and eager to talk about it. I was overwhelmed by the warm welcome of each organisation we visited. Although they were often very busy, every employee took the time that was necessary to give us a clear view on the project or the organisation.  
Every care provider we met at ‘the Deep End’ was talking about ‘compassionate care’. I love the meaning of that concept!”*

**Bruno (GP): Peter and the Drums**

*“What I’ve kept in mind is the tour with Peter around Drumchapel, ‘his’ neighbourhood, for several reasons. I recognize myself in Peter’s prolonged engagement in the neighbourhood.*

*His example to really work with and between his patients and to support and empower them over the many years. He embodied an utmost sincere interest in the people of Drumchapel, in which I strongly recognize my own motivation to be a GP.”*

**Michael (GP):**

*“I felt inspired by the genuine/truthful and profound empowerment of patients in different projects in the Deep End. The way we were spontaneously welcomed and guided by different (former) addicts shows how much they own their own recovery process and it really lives up to the name of the project: Community Recovery Everyone Welcome (C.R.E.W.). Also in Drumchapel the patients take over the lead: the JIGSAW-project is coordinated by an expert-by-experience and the CHANCE TO CHANGE project has become a self-supporting self-help group. It inspired us to put more emphasis on human experience and empowerment than economic evidence in finding (financial) support for projects.”*

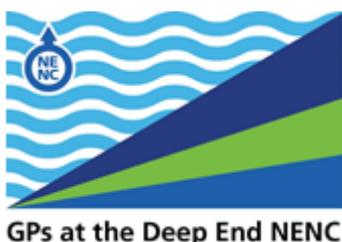


Belgian delegates: Jolin Lippens, Michael Erkens, An Van De Walle, Isabelle Van De Steene, Jan De Maeseneer, Mia Slabbinck, Eva Martens, Hanne Vanderhaeghe, Els Decroo, Bruno Art and Jessica Fraeyman.

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**NORTH EAST & NORTH CUMBRIA**



Very exciting news from the North East & North Cumbria (NENC), where - despite the unprecedented challenges of COVID-19 - we are making fantastic progress in establishing a Deep End network in our region.

We are delighted to be receiving support from across the NENC health system. We are very fortunate to have secured funding from the NENC North of England Commissioning Support Unit (NECS) to help establish our Deep End network. Using the same methodology as Deep End Scotland, the Population Health Management team at NECS have identified a set of 34 practices serving the most socio-economically deprived populations in our region who will be invited to join the Deep End NENC. Funding from NECS will be used to recruit a lead GP and a project manager to coordinate the network.

We have secured support, too, from the recently-established NENC NIHR Applied Research Collaboration (ARC). Along with our partners in the NECS, researchers from the ARC Inequalities and Marginalised Communities theme will evaluate the development and outcomes of the Deep End NENC network. The Academic Health Science Network is also keen to support us in developing innovations to tackle inequalities and improve outcomes for marginalised communities in our region.

In a further exciting development, Health Education England School of Primary Care in the North East is providing funding for eight Trailblazer Fellowship posts in Deep End practices in the south of the region, including education/peer-support time. We are hopeful that these posts will encourage newly-qualified GPs to join with established teams in working to reduce the impact of health inequalities in our region.

With our new logo in place, we had planned to host a large event in June to launch Deep End NENC. Due to the pandemic, we have moved the launch online. From early July, we will be inviting GPs to take part in a series of webinars that will enable us to come together to talk about the challenges posed by working in areas of high socioeconomic deprivation and the potential opportunities provided by joining the Deep End network. We have also secured three eminent keynote webinar speakers who have very kindly agreed to share their deep knowledge and expertise: Dr David Blane, who has been involved with Deep End Scotland for over 10 years; Clare Bambra, Professor of Public Health at Newcastle University and lead for the ARC Inequalities and Marginalised Communities theme; and Professor Chris Bentley, who headed the Health Inequalities National Support Team, which worked with the 70 most deprived areas of England with the poorest health ('Spearhead' areas).

