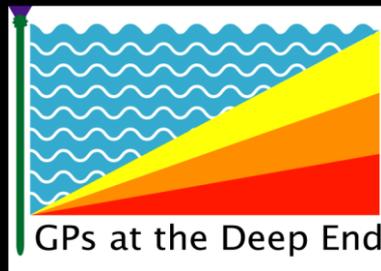


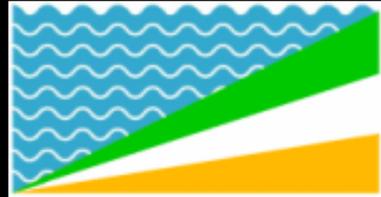
GENERAL PRACTITIONERS AT THE DEEP END

INTERNATIONAL BULLETIN NO 4

GENERAL PRACTITIONERS AT THE DEEP END – NINE PROJECT LOGOS



SCOTLAND



IRELAND



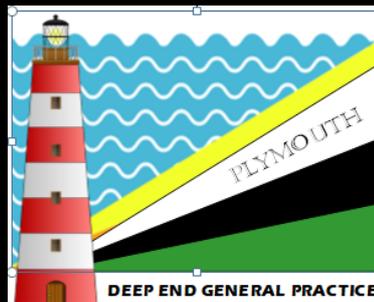
YORKSHIRE/HUMBER



GREATER MANCHESTER



CANBERRA



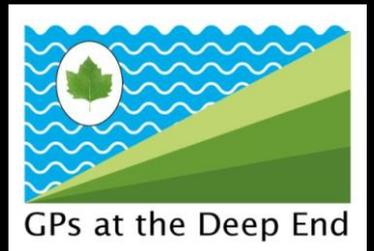
PLYMOUTH



GPs at the Deep End NENC
NORTH EAST AND NORTH CUMBRIA



NOTTINGHAMSHIRE



NW LONDON

NOVEMBER 2020

INTRODUCTION

.... in the dark age in which we are living and the new world order, the sharing of pain is one of the essential preconditions for a re-finding of dignity and hope. Much pain is unshareable. But the will to share pain is shareable. And from that inevitably inadequate sharing comes a resistance. (1)

John Berger

Welcome to the 42 pages of fourth Deep End International Bulletin. A bumper issue.

A special feature in this issue is learning from colleagues working in services for the homeless in Dublin and Glasgow, with reports from Austin O'Carroll (p 8) and Andrea Williamson (p 11), respectively.

Following Bulletin No 3, a Zoom Meeting was held for all contributors and a report of the discussion is included (p 5).

Thanks to Professor Susan Smith of Deep End Ireland who put us on the trail of "Mrs McTavish" and to Alex Scott-Samuel, founding editor of Radical Community Medicine, who gave permission to include Mrs McTavish's historic introduction to Deep End literature. (p 32)

It is a pleasure to welcome the new Deep End Project in Nottinghamshire (p 26). Their logo includes an image of Robin Hood, best known for his pioneering approach to resource re-distribution – robbing the rich to give to the poor – it was simpler in those days.

Among eight reports from Deep End Projects, pride of place goes to Tom Ratcliffe reviewing the first five years of Deep End Yorkshire and Humber. (p 14)

Deep End initiatives are sprouting all over London and are beginning to join up. (p 33)

As part of our continuing brief to broaden the horizons of Deep End colleagues, we include a poem by the late Tom Leonard, allowing readers to practise their Glasgow vernacular. (p 13)

It is a pleasure to have international contributions from our friends and colleagues, Liz Sturgiss in Australia (p 36), Jessica Fraeyman in Belgium (p 38) and Gary Bloch and colleagues in Canada. (p 39)

Finally, we include the summary of a Masters dissertation by Caitlin Whyte, a student at Strathclyde University, looking at Deep End Scotland from a management change perspective. (p 41) Her characterisation of Deep End GPs as "institutional entrepreneurs" and "political navigators" may be helpful in future discussions of Deep End strategy, leadership and advocacy.

Graham Watt

1. Berger J. Portraits: John Berger on Artists. Edited by Overton J. London, UK: Verso, 2015. Pp 335-340

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CORRESPONDENCE

In Bulletin No 3, describing her sabbatical in Australia, Liz Walton wrote,

So, as I walked through the streets of Campbelltown to the Arts Centre, racism and unfairness were on my mind. The eyes, which drew me into the powerful Vernon Ah Kee's exhibition, 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.

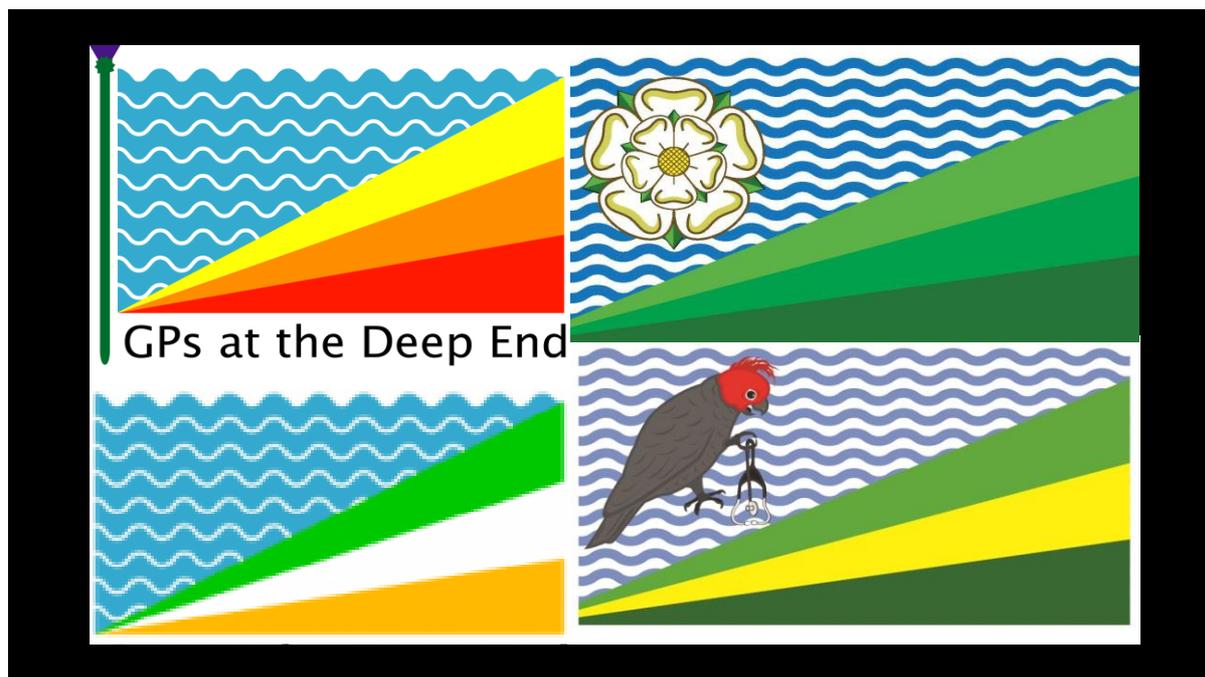


Vernon Ah Kee, Lex Wotton (profile), 2012, and tall man, 2011, installation view, Campbelltown Arts Centre, Australia 2020. Photo: Document Photography.

Professor Stewart Mercer wrote in response,

I felt a connection with Liz Walton's piece as she mentions Lex Wotton (the tall man) of Palm Island. I worked on Palm Island for 2 months in 1997, just after my time in India (and just before I started in Glasgow), and I remember the Wotton family well. I had left just before the death of one of the islanders in police custody which sparked the protests led by Lex Wotton. Palm Island was in the Guinness Book of Records as the 'most violent non-war zone on earth' – something I read in the doctors room when I flew in for my first shift on a 6 seater plane...and the only other doctor on the Island (an Accident and Emergency consultant) flew out. Violent because when you move Aborigines off their homelands (over 40 different clans all with different traditional languages), put them on an island that has never been inhabited, where there is no connection with the land and their ancestors, where there are zero jobs, and give them a 'canteen'(pub) for when their dole money comes in, it's not surprising you get fights. But towards me, drunk or sober, I never experienced the slightest bit of aggression. They were beautiful, misplaced and misunderstood people.