We have got off to a brilliant start with our region's Deep End network and we will keep you updated with our progress. The Deep End research in Scotland gave an evidence base for the first time to the anecdotal experience of those working in practices in areas of deep socioeconomic deprivation. Now is the time to build on the evidence and provide a coherent and powerful message that we have to change the way we deliver health care in the North East and North Cumbria. We have developed a mission-statement, which synthesises the aims of our Deep End network to:

1. Develop a cohort of professionals working in primary care who have an interest and expertise in managing patients from the bottom decile: build a sense of community.
2. Attract staff, especially newly qualified doctors and nurses, to work in practices with more challenging demographics.
3. Advocate for funding allocation to more meaningfully take account of deprivation.
4. Advocate for our patients to have to have the right services when they may lack the resources to advocate for themselves.
5. Develop new ways of working to address need e.g. utilising social prescribing.
6. Learn from experiences elsewhere and from what we do while we develop this project.
7. Disseminate the learning to all primary care clinicians, as most have contact with patients who face the challenges of living in deprivation (so-called pocket, rather than blanket, deprivation).
8. Find ways to engage with those practices looking after blanket populations in the bottom decile. Professionals working in these Practices are less likely to be involved in training the next generation of health professionals and that the additional demands of working with this population mean that they often do not have the time and resource to develop different ways of working.

**Dr Guy Pilkington**  
**Clinical Lead for Prevention,**  
**Newcastle Gateshead CCG**

**Dr Dave Julien**  
**Clinical Lead, NHS**  
**South Tyneside CCG**

**Dr Martin Weatherhead**  
**Bridge View Medical**  
**Group**

## DEEP END CANBERRA



We write this with an awareness of the privileged position we are currently in with regard to the global pandemic. Due to a combination of factors – our remote island status, the benefit of a few weeks' more notice, a public health-informed collaboration between federal and state governments to introduce both a shutdown and an accompanying raft of social and financial supports for the millions affected by lockdown, and co-operation from the Australian community – we have so far avoided the widespread community transmission, health care system overload, and death toll that many countries have experienced.

Canberra has so far had a particularly low numbers of cases - just over 100, with 3 deaths. We have had minimal community transmission, generally adequate PPE, and good testing protocols. Our health and hospital services have been competently led and plans well-

executed. Nonetheless, the pandemic and lockdown have impacted our services and community in complex ways which are still evolving. We have experienced great disruption due to job losses, school closures, reduced services, and general confinement to home. Winter with our flu season is ahead of us, and we are concerned about a second wave as we start to gradually open up society again.

We have had to creatively adapt our services to protect patients and staff. Many of us have shifted to consulting via Telehealth (telephone or video, with in-person attendance if required). This has been possible with the welcome (albeit temporary) introduction of Medicare rebates for telehealth consultations. (Medicare is our taxpayer-funded universal health insurance scheme, which covers most or all of a doctor's visit, depending whether the doctor chooses to accept the smaller rebate offered for 'bulk billing'. We are fortunate that, unlike in the US, our health insurance is not linked to employment, so people have not lost it if they have lost their jobs.) Vulnerable groups (e.g. over 70, pregnant, chronic conditions) are required to be bulk-billed (no out of pocket cost to patient) for telehealth consults during the pandemic. This increases whole community health access for people who may be under increased or new financial stress.

At services such as Companion House, the refugee health service, telehealth has allowed appropriate physical distancing which, given the size of the building, would have been impossible otherwise. It has decreased the infection risk for many new arrivals, who would previously often need to catch 3 buses to attend medical and counselling appointments. As a result, it has improved attendance rates. Telehealth has also meant staff who are at particular risk from Covid-19 are able to work from home, maintaining service capability, and allowing the few remaining onsite staff to physically distance.

However, many of our Deep End clients are unable or unwilling to use telehealth as they have no mobile/internet access, are disabled or homeless. We struggle with the limitations of telehealth, especially for complex clients where we depend more on non-verbal cues. On the other hand, some patients with mental health problems who find it difficult to come to appointments have found it easier to consult over the phone.

Some outreach clinics and screening services for marginalised populations have temporarily halted. However, Directions, our drug and alcohol service, has been able to provide Opiate Maintenance Therapy to selected patients at home during the pandemic. Winnunga, the local Aboriginal and Torres Strait Islander Medical Service, has been providing a dedicated Covid-19 screening service for their population, and has separated this part of the clinic for any future pandemic surge.

The mental health toll of the pandemic and lockdown is making itself felt. Many of our patients are showing increased anxiety and distress, especially with Covid-19 following straight after the horror summer bushfires surrounding Canberra, and the resultant prolonged smoke hazard. Some services had masks left from that danger that are now being used for the current one! At the refugee health service patients are concerned about family left behind in refugee camps and home/transit countries. Some had received visas to come but were caught when the borders were closed.

There have been positive benefits noted, with strengthening of some family units as parents and children spend more time together during this period. Some 'intractably' depressed patients have improved with the increase in basic social security payment (temporarily doubled from its next-to-nothing base). One colleague shared the story of a patient whose chronic pain and low mood has lifted: 'for years Doc I haven't had enough to feed myself... Now I can eat properly, I've replaced my old bed linen with a bright new doona, I have some new clothes not from an op shop, I've replaced my broken TV and phone ... I am starting to feel like I am a normal person because I am being treated like a normal person'.

The roll-on effect from the social and economic disruption is yet to be fully felt. Our Women's Health Service is seeing an increase in family violence and protection orders as people start re-engaging with services. Alcohol and other substance misuse appears to be increasing, as are calls to mental health crisis lines.

The current government support payments for people unemployed or facing job loss are due to end in September. We will join in advocating for more continued support for vulnerable groups. We also expect to lobby for the continuation of Telehealth rebates beyond their September end date.

Elective surgery, hospital outpatient clinics, allied health services, and population screening such as mammograms have been reduced or halted during the pandemic, and people have been presenting less to primary health care. We anticipate a morbidity flow-on effect from this down the track.

We have found our Deep End group a valuable professional and personal support during this time of stress and uncertainty. We extend our solidarity to our international Deep End colleagues.

**Joo-Inn Chew** [joo\\_inn@hotmail.com](mailto:joo_inn@hotmail.com)  
**Sue Baglow** [susanbaglow@gmail.com](mailto:susanbaglow@gmail.com)

IRELAND  
Patrick O'Donnell



General practice and primary care in Ireland have changed fundamentally in recent months with the advent of the Covid-19 pandemic. From the beginning, GPs were designated as the main gatekeepers to the testing system for symptomatic patients in the community. New referral processes and management algorithms were introduced and then frequently altered as knowledge of the virus and its transmission advanced. The way that we consulted with patients shifted to mostly telephone contact for the first six weeks of the pandemic, with some face-to-face reviews carried out in selected cases. These changes have been challenging for all practices, but there has been added complexity noted in Deep End practices. To give some examples; appointments for Covid-19 testing and results are mostly conveyed by text message. If a patient has no phone, or has problems with literacy, then this form of communication is challenging. We also know that many of our patients struggle with multimorbidity or have poor living circumstances, and these are both seen as risks in terms of this Covid-19 virus. Many of our patients who were working were laid off at the start of the pandemic and are very uncertain if they will have jobs to return to when it settles. This all contributes to the potential of downstream consequences of the virus itself and the national efforts to control its spread.

One of our founding members Dr Edel McGinnity was interviewed for a national newspaper here in late March and explained that many of our patients could be considered as the “unworried unwell”, people who are already so busy dealing with family and social problems that they can be slow to report worrisome symptoms relating to Covid-19. She went on to say, “There is an enormous amount of denial out there. There are a lot of people who don't want to think about having this virus. I have referred 200 people for testing since it started on March 16<sup>th</sup>. Obviously, some of those have been tested but a significant number have not been tested. Only three or four phoned us to find out what was the story.” (see <https://www.irishexaminer.com/breakingnews/ireland/people-in-disadvantaged-areas-in-denial-about-having-covid-19-doctor-warns-990275.html>)

In terms of planned research, in the last bulletin we mentioned the Linkworker Randomised Controlled Trial planned for ten Deep End Ireland practices. This project will look at the cost-effectiveness of having a practice embedded linkworker over a period of time. This study was suspended in March 2020 due to the difficulties training link workers and starting a new intervention in such uncertain times. However, the need for social supports for our patients has been amplified by the lockdown and social isolation, so we are now planning to restart the study in July once travel restrictions are lifted. We are redesigning the intervention to take account of the ongoing need for social distancing and the likelihood that many group social activities will be slow to restart, especially for more vulnerable patients with multimorbidity. Having initially thought that our research would be another casualty of Covid19, we now feel more hopeful that it will test an intervention that might be particularly important for Deep End practices and their patients.

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## JULIAN TUDOR HART

Friends and colleagues of Julian Tudor Hart may like this last picture of him in his 92<sup>nd</sup> year.