DEEP END ZOOM MEETING NO 1



A basic tenet of the Scottish Deep End Project has been that when a group of GPs has gathered to share their experience and views, no matter how interesting the exchange has been, the event will have little lasting value to the participants, and none to those who were not present, unless at least the summary points are recorded and shared.

This report is a brief summary, therefore, of the first Deep End International Zoom meeting, held on 9th July 2020 and exploring the shared agenda of Deep End Projects.

Invitations were largely restricted to current and potential future organisers of Deep End Projects, as demonstrated in contributions to Deep End International Bulletin No 3. The meeting attracted 20 participants from Scotland (5), England (9), Ireland (2), Belgium (1), Australia (1) and the United States (2). A starting time of 20.00 BST made it possible for everyone to take part, although our Australian colleague had to get up at five o'clock in the morning.

The following points stood out.

Inspiration

The conference in Glasgow in 2019, celebrating the life and work of Dr Julian Tudor Hart, the publication of *The Exceptional Potential of General Practice* and the achievements of Deep End Projects in Scotland, Ireland and England, had been cathartic, bringing together a large company of like-minded colleagues, without the range of competing and distracting interests that are present in more general meetings of practitioners. At least one Deep End Project had been inspired by attendance at this conference.

Getting started

The first step in establishing a Deep End Project is engagement with general practitioners serving socio-economically deprived communities, with vehicles for continued interest and activity. Projects have varied in their vehicles of choice, ranging from education and training to service development. Some form of organising role has been necessary to ensure communication, coordination and continuity. Organisers have often worked from an institutional base, not always with the explicit or practical support of the institution. The “Deep End” has many features of a resistance movement.

Common cause with other general practices

These efforts have helped to establish and build identity and voice for otherwise poorly connected colleagues. While collegiality and solidarity have been strengthened *within* Deep End networks, a continuing challenge is obtaining understanding and support for the work of Deep End practitioners from other parts of the health system, including other general practitioners, managers, policy advisors and politicians.

An exclusive focus on Deep End practices can alienate GPs working in other practices. For this reason, the Scottish Deep End Project now also focuses on “Deep End patients”, most of whom are not registered with Deep End practices.

All general practices have in common a commitment to unconditional, personalised continuity of care. Deep End advocacy has a place, therefore, in the defence and promotion of clinical generalism, with the rider that generalism is needed most where multimorbidity and complexity are most prevalent.

Health inequalities

Another challenging relationship is with experts, organisations and policies on health inequalities which often see little role for general practice.

By preventing, postponing or lessening disease complications and crises, personalised health care can improve health, reduce demands on emergency services and, by doing this for large numbers of individuals, narrow health inequalities.

Tudor Hart’s comment that *“Intellectual opposition to injustice is only the beginning of social understanding”* underscores the frustration of engaging with colleagues and organisations whose declared interest in addressing health inequalities is not matched by practical commitment. Addressing health inequalities in a half-hearted, episodic way is certain to leave their structural causes intact.

The common cause of Deep End practitioners, as distilled at the Glasgow conference, is commitment to doing what’s best for and with patients with complex problems, often lacking the knowledge, confidence and assertiveness of healthier patients. They choose not to ignore patients who are easy to ignore. Driven by values rather than evidence, evidence is needed to persuade others.

Media enquiries

Colleagues shared their experience of dealing with media requests for patient contact to illustrate news items. Such contact is sometimes possible but often inappropriate, given the nature of patients' problems. GP anecdotes can help journalists writing print articles – coverage of [Deep End Report 36](#) drew heavily on quotations drawing directly on recent GP experience.

Patient involvement

Colleagues discussed the desirability of closer alignment with patients and patient groups in pursuing advocacy objectives. Politically, and in principle, this makes sense. The Belgian group visiting a Deep End practice in Glasgow recently commented on the positive patient and community links which had been developed. In *The Exceptional Potential of General Practice* (p 21), Professor Jan De Maeseneer described the long history of such engagement in Ghent.

It was noted, however, that one of the strengths of Deep End Projects has been the gathering of like-minded GPs without the distraction of other interests. Increased patient involvement should be an addition, rather than an alternative, to this approach.

Zoom meetings

The technology allowed colleagues to take part from across the world, at little inconvenience or cost. With organisers of Deep End Projects it was possible to share experience and views on organisational and advocacy aspects. Twenty seemed a manageable number.

Another possible use of the technology would be to convene meetings of Deep End practitioners to share experience and views of clinical and organisational issues arising within their practices.

Graham Watt

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LEARNING FROM SERVICES FOR THE HOMELESS

Health care for homeless people in Dublin during the Covid epidemic

We know that homeless people have some of the worst health indices in the Western World with significantly lower life expectancy and a morbidity profile that has been described as a cliff face at the end of the rising slope of morbidity one finds in areas of deprivation. (1-3) We also know that homeless people live in congregated, crowded settings. (4) With the approaching Covid-19 pandemic this coalescence of vulnerability created a frightening prospect of wide-scale infection in the homeless population with resultant poor morbidity and mortality outcomes.

Dr Michael Ryan, Director of the World Health Organization advised early on *“If you need to be right before you move you will never win. Perfection is the enemy of the good when it comes to emergency management. Speed trumps perfection and the problem in society we have at the moment is everyone is afraid of making a mistake, everyone is afraid of the consequence of error. But the greatest error is not to move, the greatest error is to be paralysed by the fear of failure.”*

The prospect facing homeless people galvanized a response across the homeless service provider sector. (5) A flurry of Zoom and teleconference meetings resulted in a series of coordinated responses between Homeless Health and Accommodation Providers:

The Health Service Executive (HSE) Social Inclusion Directorate appointed both an Operational and Clinical Lead for the Dublin Covid Homeless Response.

- A joint operational command structure was set up involving the HSE and the Dublin Regional Homeless Executive (DRHE).
- Regular meetings were set up between:
 - The HSE and DRHE.
 - The Clinical Lead and all Health Service Providers in the homeless sector.
 - The Operational and Clinical Leads and Accommodation Providers.
 - The Operational and Clinical Leads and Addiction Service Providers for homeless persons.
- We consulted with our colleagues working in homelessness in the UK (in particular Profs Al Storey and Andrew Hayward).

These meetings generated a plan that continuously evolved with multiple adaptations. Despite seeming chaos, within four weeks a series of actions had been implemented:

- A triage and mobile Covid test system had been set up, operated by Safetynet, a Primary Care Service for homeless people. Safetynet also provided medical support for patients who were diagnosed as positive.
- Several isolation centres were set up in newly acquired accommodation where people who tested positive or who were awaiting results could be isolated until they were not an infection risk.
- A transport service was set up for Covid suspect/positive patients.

- All homeless people deemed medically vulnerable due to their age or medical morbidity profile were moved into shielding units where they had their own bedrooms, and meals and essentials were delivered to them.
- All patients placed in isolation and shielding had their addiction needs addressed by GMQ, a primary care and addiction service for homeless people. This included initiating methadone treatment in a new inpatient facility and as outpatients; benzodiazepine maintenance or detoxification; and alcohol detoxification. Administrative services developed new protocols to enable clients to commence rapidly on treatment.
- A number of accommodations were identified as having too high an occupancy rate and had clients decanted into new hostels.
- Addiction in-reach services providing support included the daily delivery of medication, provision of harm reduction advice, distribution of naloxone etc.

My role as clinical lead was firstly, to ensure there was appropriate governance; secondly, along with the operational lead to develop an overarching planned response and to assign clear and distinct roles and responsibilities to the differing organizations. The frenetic level of activity did create disagreement and conflict which required me to intervene and resolve. Thirdly, my role entailed protecting patient and staff safety and health through the drawing up of clinical and organizational protocols that ensured high quality care was delivered. Lastly, and most importantly, the clinical and organizational leads needed to ensure all organizations and all staff both shared a common vision, and felt supported and protected from harm, while delivering on that vision. The network of relationships with managers and staff of organizations in this sector helped in achieving this objective.