“Intellectual opposition to injustice is only the beginning of social understanding”

NORTH WEST LONDON

Chad Hockey

Hammersmith & Fulham CEPN started a version of the ‘Deep End’ program in May 2019. Inspired by the Deep End Pioneer scheme in Glasgow, they applied the same principles to local contexts and created an educational initiative designed to:

- Connect frontline staff within and between deprived NW London communities
- Develop a core group to be a system resource for addressing health inequity
- Build confidence and capacity as part of a grass roots change initiative

Content and recruitment

The scheme provided funding for one day a week for 6 months per participant. Within this, 50% was unstructured ‘headspace time’ to undertake service improvement projects and the other 50% was structured with formal QI training via the NHSEI ‘QSIR’ program. The group also met for regular sessions as part of this structured time and explored topics relevant to clinical practice in deprived areas, always with a focus on practical change. Sessions built on each other in a ‘course’ format which was designed to form the basis of a Fellowship:

1. Understanding complexity - why it’s different in deprived areas
2. Adverse childhood experiences - growing up in deprivation
3. Harnessing the power of consultations- the impact of empathy
4. Promoting continuity - approaches with a part time workforce
5. Mental health and wellbeing - the impact of hope and agency
6. Access to care - perspectives of sub-sections of the community
7. Self-care and deprivation - concepts of rational choice and agency
8. Financial wellbeing - understanding social capital and assets

9. Peer support - communities as a tool for professional resilience
10. Advocacy - understanding passivity and approaches to change
11. Inclusion health - barriers and engagement strategies
12. Chronic pain - pain as the physical expression of social distress
13. Personality disorder - causes, consequences and management
14. Food poverty - exploring the social gradient to diabetes and obesity
15. Vulnerability- domains of vulnerability and the link with resilience
16. Dependence- social constructs including disability and frailty
17. End of life- dying in poverty, compassion and anticipatory care
18. Data & research- training, mentoring, writing bids

We initially started with a cohort of 4 GPs, but in October 2019 managed to fund a second cohort of 6 GPs and extended 8 places to nurses and allied health professionals. Despite a short notice period, the scheme was over-subscribed. Applicants included mental health nurses, district nurses, practice nurses, nurse practitioners, community matrons, ED nurses, a paramedic and a range of GPs- partners, salaried and locums.

The scheme was about building and using networks, and 74% of applicants heard about it by word of mouth or via a forwarded email. It was also about creating a culture of activism, and applicants expressed 'desire to help the neglected parts of our society', 'being part of a movement' and 'solidarity' as key motivators for applying.

### Attendance and evaluation

Sessions were hosted at a local community space and were open access, with invitations actively extended to voluntary sector groups, medical students, commissioners and anyone who was interested. By using this approach we were able to use the platform of the 'core' funded cohort to engage and extend training in health inequity to a much wider group, and ended up with 94 people attending sessions over the year.

They came from 40 health, social care and voluntary sector organizations from 8 CCGs across NW and NE London and worked in 22 different clinical and non-clinical roles. In total 76 people came unfunded, many to multiple sessions. A critical mass of people was needed to generate enough energy to attract this unfunded group - above this it snowballed and people came despite minimal ongoing advertising of sessions.

Over 50 clinical staff attended, but despite being frontline in deprived areas, <15% had ever had any significant training in the selected topics. Overall, 93% strongly agreed that the content was relevant to their work; 91% strongly agreed that sessions increased their knowledge and understanding; and 100% agreed or strongly agreed that the multi-sector nature of workshops

was valuable and had improved connections. Overall, 100% said they'd recommend the sessions to friends or colleagues and that they were 'extremely likely' to attend future events.

Comments from participants about the sessions included the following:

*"This was the first time we've seen a whole room of healthcare professionals completely focused on considering health inequalities, it was a real inspiration to see people role modelling and taking time out to do this."*

Medical student

*"The sessions allowed me to justify the allocation of resources to high need practices, gave me insight into what services to link with in the community, and gave me language to discuss how the project benefits organizational aims. It inspired small projects within our service."*

Mental health nurse lead

*"I felt empowered to apply what I learnt within clinical consultations and discussions with colleagues...the power of camaraderie cannot be underestimated: with 'Deep End' GPs from other CCGs and networks and people from many different disciplines, all working in a similar way and with similar challenges without, till then, realizing it."*

GP

*"The 'Deep End' scheme filled an essential gap in knowledge, connection building and reproduction to address health inequities at a scale in NWL not seen before."*