The results of these initiatives exceeded expectations. By September 2020:

- We had tested over 1000 symptomatic patients of whom just over 70 were positive.
- We conducted a screen of 450 asymptomatic residents and 165 staff in hostels to estimate the level of asymptomatic infection in the sector. 10 residents (2%) and 5 staff (3%) were found to be positive.
- We placed over 700 symptomatic clients in isolation.
- We placed over 550 people in shielding of whom 340 were in newly acquired accommodation units.
- We decanted over 120 clients from facilities where there were large numbers sharing rooms.
- We offered accommodation to all rough sleepers.
- Waiting times for methadone dropped from 12-14 weeks to 3 days. We commenced over 180 new people on methadone.
- Over 70 people were commenced on benzodiazepine maintenance treatments.

A predictive model provided by our colleagues at University College London suggested that we would have, at worst, 23 and, at best, 6 Covid-related deaths. We had only two deaths.

There are several possible reasons for the positive results in this initiative and the outcomes cannot be attributed solely to the efforts within the sector. However, this collaborative model involving Health, Housing and Addiction services is rooted in a recognition that health is socially determined. The recognition of this resulted in the Irish Ministers of Health, Housing and Addiction meeting in July and agreeing to work in partnership to address the issues facing homeless people.

This approach could provide a model to address health issues related to health inequity that are encountered in Deep End practices. The model encompasses the range of policy partners required to address the social determinants of health. We all know how frustrating it can be to seek to address depression in patients who are facing a range of social issues (e.g. housing, social welfare, addiction etc.) when our medical armament of counselling/medication is insufficient to address the patient’s emotional state which is usually rooted more in their social circumstances than their psycho-physical genetic predispositions. A key factor that enabled this collaboration was the sharing of a common vision and mission at all levels in the various health, housing and addiction bodies (policy makers/CEOs managers/health professionals/community workers). Vision is how one wants to see the world (in this instance we wanted a world whereby homeless people had the level of protection against Covid-19 warranted by their health status). Mission is what one decides to do to help achieve that vision. The sharing of a vision and mission empowers teams to collaborate effectively.

Another enabling feature that is particular to the Irish Health system was the presence of a social inclusion directorate in the Irish Health Services Executive (see Fig 1). Social Inclusion’s brief is “to reduce inequalities in health and improve access to mainstream and targeted health services for vulnerable and excluded groups in Ireland”. Every Community Health Organization (CHO) has a social inclusion officer who reports to the National Social Inclusion Office who report to the HSE CEO. The presence of social inclusion ensured that addressing health inequities for marginalized groups was institutionalised at policy level and enabled the development of collaboration across the various sectors.

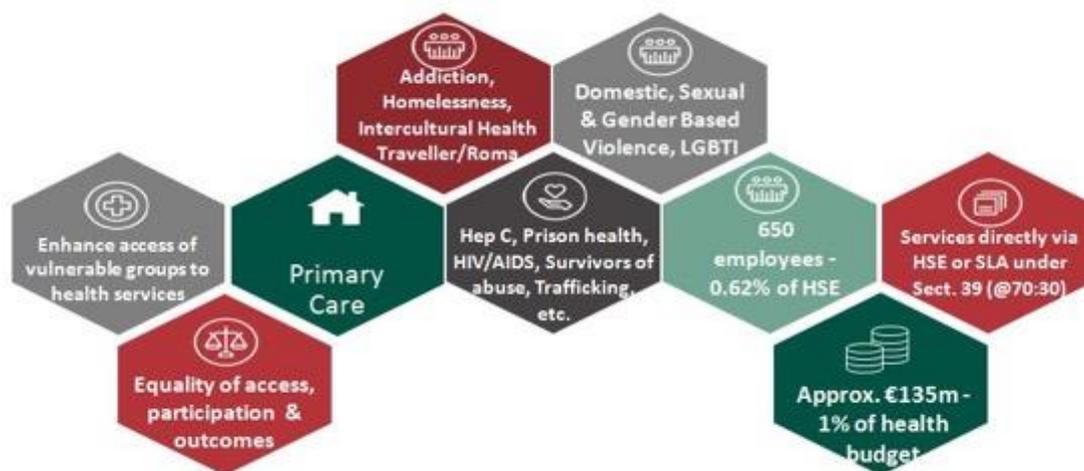


Fig 1: HSE Social Inclusion (6)

In summary, the response in Dublin to the Covid-19 pandemic demonstrated the value of a co-ordinated response from policy to practitioner levels between health, housing and addiction services. It offers a model for the addressing of health inequities that takes into account the fact that health is both genetically and socially determined.

Austin O'Carroll

1. Story A. Slopes and cliffs in health inequalities: comparative morbidity of housed and homeless people 2013:382(s93) doi: [https://doi.org/10.1016/S0140-6736\(13\)62518-0](https://doi.org/10.1016/S0140-6736(13)62518-0)
2. O'Carroll A, O'Reilly F. (2008) Health of the homeless in Dublin: has anything changed in the context of Ireland's economic boom? European Journal of Public Health. Oct;18(5):448–53. doi: 10.1093/eurpub/ckn038. Epub 2008 Jun 25
3. O'Carroll A, Wainwright D. Making sense of street chaos: an ethnographic exploration of homeless people's health service utilization. Int J Equity Health. 2019;18(1):113. Published 2019 Jul 23. doi:10.1186/s12939-019-1002-6
4. <https://www.rte.ie/news/ireland/2018/0125/935886-a-state-of-emergency/>
5. https://www.who.int/docs/default-source/coronaviruse/transcripts/who-transcript-emergencies-coronavirus-press-conference-full-13mar2020848c48d2065143bd8d07a1647c863d6b.pdf?sfvrsn=23dd0b04_2
6. <https://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/#:~:text=HSE%20Social%20inclusion%20aims%20to%20reduce%20inequalities%20in,to%20support%20the%20following%20vulnerable%20groups%3A%20addiction%3B%20homelessness>

Homelessness health - Glasgow in Covid times

It has been fascinating, exhilarating, draining and just hard work being a GP in homelessness health in Glasgow during these past Covid months; mirrored in mainstream Deep End GP practices too.

I can't get past the emotions.

.... no knowledge of what the future brings, no sense of control, a feeling of impending doom, too many things coming at us at once, worries about how to cope....

Whatever it is we are feeling – as socially connected, comfortably off, high status professionals – is for most people a minor version of what many of the patients we care for are feeling.

This helps me re-remember two things about trauma-informed practice approaches – that are so vital in Deep End settings.

Emotional arousal levels may be very high for patients. Do not underestimate the power of connection, empathy and validation in the patient consultation (harder over the phone for sure). Find a positive aspect of what your patients have achieved and remind them of that if you can. That time spent drug free, that caring generous person who helps others in their supported accommodation, that amazing survivorship from a horrendous childhood, that brave journey to seek asylum in a new culture. It is powerful to hear from a trusted professional especially when little else gives hope.

Glasgow has done some wonderful things during lockdown and beyond to support people experiencing homelessness; a distillation of the motivation professionals and volunteers have for

working in this field. As widely publicised, en suite hotel rooms meant no one had to rough sleep, and astoundingly 'no recourse to public funds' was paused so this meant everyone was accommodated (1). Voluntary sector services quickly reshaped what they do to deliver food parcels, phones and vital medicines. NHS staff of all backgrounds became more flexible and entrenched ideas about service delivery were suddenly thrown into the air and seen anew. Some things were undoubtedly in the pipeline already – however, there is much more emphasis now on assertive outreach by the addictions and mental health teams, and much more emphasis on keeping in touch depending on risk concerns.

It has been very tough for people – as despite best efforts the hotels are not always safe, the housing allocation system ground to a halt and, with so many services being about phone or online contacts only, and so many restrictions about meeting people; the prevalence of loneliness, boredom and despair has been (and is) high.

This brings into sharp relief the old adage that homelessness is not just about rooflessness. It is about the experience of severe and multiple disadvantage over a lifetime for the vast majority of people (2) with the attendant scars, vulnerabilities and behaviours that follow; all adaptive, and often challenging with new ways of working required.

As we collectively ride the Covid second wave and look to the future, not only do we need to provide the physically tangible things a person needs - accommodation, income, food and heating - we also need to ensure that communities and organisations (3) ensuring social connectedness, recovery and hope are protected and supported. So alongside our work with individual patients we need to find the deep reserves of resilience to keep our campaigning going. I think collectively we can.

Andrea Williamson

1. <https://everyonehome.scot/>
2. <https://lankellychase.org.uk/resources/publications/hard-edges-scotland/>
3. <https://homelessnetwork.scot/housing-first/>



Welcome to Carey Lunan, folk singer, GP at Craigmillar Health Centre in Edinburgh, outgoing chair of RCGP Scotland and incoming chair of the Scottish Deep End Project.

PARLIAMO GLASGOW

For those interested in acquiring a second language here is an opportunity to practise Glaswegian, based on a poem by Tom Leonard written in phonetic Glasgow patter. To obtain the full effect, the poem is best read out aloud.

THE LIAISON COORDINATOR

Efturryd geenuz iz speel
iboot whut wuz right
nwhut wuz rang
boot this nthat
nthi next thing
a sayzty thi bloke
nwhut izzit yi caw yir joab jimmy
am a liaison co-ordinator
hi sayz oh good ah sayz
a liaison co-ordinator
jist whut this erria needs
whut wi aw thi unemploymint
inaw thi bevvyn
nthi boayz runnin amock nthi hoossyz fawnty bits
nthi wummin n tranquilisers
it last thiv sent uz
a liaison co-ordinator.
Summy wia digree
in f*ck knows whut
getn pyd fur no known whut thi f*ck ti day way it.

Tom Leonard (1944-2018)



Reproduced from "Ghostie Men" with the permission of the Tom Leonard Literary Estate (www.tomleonard.co.uk). See his Author page on Amazon for more brilliant stuff

YORKSHIRE/HUMBER



Deep End GP Yorkshire and Humber at 5 years – a personal reflection

I had been working as a GP in Airedale, just west of Bradford, for around 2 years when I got involved with setting up GP at the Deep End Yorkshire and Humber. Like many parts of the country, Airedale is an area of socioeconomic extremes. On one edge of our patch lies Skipton and Craven, reportedly the happiest place in the UK, and on another, Wharfedale, which hosts some of the most expensive housing in Northern England. I had completed most of my GP training in Keighley, a town closer to Bradford with a much more mixed socioeconomic outlook, and eventually took up a permanent position at Holycroft Surgery, located within one of the most deprived council wards in the UK.

As with many areas, travel across the Airedale locality and life experience, along with pretty much every other indicator of health and wellbeing, varies dramatically – an 8 mile journey can encompass a 10 year difference in life expectancy at birth for local inhabitants. However, it was not the abstract idea of health inequality and these statistical variations that got me interested in the Deep End movement. Rather, it was the shared experience of healthcare professionals working in areas of socioeconomic deprivation.

It was immediately apparent that our patients came with layers of problems and issues born out of a lifetime of disadvantage. Even something simple like a rotator cuff strain was rarely just a rotator cuff strain. How would you help get this better when the patient was working 12-14 hours a day as a carer on a zero-hours contract doing manual handling all day, did not have the money to take time off work, had the recovery rate of someone 20 years older due to a lifetime of stress and childhood trauma and struggled to remain motivated to exercise due to depression and having to look after her alcoholic partner?

It was also a period when I'd watched a procession of brilliant GPs move out of my practice in Keighley to work in leafier neighbouring areas, emigrate or become unwell and retire. One GP remarked to me: *"I spend a lot of my time doing social work and I just can't carry on being here until 8 or 9pm every day trying sort peoples' lives out. It's making me ill"*. It was around this time I read about GPs at the Deep End in Scotland. Graham Watt's swimming pool analogy really struck a chord.

Reading through the Deep End group's short papers made me realise there were others out there grappling with all of the problems I was seeing and that there was this vast well of wisdom

that I, a relatively newcomer, could tap into. It was also inspiring and energising to see this tough and vital work given recognition through academic and Government institutions.

From October 2015, we hosted a series of increasingly well attended meetings under the GPs at the Deep End banner. We decided that the areas we needed to address were Workforce, Advocacy (for GPs and people in the communities where they worked), Education and Research.

Things developed quickly. As well as the accumulated wisdom our of colleagues in Scotland and figures such as Julian Tudor Hart, we met amazing people like John Patterson, Laura Nielsen and the Shared Health, Focussed Care and Citadel Healthcare teams from Greater Manchester, who had set up primary care with the aim of tackling health inequalities at its heart and transformed lives across their communities in Oldham and beyond. Irish GP Austin O'Carroll inspired us all with the amazing North Dublin City GP Training Programme, which trains GPs to work with people living in areas of deprivation and with marginalised groups. Jonathon Tomlinson from Hackney in East London helped us learn about the role of trauma in peoples' lives and how GPs could help through "trauma informed care". Greg Fell, now Director of Public Health in Sheffield, has helped us focus on the role of public health in primary care and the evidence base for addressing health inequalities as GPs. Perhaps most importantly, GPs working in Yorkshire and Humber's major cities got to meet each other and share stories of how they'd helped patients living in communities with huge and, at times, seemingly insoluble challenges.

We set up the award-winning Fair Health website to share this collected knowledge and experience with GP trainees across the region and, now, nationally and internationally through e-learning modules, blogs and podcasts. We have "Trailblazer" training programmes specifically focussed on deprivation for GP trainees and new qualified First5 GPs. We have hosted a series of brilliant and motivated "health equity leadership" fellows in the School of Primary Care who have helped ensure every new GP in Yorkshire and Humber has received specific training around health equity and spent time out of the surgery in their communities.

In undergraduate education, Ben Jackson at the University of Sheffield has set up a programme of community based medical education around health inequalities. Liz Walton has set up a research network across practices in the city's most deprived communities, increasing patient participation in designing and enrolling in medical research, and also helped write up our experiences in the BJGP and other journals.

Increasingly, our Deep End colleagues are taking on senior leadership positions or becoming involved in advocating for change across the NHS in Yorkshire and Humber. We have been lucky enough to contribute to two books: *Tackling Causes and Consequences of Health Inequalities*; and *The Exceptional Potential of General Practice* (p21) which set out approaches to workforce development and curriculum delivery.

Yorkshire and Humber GPs at the Deep End cannot and would not want to take credit for all this amazing work. But it has provided a rallying point for enthusiastic GPs. We hope it has provided some inspiration and helped us learn from each other. Perhaps most importantly, the movement has raised the profile of some of the most challenging and important work in the NHS and made those people doing it feel a little less alone and a little more supported.

Tom Ratcliffe

GP AT THE DEEP END YORKSHIRE AND HUMBER – 5 YEAR REVIEW (2015-2020)

Workforce and Education Activity

	Workforce	Education
Pre-medical school	<ul style="list-style-type: none"> • SHOut: Sheffield Outreach - widening participation to medicine across South Yorkshire 	
Medical school	<ul style="list-style-type: none"> • MD: Integrating Advanced Clinical Practitioners into teams serving deprived communities. 	<ul style="list-style-type: none"> • Chapter on Teaching Social Determinants of Health in Teaching General Practice • Student Fair Health • Health Inequity Masterclass at UoS med school • Deep End Student Selected Components at UoS med school
Foundation		
School of Primary Care	<ul style="list-style-type: none"> • HEE leadership fellows • Innovative Trailblazer training posts for STGPs • Book chapters – Tackling Causes and Consequences of Health Inequalities; The Exceptional Potential of General Practice • Training capacity: audit of GP training practices in areas of deprivation (2016) • Learning needs assessment of Y&H GP trainees in relation to health inequalities (2016) 	<ul style="list-style-type: none"> • Award winning Fair Health website • Community placements for GPSTs • Social accountability • Regional and sub-regional training days • International training conference (Dublin – cancelled)
First5	<ul style="list-style-type: none"> • Trailblazer post-CCT fellowship programme 	
General CPD for GPs		<ul style="list-style-type: none"> • Webinar programme • Regional and national conferences (Wetherby 2016, Leeds 2017, Gt Manchester 2018, Sheffield 2018, Glasgow 2019)
Practice & PCN targeted education	<ul style="list-style-type: none"> • Deep End Workforce Fellows in SY&B ICS (completing survey of PCN CDs on addressing health inequities) 	