Commissioner

#### Connectivity and system impact

Besides content and connectivity, the scheme had intended to create a 'core' group that could advocate and be a resource at a system level, and this had started to happen by:

- Hosting groups of Darzi Fellows- providing exposure and training in health inequity
- Hosting and contributing to a national 'Asset-Based Inquiry' on social prescribing
- Contributing to national scoping about the impact of PCN contracts in deprived areas
- Embedding training on health inequity as part of NW London link worker induction
- Supporting GPs in other parts of London and SE England wanting similar schemes

Details about the impact on participants at a personal level are still being collated, as is the personal project element. However, the program enabled a participating practice to attract a GP to a salaried post, led to a paramedic exploring how the ambulance service can be used to facilitate GP registration for vulnerable groups, and has played a part in a GP establishing targeted wellbeing webinars as part of their practice's Covid-19 response.

#### Covid-19 and next steps

The group was planning a series of 'festivals' to strengthen this platform, had a recruitment event scheduled to target newly qualified GPs, and had engaged local academic institutes to promote deprivation-focused research when the pandemic started.

Covid-19 changed all of this - sessions stopped as the venue closed and the focus shifted to intra-organizational service delivery. The way the scheme had flourished made this sudden cessation feel like a loss, but something more profound was also happening.

Our program was about dissemination of power, building connections between people and places. It framed general practice as part of public health and identified GPs as an intrinsic part of a community, providing relational rather than transactional services.

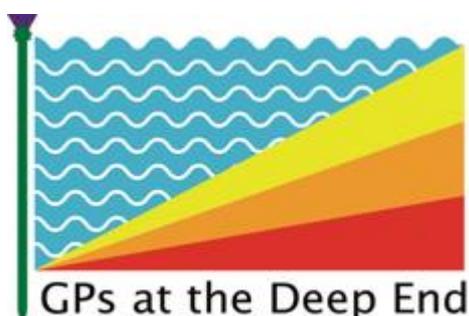
By contrast, the response to Covid-19 centralized decision-making, transactionalized care and disconnected people from places via remote working. For some GPs on the scheme the crisis therefore became an existential one, challenging their values and identity.

In reality, these tensions already existed but, like inequity, were being exposed by Covid-19 and amplified by parts of the system response. But unlike before we now have a strong core group of GPs, committed to supporting and sharing with each other, irrespective of funding.

Our challenge is therefore adaptation - the principles on which our scheme was based still apply, but we need to revisit how we apply them. Sessions are about to continue in virtual format. We'll use them to collate our collective narratives and showcase the innovative initiatives that have emerged during the last 3 months, especially work being done by local communities like health literacy training, supporting the food bank and volunteering.

We'll also be assessing the indirect harms that have happened as a result of the system's response. It's fantastic that 'Inverse care' and 'Community Resilience' now feature as part of strategic documents, but unfortunately that doesn't mean this is the end of the Deep End. The risk is that unless this is treated as a complex adaptive problem, 'recovery plans' will worsen the inequity they are trying to 'fix'.

## SCOTLAND



12 general practitioners in Deep End practices in Glasgow and Edinburgh report and reflect on their experience of how the Covid-19 pandemic has affected patients and practices during May 2020, and on the implications for what happens next.

#### General practice during the pandemic

- General practice adapted rapidly and universally in response to the Covid-19 pandemic, using remote consultations for initial triage and keeping in touch with shielded patients.
- Practice teams proved agile, resilient, enterprising and committed.
- Usual general practice activities have been reduced (routine consultations), some significantly (home visits), while others have stopped (practice nurse triage).
- Remote consulting, by phone or video, works for some types of patients, problems and purposes. The best uses of these technologies need to be established.
- Community link workers have been “invaluable” in contacting vulnerable patients, meeting their needs and making connections with community resources for health.
- PPE supplies were inadequate at the outset. Many practices bought their own. Eventually these problems were resolved.
- Symptomatic staff were frustrated at the delay in getting a Covid-19 test and obtaining the result at the beginning of the outbreak.