ICS / wider system targeted education		<ul style="list-style-type: none">• West Yorkshire Deep End education programme (funded by HEE)
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Advocacy and Research Activity

Research Publications

(a) Health Inequalities

Walton E. Book Review: The Inner Level: How more equal societies reduce stress, restore sanity and improve everyone's well-being. Richard Wilkinson and Kate Pickett. Br J Gen Pract. Sep 2019. DOI: <https://doi.org/10.3399/bjgp19X705377>

Payne K, Walton E and Burton C. Steps to benefit from social prescription: a qualitative interview study. Br J Gen Pract (accepted for publication 17 Aug 2019)

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Advocacy

- RCGP conference sessions x2
- Health at a Price: Reducing the impact of poverty, BMA June 2017
- Deep End meetings (Wetherby 2016, Leeds 2017, Greater Manchester 2018, Sheffield 2018, Glasgow 2019)
- Blogs – Fair Health reaction to Covid-19 and Trailblazer fellowship insights 2019 to present

CANBERRA



Canberra has so far managed to avoid many COVID cases and has been able to open up most health services and many businesses over the last six months. Government support for the many people hit economically by the pandemic continues, albeit at a reduced rate. Our Deep End services have largely adapted and are functioning using telehealth and physical distancing as appropriate.

Recently Deep End Canberra has been focussed on advocacy for disadvantaged populations, and for local general practices providing relevant care to them. In the lead up to our territory election in October we met with the local health minister's office to advocate for ways to improve access to quality primary health care for disadvantaged populations. The election saw

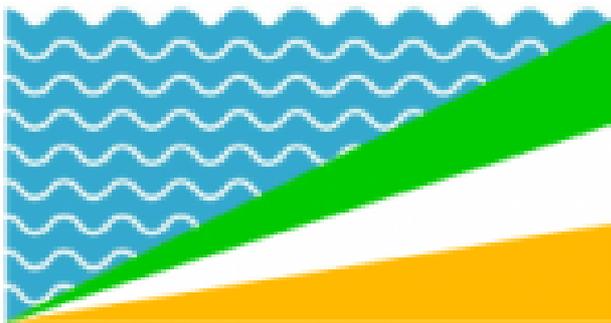
a return of Labour-Greens Coalition government with a large swing to the Greens – we will see whether this offers further opportunities for advocacy and reform as the dust settles.

We have been invited to work with Canberra Hospital to increase access to outpatient services for vulnerable populations. We have been able to adapt the evidence-based disadvantage screening tool tested for Canberra populations, developed by academic Deep End members over the last couple of years, into a streamlined version which can be used to assist outpatient triaging. We will seek out further ways to develop and extend this tool, such as in conjunction with our local primary health care network.

As our local DE group has matured and become more involved in advocacy we have had to consider who we are as a group when we speak out. We are a voluntary network which receives no funding or external support. We all work for various practices serving disadvantaged populations, but realise through DE we must speak not for our services (which could restrict what we are able to say) but as individuals with experience working with disadvantaged Canberrans.

We extend our solidarity to our Northern Hemisphere colleagues in this very difficult time.

IRELAND



GPs at the Deep End Ireland are still awaiting the outcomes of an application process for new Health Service Executive Urban Deprived GP Allowances and hopefully these will be announced shortly and will provide much needed additional supports for practices in these areas.

Dr Patrick O'Donnell was invited to speak on the ICGP Covid-19 Webinar series on management and support of patients from marginalised groups in relation to Covid-19. These webinars are attended by more than 1,000 GPs across the country seeking to keep updated on the many modifications happening in GP care at the present time.

The Link Worker RCT is ongoing. It has been a real challenge to recruit patients with multimorbidity during a pandemic but the practices and link workers have been working hard and we have now nearly recruited 200 patients across 10 practices in Dublin, Limerick, Cork and Waterford who are part of Deep End Ireland.

Case Study from the Link Worker RCT: Jody

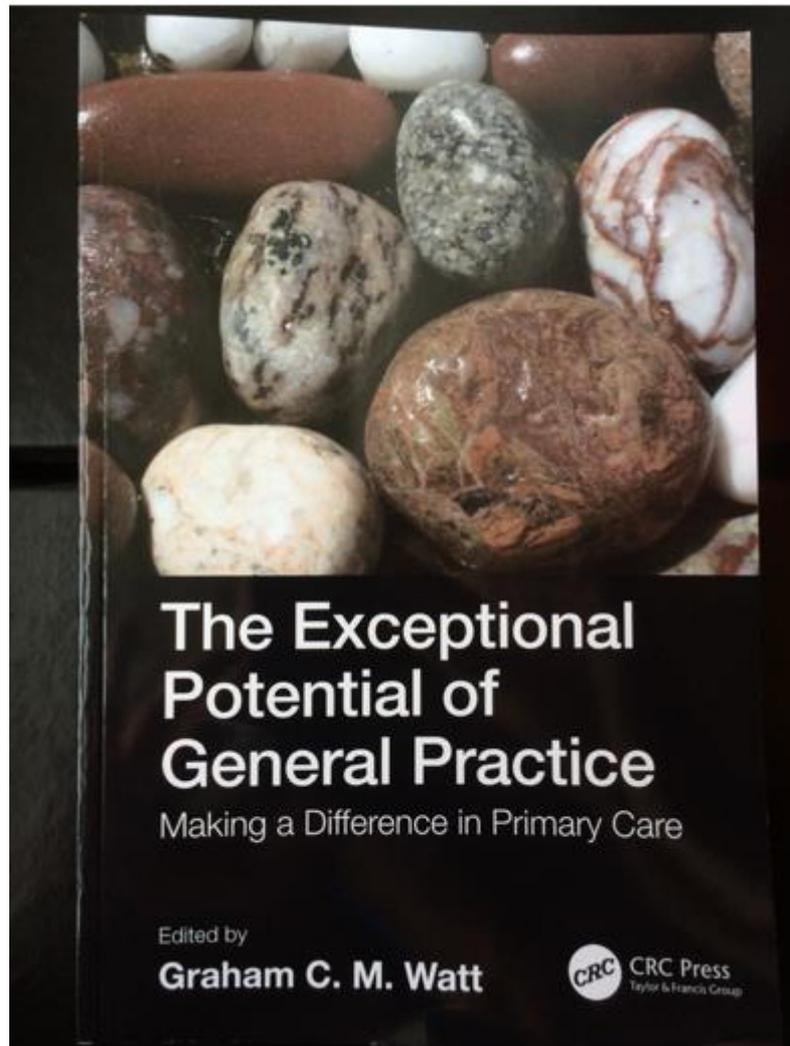
Jody is in her mid 50s and was very eager to meet with a Link Worker as she felt isolated and excluded from society. She is living with multimorbidity and appeared erratic within our first conversation. After 2 meetings Jody began to relax and feel confident disclosing information on her life.

We discussed Jody's living arrangements and she opened up about hoarding a lot of her possessions and continues to add more and how it now makes her feel uncomfortable. She wanted to discuss a plan on removing items that she no longer needed. Jody knew this would not be a quick fix and that we needed to deal with it slowly. The Link Worker encouraged her to go through each item, taking the time to consider its worth or value to her. Jody did this and was happy to have eventually removed items she did not need.

We discussed ways on supporting her to do this in a way that she felt included in society and decided upon a Car Boot Sale. Jody was encouraged to contact the local Car Boot organizers and she did. She was delighted that she arranged a date and a slot in her local Car Boot venue. She felt empowered that she had made the decision and made the contact herself. She has now done two Car Booth sales so far and is delighted with the extra money and the chats she's had with other people. The sales start very early in the mornings and Jody confided that she does not drink her usual bottle of wine the night before the sale and that makes her feel confident in addressing her alcohol intake going forward

Due to increasing COVID-19 restrictions the Car Boot sales have been suspended, however Jody is still de-cluttering and arranging items for sale when they reopen and is considering joining a class for upcycling furniture in the future. With the help of her Link Worker she is also learning how to make the best use of her Android phone by learning how to use Zoom and contacting her family.

ADVERTISEMENT



55 contributors from 11 countries including Stewart Mercer, Susan Smith, Tom Ratcliffe, John Patterson, Austin O'Carroll, Jan De Maeseneer, David Blane, Andrea Williamson, Iona Heath and Graham Watt.

"The Exceptional Potential of General Practice is an important academic resource for GPs who can use the huge number of academic papers quoted in it to underpin their practice and to argue for more resources in their areas."

Lancet Review

"a more illuminating constellation of contributions from GPs at the frontline, academics, and other health professionals who are seeking, through a variety of methods, to realise the exceptional potential that high-quality general practice can provide for those who it serves."



The pandemic has seen a new light shone on widening health inequalities in our population. COVID-19 cannot just be considered in terms of the spread of infection but also the social inequality and non-communicable diseases that underlie its transmission and effects.

The work the Deep End community does to unpick how the biological, social and economic interact will be crucial to positive long-term health outcomes.

Focused Care

Throughout the pandemic many people's lives have been thrown into chaos. On the ground the Focused Care team has stepped up, adapted, responded and continued to support vulnerable patients at this particularly difficult time. The number of patients supported by Focused Care Practitioners during lockdown up until the end of May 2020 exceeded 2,500. Many of these patients received our care for the first time. Our team has offered a service of practical and health support which has proved invaluable.

Additionally, Shared Health Foundation are piloting a variation of the Focused Care model to support families staying in temporary accommodation. In Greater Manchester, when families become homeless, they are often displaced far from their previous home, making it difficult to maintain existing primary care and support networks. Therefore, this service takes referrals from housing officers to rebuild this vital support.

As other services have moved online, become more difficult to access, or seized altogether, the work of Focused Care, to make the invisible, visible, is crucial.

Find out more about Focused Care's COVID-19 response [here](#).

I was referred a patient who was difficult to engage in the early stages and was quite combative when I went to the house following a series of failed encounters. As I rang through my list of patients, I called upon her. That

morning she'd had a medical episode and didn't have the equipment she needed. She was also running low on basic food. Together with a colleague, we managed to provide the equipment she needed and a small food parcel for doorstep delivery within an hour or so. That practical help when she needed it the most has led the way to her engagement with Focused Care.

Focused Care Practitioner



Focused Care Team March 2020

Infant and parent service

Shared Health are piloting a new service of psychological help for new parents based in a GP practice. Clinical Psychologist Dr Jen Davies has been supporting children to get the best start in life and helping parents to use the birth of their new child as an opportunity to bring about positive change in their lives.

GP training programme

The Deprivation-Focused GP Speciality Training Programme has entered its second year, welcoming six new trainees. Trainees have benefited from teaching sessions on safeguarding, homeless families, advocacy & campaigning, the benefits system and worked towards the RCGP Certificate in the Management of Drug misuse. One trainee has completed an exciting

new placement delivering primary care in a prison and further placements in substance misuse and psychiatric medicine have continued. A process of evaluation has begun which will sustain the programmes development and assess how effective it is as a strategy to reduce health inequalities.

The engagement of the trainees in work relating to health inequalities has been brilliant. They have been looking at developing a pathway of support into medicine for young people from disadvantaged backgrounds. It will be designed to guide people from primary school to medical school and include mentoring and work experience.

*The training programme especially in the Primary care setting has opened my eyes to the impact social isolation, childhood trauma, criminality, drug addiction, mental health and economic destitution could have on physical health; not only that but how and why these issues arise and most importantly the significant role of a GP in improving the Quality of both social, mental and physical health of local community. **GP trainee***



Dr John Patterson delivering teaching on the importance of letter writing for patient advocacy

The programme is looking to expand and as such will need new trainers. If you know of any GPs in the Greater Manchester area, not yet involved in a training programme, and who may be interested, please do get in touch on gpst@sharedhealth.org.uk.

Further contribution to medical education

Dr James Matheson, GP in Oldham and Shared Health's Deprivation Medicine Lead, has helped review the curriculum and reinforce Edge Hill Medical School's content on health inequalities, the social determinants of health and deprivation medicine in support of their strong commitment to addressing inequity and campaigning for social justice. Shared Health are now part of the medical school team designing and delivering core content to put deprivation medicine and social justice at the heart of mainstream medical schooling, which is really promising for the outcomes of the generations of doctors to come.

Shared Health have also been contributing to work at University of Cambridge's Health Inequalities research department. This includes research on screening for poverty and vulnerability in primary care, a review of evidence on interventions to reduce health inequalities in primary care and mitigating the effects on inequality of consulting at a distance.

Tackling Causes and Consequences of Health Inequalities: a practical guide was published in February 2020. Thank you again to everyone in this network who contributed.

RCGP Health Inequalities Standing Group

Dr James Matheson continues to chair the RCGP Health Inequalities Group. Alongside Deep End colleagues Gemma Ashwell, David Blane, Carey Lunan, '[General practice post-COVID-19: time to put equity at the heart of health systems?](#)' was published in BJGP. They write:

Yet, through this adversity, there is hope and opportunity: the pandemic offers a 'compassion window' of societal, political, and professional awareness and willingness to act, and general practice has a key role to play in putting equity at the heart of our health system renewal.

General Practice has shown an amazing ability to adapt to the current circumstances. We hope it can continue to implement positive change to tackle health inequalities.

If you would like to get in touch please email contact@sharedhealth.org.uk.

NORTH EAST AND NORTH CUMBRIA



GPs at the Deep End NENC

Despite the ongoing challenges of COVID-19, we are making good progress in establishing a Deep End network in the North East and North Cumbria (NENC). We are in the process of recruiting Clinical Leads to drive the development of our network. Dr Martin Weatherhead has been appointed to one of the Clinical Lead roles and we hope to announce two other

appointments very soon. Martin is a GP partner and a driving force in establishing the NENC Deep End network. We are also progressing our post-CCT Deep End Trailblazer Fellowships, with one Fellow confirmed and four further posts approved.

Over the summer, we held three well-attended webinars, which have helped to guide our network's priorities. We are co-designing our network with support from researchers from Newcastle University. Dr Claire Norman (GP Registrar and Extended Integrated Training Post Holder) is currently conducting in-depth interviews with primary care professionals working in our region's Deep End practices to identify their priorities and ambitions for our network. Claire is supported in this work by Dr Jo Wildman (NIHR NENC Applied Research Collaboration Health Inequalities Research Fellow) and Dr Sarah Sowden (NIHR/HEE ICA Clinical Lecturer and Public Health Speciality Lead). Data from these interviews is being used to identify pilot projects that will be launched in the new year. Early next year we will also host a series of workshops with GPs in our network to continue to share learning and continue to identify what needs to be done to better serve our communities.

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

NOTTINGHAMSHIRE



A chance reference on a tweet led to listening to Episode 14 of the [Fairhealth podcasts](#) where Jonathon Tomlinson talked about the role of GPs working in deprived areas and made reference to 'Deep End' Collaboration & Advocacy, and from this the idea of a Deep End Notts group started.

Along with this there was also the realisation that Covid-19 was further exacerbating inequities and that now was the time to 'bang the drum' about health inequalities in Nottinghamshire and wider. From this Deep End reference contact was made with Graham Watt and the process of forming a Notts Deep End group based on a quantifiable system for practice membership was started.

In Notts there are 17 practices with an IMD over 40 (13% of Notts practices), and contact was made with the practices to explore setting up a Deep End Notts group. Of the 17 practices 15 are represented by 3 primary care networks, and a Deep End working group has been established with representatives from the 3 PCNs (which has included CDs from the PCNs, a PM, and a GP fellow with an interest in health inequalities).