#### Concerns

- The NHS has protected itself by putting much of its work on hold. There are many challenges to come.
- GPs are worried about “missing patients” and the backlog which has built up in chronic disease management, screening, immunisation and cancer referrals.
- Face to face consultations are still essential for many patients with complex problems and for those unable to access or use remote consultations effectively.
- There is concern about vulnerable children and families who have had their support networks withdrawn, including the watchful waiting function of general practice.
- Mental health problems are increasing and impacting directly on general practice capacity, particularly in areas of socio-economic deprivation.
- The economic consequences of the pandemic will impact most on disadvantaged groups, who live in precarious financial circumstances, and will widen the health inequality gap.
- Will the generous support for people experiencing homelessness and those with no recourse to public funds survive the pandemic?
- There are significant concerns for women’s mental health and child wellbeing as more women stay at home to look after children, losing their financial security and independence.

## What comes next?

- General practice is going to have to be centre stage in addressing the health consequences of the pandemic.
- New challenges will include the clinical backlog, the complications of neglected conditions, new types of health inequity due to remote consulting and an epidemic of financial and psychological distress.
- Continuing and increasing challenges include multimorbidity, health service fragmentation, inequity in health care provision and the workforce crisis in general practice.
- If the generalist clinical function is not strengthened, disease complications and crises will occur earlier, putting pressure on emergency services.
- The balance between specialist and generalist services in the NHS, which for 15 years has been heavily weighted towards the former, needs to be re-set.

## Promoting generalist clinical care

- Generalist care provides unconditional personalised continuity of care, whatever problem or combination of problems a patient has.
- The package of necessary measures includes extended consultations for selected patients, enhanced multidisciplinary teams, embedded co-workers (link workers, social care workers, alcohol nurses, financial advisors etc) and collegiate learning.

## Addressing inequity in health and health care

- Unresolved aspects of health care inequity include the toxic combination in very deprived areas of a time-poor service with lower levels of health literacy; for different reasons patients, practitioners and the system settle for sub-optimal care.
- New partnership is needed within Health and Social Care Partnerships (HSCPs) between general practices dealing with the consequences of longevity and practices serving groups with premature mortality and lower healthy life expectancy.
- Provision of Community Link Workers should be increased from 50% to 100% of Deep End general practices.
- The proven benefits of embedding Financial Advisors in general practice should be recognised and funded as part of the new Scottish Social Security system.
- Most of the new mental health morbidity will present in general practice, below thresholds for referral to mental health services. There is an urgent need to expand the model of embedding mental health workers in general practice.
- New metrics are needed to inform, monitor and evaluate policies to improve health equity.

The Covid-19 pandemic has displayed many positive features of general practice: the unconditional approach, adaptability, teamwork, collegiality, passion, caring, commitment. Can the tragedy of Covid-19 be converted into opportunity, collectively addressing inequalities in health and the fragmentation of care?

Quotes from Deep End Report 36

*At a human level our response to the crisis has involved neither heroes nor villains - we have all in our own ways been affirming, resilient, frightened, angry, kind, selfish, loving and self-sacrificial, in different measures. We mostly try to avoid contemplating the bigger picture, for no other reason than our brains do not cope well with existential threats. To a greater or lesser extent, we take comfort in denial. However, it is at this human level that more authentic ways of living emerge.*

*The communities who have been most failed by the state have perhaps done the most to respond in a life affirming way. Kindness, mutual aid, civic responsibility and solidarity have been shown to be far more powerful forces for sustaining human survival than consumerism or rank individualism.*

The full, 37 page, Deep End Report 36 is available at  
[https://www.gla.ac.uk/media/Media\\_728030\\_smxx.pdf](https://www.gla.ac.uk/media/Media_728030_smxx.pdf)

## YORKSHIRE AND THE HUMBER



The following contributions are included with the permission of their authors, Tom Ratcliffe and Ben Jackson, respectively.

fair health

HEALTH EQUITY ACTION AND LEARNING  
Fair Health in the Time of Covid-19

Covid-19 is emphatically **not** the great leveller. It has shone a light on the great divides in our society. Everyone can catch it, everyone can die from it but the impact of the virus and the necessary measures to control its spread is not shared equally across society.

Our response will require kindness, caring and compassion. The current upsurge in these values should give us cause for hope during an otherwise very difficult time for many people. And they will be most needed where suffering is greatest.

What is interesting about the risk of death or hospital admission from the virus is that it almost perfectly tracks your current risk of death. So, if you are already sick, from a BAME background, grew up in poverty or already older you are more likely to develop serious symptoms and/or die.

The economic impacts will be most acutely felt by those with the fewest resources: people in low paid jobs, people who have chronic mental or physical illness, people on temporary or “zero hours” contracts and those who are living from pay check to pay check. It is also likely that those in low paid manual jobs (e.g. supermarket, social care, construction workers etc) will be less able to socially distance by working from home and, hence, less able to minimise the risk of Covid-19 infection. Those who are now confined to home in poor quality or cramped housing will have the most miserable experience and those living in the least affluent, vibrant and green surroundings will suffer the biggest fall in wellbeing.

These individuals are all part of the same group: the poorest in society.

Michael Marmot recently reminded us that, in the UK, the poorest 10% of households have less than 30% of their income remaining after deducting housing costs and the cost of healthy food. They also have very little wealth to fall back on in times of economic crisis. The implications are clear: loss of income due to Covid-19-related unemployment or illness will cause destitution among those who are already struggling to get by.

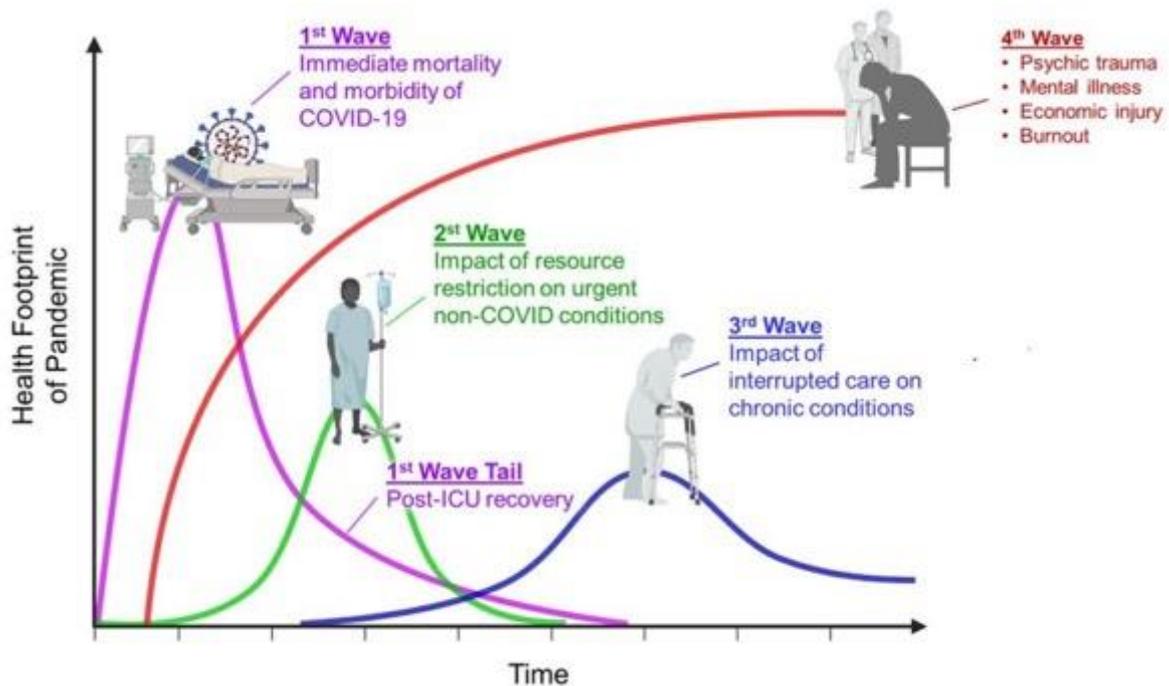
Health inequalities were already widening before Covid and these divides are now likely to be accelerated by another economic crisis, massively compounded by a virus that kills those already suffering from chronic illness and multimorbidity, the rates of which already follow a sharp social gradient.

Covid has taken the social determinants of health, which have insidiously been working away behind the scenes, slowly eroding peoples’ health and wellbeing, and exploded their impact into full view. Our civic, community and healthcare resources have been degraded by a decade of austerity, as have many aspects of the welfare safety net. Covid has triggered substantial reinvestment but we must not let these issues disappear back into the shadows as the crisis recedes.