Virtual meetings have enabled regular meetings, and the main focus to date for Deep End Notts has been advocacy, work force and trying to build connections. We have taken every opportunity to raise health inequalities and have presented Deep End Notts at several meetings and are starting to make local connections. We have also developed a logo for Deep End Notts and have a twitter account @deependnotts. We look forward to being able to have a face-to-face meeting with all Deep End Notts practices.

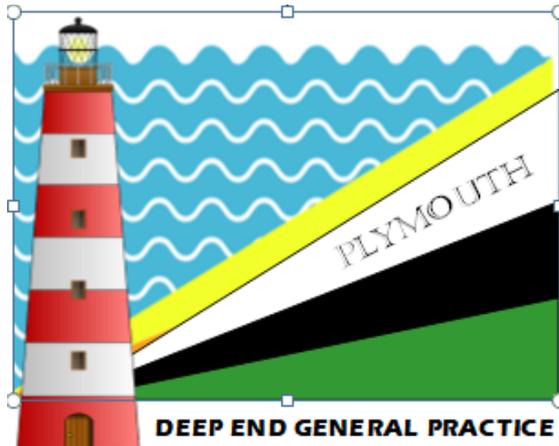
We were really pleased to work in partnership with the Phoenix programme on a successful local bid for Trailblazer fellows in Notts, and 5 fellows are in the process of being appointed on the scheme (3 in Deep End Practices). We hope the fellows will further connections with our health care allies and local community groups, and that they will continue to work in deprived areas and strengthen the workforce.

We were very grateful to be invited to the Deep End zoom meeting in July 2020. (p 5) It did feel like a 'gathering of the clan' and was great to feel such enthusiasm from everyone even over zoom! From the meeting we made contact with Dominic Patterson, and it was great to hear about the work in Yorkshire and Humberside (p 14), to discuss the Trailblazer scheme and now to be part of the Trailblazer fellowship scheme in Notts.

Sometimes positives come out of difficult times and formation of Deep End Notts has been one of the positive things to come out of the pandemic. We look forward to further progressing the work of Deep End Notts.

Helen Davies and Julia White

PLYMOUTH



These are some of the many things that the Plymouth Deep End (PDE) group has been involved in this year: we have summed it up in the acronym WEAR: – Workforce, Education, Advocacy and Research.

Workforce

Practices serving high deprivation communities struggle to recruit staff. Deep End groups, for example in Glasgow, have been able to create innovative posts and attract additional funding to get more staff. We have drafted a Fellowship scheme with the following aims:

Build individuals' interest, expertise and resilience to work in Plymouth Deep End practices - both in the short term and future (beyond the 2-year programme).

- Increase individuals' expertise and interest in additional specialist areas, as well as their leadership capability.
- Support the development of cultural change and enable Fellows to act as key role models to future doctors and health professionals.
- Contribute to the development and evaluation of new models of care including research and advocacy.

Education

Most of our practices take medical students from the Peninsula Medical School. We provide the only Pathway Week (part of the mainstream curriculum that all students go through) that is in primary care. The subject is complex needs and substance misuse, which used to be taught in secondary care.

We hope to develop other Pathway weeks, because most care for many conditions from diabetes to mental health is provided in general practice, so that is the best place to learn about it!

We also provide placements for nursing, occupational therapy and clinical psychology students.

There is good evidence that providing good quality clinical placements in areas of high deprivation increases the likelihood that students will consider working in similar areas or, even better, staying with us in Plymouth.

Advocacy

We provide the homeless outreach service in the city:

- Based at one of our Deep End Surgeries – so part of mainstream GP services
- Separately commissioned via CCG, via a competitive bidding process
- Doctors and nurses with special experience and qualifications
- Outreach clinics in homeless hostels and in probation
- We have very close links with all the “alliance services” that include the statutory and voluntary sectors in the city - including joint meetings and planning
- >300 patients on Methadone and Buprenorphine
- BBV screening and treatment programme
- Strong contribution to education and training

Research

The Deep End PL1 project funded by Devon CCG and conducted by Semiotic Intelligence is an in-depth qualitative study on the interface between hospital and community services by homeless/No Fixed Abode (NFA) patients.

Initial quantitative work demonstrated that homeless/NFA patients as expected have much higher rates of Emergency Department (ED) use and emergency in-patient (IP) stays than the neighbourhood average. However, the data also showed that these patients had nearly 6 times the rate of self-discharge from IP and 3 times the rate of incomplete care or Did Not Attend (DNA) at ED and planned outpatient appointments.

The study conducted detailed interviews with >40 homeless/NFA patients, >18 frontline hospital staff and > 16 community and GP organisations.

Findings included:

- Non-attendance due to low health expectations, unfamiliarity with health institutions and environments, perceptions of stigmatisation and personal shame; and practical challenges relating to travel and costs.
- Early discharge prompted by incompatibility between complex needs and the processes involved in acute service provision; including long waiting times, fear of withdrawal while attending, and general confusion and/or anxiety.

- Inappropriate presentation stemming from compromised access to relevant healthcare services, limited pathway links between care agencies, and the lack of alternative 'safe spaces'.
- Circular attendance pathways whereby patients present, self-discharge and re-present, culminating in deterioration of health, repeat admissions and spiralling of morbidity issues for patients and resource burdens for care providers in both community and acute settings.
- Limitations to data and coding for different categories of NFA/Addictions, and different types/numbers of attendance figures, which compromise transparent audit, quantitative research and subsequent responsive action.

Other research

The "remote by default" Covid-19 project.

- Funded by ESRC.
- Collaboration with Trisha Greenhalgh at University of Oxford.
- focus on the impact of remote by default on inequalities.
- reveal any positive and negative impacts on individuals living in poverty or with complex needs.
- working closely with the 'Deep End' group of practices and Devon CCG.

The Stonehouse "pop-up technology hub"

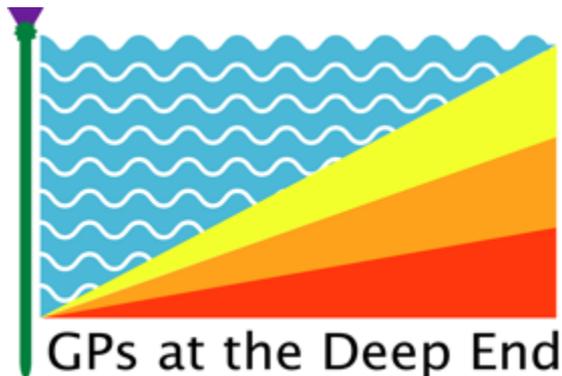
- collaboration between University of Plymouth, Nudge Community Builders, Plymouth City Council, Plymouth Community Homes, Crowdfunder and Adelaide St GP Surgery (Deep End Stonehouse).
- Received a UKRI Enhancing Place-Based Partnership award.
- building capacity in Stonehouse to make better use of health technologies, addressing digital and health inequalities and to contribute to future health technology research through collaborative working.

Overall, it has been an eventful year, overshadowed of course by the Covid-19 pandemic which has exacerbated the inequalities that led us to set up Plymouth Deep End.

Because of Deep End we have a voice, we are often asked to contribute to planning and, especially, to teaching about Deep End issues at both undergraduate and postgraduate levels. We presented our work recently to Dr. Nikki Kanani: Medical Director for Primary Care at NHS England and made sure that she was very aware of Health Inequalities, the inverse care law and the funding issues in England arising from the Carr-Hill funding formula!