The response to Covid has been to put the whole NHS on an acute footing, aimed at treating a single disease, whilst trying to also provide care to the non-Covid acutely unwell. This means that planned primary care, which can narrow the health gap by 10-20% if access is good and quality high, has been temporarily suspended (or at least deprioritised). Because the system was already at capacity, and because capacity was already inadequate in the most socioeconomically deprived communities, it will take a long time to catch up after this crisis. After Covid we will discover a massive pool of morbidity, mortality and unmet demand. Mental illness that existed before this crisis will also sharply deteriorate due to increased stress and isolation plus a temporary withdrawal of face to face primary care.

GPs also know that the aftermath of social trauma can last years or even decades and blight peoples' whole lives. GPs have spent years trying to help people traumatised by war, tragic events, childhood neglect or mistreatment, crime or domestic abuse. Covid will leave thousands, perhaps hundreds of thousands, of people traumatised by its direct effects or as a result of vulnerable people being left isolated in toxic social situations, where the abuse or mistreatment they have suffered becomes temporarily inescapable.

The long tails of this crisis are neatly summarised here:



The Four Waves of Impact: Covid-19

Source: [https://pbs.twimg.com/media/EUX2TipWoAMa\\_19.jpg](https://pbs.twimg.com/media/EUX2TipWoAMa_19.jpg) (thank you to Dr Victor Tseng)

So how can we respond?

If there is a positive thing to take away from the Covid crisis it is the outpouring of kindness, the renewed recognition of the contribution of people with jobs whose value may have been forgotten or overlooked, a huge injection of investment into healthcare and social welfare and a revived willingness to think about the needs of others.

We might reflect on J.B. Priestley's words:

"We don't live alone. We are members of one body. We are responsible for each other."

An Inspector Calls, 1945

So how should we respond in primary care?

As our colleagues at Citadel Healthcare in Greater Manchester remind us, for general practice, we should go back to basics: “find the sickest and give them the best care”. And we must double down on our efforts to do this during and after Covid-19.

- We will have to catch up peoples’ chronic disease management – prioritise the poorest, who can be identified by integrating the available databases on socioeconomic deprivation with primary care records and by examining chronic disease data (time to collaborate with our wonderful colleagues in public health – at Fair Health we are also trying to create some resources to make this easier for practices, watch this space!). Also prioritise those things that have the biggest impact on health outcomes – start with cardiovascular disease prevention. Perhaps revise where to focus your efforts by working through our [learning modules](#).
- Now will be the time to adopt an approach based on “Trauma Informed Care”. You can read more about this in our [learning modules](#) on this site and on the “A Better NHS” blog (see resources below).
- Use the Primary Care Network DES to invest in social prescribing to try and deal with some of the acute social issues that Covid will exacerbate and use this to build better links with your local Voluntary and Charitable Sector, who may need your support and advocacy more than ever
- Collaborate with the “social determinants of health workforce” more than ever:
  - The social workers, teachers, school nurses and health visitors who will be helping safeguarded children during and after the crisis
  - The Citizens Advice Bureau, debt advisors and Department for Work and Pensions operatives who will be needed more than ever to help people through the multiple domestic financial crisis that Covid will create
  - Organisations providing care for people who are homeless, refugees and other vulnerable groups to ensure they can access very strained services in the post Covid world
  - Drug and alcohol services, whose users won’t have been able to socially distance and access support as easily during this crisis
  - The nurses and carers out in the community supporting our most vulnerable
- Remember that primary care organisations are anchor institutions for many communities – just being there is so important: you can hold onto the memories of how Covid impacted your community and you can hold the NHS leadership and politicians to account for their decisions, their efforts to address health inequalities and future readiness for a pandemic or the slower health “emergency” represented by growing health inequalities
- Try and ensure that information about Covid and the social safety net that is being created is accessible to all by providing information in multiple languages and formats (see resources for free translations of material provided by Doctors of the World)
- As illustrated above, the Covid crisis will have a long tail, perhaps stretching out over many years, this is where health equity focussed primary care will be needed most

## Resources

A Better NHS Blog: <https://abetternhs.net/> (see 23<sup>rd</sup> February 2020

The Marmot Review 10 Years On: <https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on>

Doctors of the World patient

information: <https://www.doctorsoftheworld.org.uk/coronavirus-information/>

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## CAREERS

*Attitudes are more important than abilities, motives are more important than methods, character is more important than cleverness and the heart takes precedence over the head.  
Perseverance is more important than pace. Making the right choices at various junctions in life can be of greater importance than outstanding ability.*

**Denis P Burkitt**



Highgate Cemetery, from Karl Marx to George Eliot, then as far again, in front of a wall