Richard Ayres

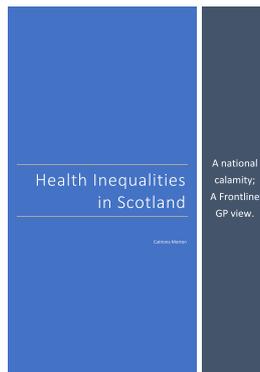
SCOTLAND



*There's a thread you follow. It goes among
things that change. But it doesn't change.
People wonder about what you are pursuing.
You have to explain about the thread.
But it is hard for others to see.
While you hold it you can't get lost.
Tragedies happen; people get hurt
or die; and you suffer and get old.
Nothing you do can stop time's unfolding.
You don't ever let go of the thread.*

"The Way It Is" by William Stafford

The Scottish Deep End Project steering group has been busy since the last international bulletin. We continue to 'meet' up quarterly and exchange our news and ideas in our altered world of a Covid landscape. New colleagues have joined the Steering Group and we are working more closely with Public Health Scotland. There are new reports added to the website including a remarkable piece about health inequalities by a GP colleague Catriona Morton (https://www.gla.ac.uk/media/Media_735435_smx.pdf). Her impassioned and accurate account of the origins and current manifestation of health inequalities in a Deep End community was not motivated by financial or personal reward to write but a lifelong commitment to improving the health and wellbeing of her patients. This piece sums up the spirit of a committed general practitioner working in a challenging environment.



General Practice has survived the initial shock of a pandemic having rapidly adjusted systems in primary care to implement online consultations, phone triaging and virtual assessments of medical presentations. But General Practice is left with an unfiltered workload, no natural break in the day and a reduced human interface in the consultation. I cannot pop upstairs in the health centre to speak to my Health visitor or District Nurse. The MDT meetings which are so vital for case management of complex patients – whether vulnerable children, frail elderly, someone who is struggling financially and with impacts on mental health – have ceased. The same challenges of availability and accessibility in daytime GP spill over to Out of Hours GP with a mismatch between two services that serve the same populations, are funded by the public purse but yet do not actively engage together over strategy, training and governance.

What is not being said in the virtual or phone consultation whenever it takes place affects DE patients disproportionately as they become the excluded unwell – worried but struggling to access services. Health literacy remains a very real barrier to health care and a common theme that must be addressed by any innovative solutions to minimise the exposure of Covid-19 to patients and staff. This must be one of the biggest challenges for the GP profession as it moves forward.

Finally, on a personal note, my time as chair of the DE group is coming to a close after 3 fantastic years. I have been with the DE steering group from the start and it has been a privilege to chair the group although it was initially daunting to inherit the role from Graham Watt whose energy and commitment inspired the DE project and who has ensured a fitting legacy for Julian Tudor Hart's work. Carey Lunan will take over the role as Chair in January 2021 and Carey will bring her considerable experience as a DE GP and as outgoing Chair of RCGP Scotland to the DE group. There will be exciting times ahead for the DE group under Carey's leadership as we aim to connect with all practices across Scotland and build the international DE movement.

The NHS in Scotland is the common thread that the DE holds onto. It binds a rich tapestry of life experience, human endeavour and compassion through strong connections but it's sometimes difficult to see the whole picture beyond our own small patch. Now more than ever we must strengthen those connections and not allow the threads to fray and break.

Anne Mullin



BOOK REVIEW

This book review by Sonja Hunt of the former Research Unit in Health and Behavioural Change at the University of Edinburgh has survived much longer than the book it reviewed.

THE PSYCHODYNAMICS OF MEDICAL PRACTICE: UNCONSCIOUS FACTORS IN PATIENT CARE

Howard F Stein, University of California Press, London, 1985, £14.50

The Scene : A doctor's surgery somewhere to the northwest of Edinburgh. It is 9 o'clock on a Monday morning. Beyond the bars on the window behind where the doctor sits can be seen several concrete housing blocks, some with boarded windows. Occasionally, a blue plastic garbage bag (perfectly designed to both hold litter and to be litter and thus simultaneously improve services and create jobs) blows past the window. It is, of course, raining but through the sodden air there can be discerned the words *F*** the Queen* sprayed rather artistically in carmine red across the door of the community centre.

The door opens and a woman comes in. In spite of the cold and wet she is wearing a thin cotton dress and a short nylon jacket. There is the suspicion of a bruise under her left eye. Her legs are bare and sturdy.

Doctor: Good morning Mrs McTavish.

Mrs M: Good morning doctor.

Doctor: What seems to be the problem?

Mrs M: It's me nerves again, doctor, ken? I'd like some more of those blue pills.

Doctor: And I wish I could oblige you Mrs McTavish but I've just returned from a weekend seminar with Dr Stein and I've learned that my former desire to tranquillize you represents a countertransference of my deep-seated anxiety and inability to deal with my own feelings of being overwhelmed by the denial of my repressed humanity.

Mrs M: Och, weel. It's ma man, ken, doctor? He's out of work again an' the bairns bother him, ken, an' the walls are running wi' damp. Ah dinna think ah can cope, ken?

Doctor: Try to see my point of view, Mrs McTavish. My former rejection of your existential condition was externalized in inappropriate prescribing behaviour, which is, in itself, an instance of culturally institutionalized countertransference. It represented the negation of a persistent unconscious message transmitted by projection of my own frustration.

Mrs M: Och, weel, ah see. It's no catching is it? Ah cannae afford to tak time off now, ken? If ye could just write the prescription doctor.

Doctor: Don't you realize, Mrs McTavish? I'm trying to repair the cartesian split that deceived me into once regarding you as piss-poor protoplasm. That was when I refracted reality through the prism of projection to satisfy my own hidden needs. I understand now that my flight from empathy into a detached pseudo-objectivity attests to my involvement with its compensatory opposite.

Mrs M: Weel, the police have been round to see our Jack again, ken? An'ah'm not quite right yet from when ma man kicked me downstairs, ken? So if ye wouldn't mind doctor....

Doctor: Please appreciate my position Mrs McTavish. Acknowledgment of the inevitability of countertransference diminishes the distance between clinician and patient allowing the philosophical issue of human suffering to return to the centre of Medicine. My terror of being eaten alive by you generated an autistic response and my unconscious fantasies, interpreted through a distorted subjectivity, led me into acting out the omnibenevolence of the scientific healer.

Mrs M: Ken? Our Maggie's running wild w' that gang and yesterday ah found one o' them needles, ken? On the floor in the bathroom. Ah'm at me wit's end.

Doctor: Mrs McTavish, it is important that I recognize that my need to control disorder and disease is merely a manifestation of my fear of chaos and my compulsion to control my own undesirable impulses and thus gain the approval of my parents. Through you I can redeem my buried self, restore the lost mother-infant unity and protect my tormented ego.

Mrs M: Weel. Ah dinna want to keep ye doctor. There's a lot of people in the waiting room, ken? If ye could just gimme a few to keep me goin'.

Doctor: Look, Mrs McTavish, my medical education did not prepare me for understanding countertransference phenomena, instead it taught me to perpetuate distorted reactions to mutuality situations and facilitate the transition to bio-medical solutions by emphasizing autonomous individuality at the expense of emotional analysis. In reality, I am no better prepared for this encounter than you are. Writing prescriptions was a device to bolster myself against separation anxiety enabling me to foster the illusion of omnipotence, engage in fleeting catharses and protect myself from the merciless rage of a superego confronted with clinical failure. Now I am trying to take a psychodynamically-informed contextual view of the complementarity inherent in the functional relationships implied by the interpretive mode and thus avoid secondary gain.

Mrs M: Och, weel. Ah must be away, ken doctor? Mebbe one of your partners...

Doctor: Mrs McTavish, come back we're just beginning to have a meaningful therapeutic communication....

***** CURTAIN *****

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NORTH WEST LONDON LOGO



Chad Hockey explains the new logo for the Deep End in North West London featuring the London Plane Tree.

“It is an immigrant, a hybrid, going back to the age of the plant explorers and apothecaries and emerged on the embankment near the Chelsea Physic garden, which is integral to the history of UK general practice. It is ubiquitous on the streets of London but goes unseen, it cleans our city's air but does so without fanfare, it has adapted to its life on our streets, learned to cope with the pollution.”

OTHER NEWS FROM LONDON

Health Equity for Doctors and Patients in North East London

In September 2020 'soft' conversations started in the [RCGP North East London Faculty](#) about spearheading a movement for equitable health for doctors and patients based on Deep End principles of support, learning, improvement and advocacy.

The Faculty covers thirteen Boroughs and includes areas of significant racial, ethnic and social diversity. It also has areas which are some of the most disadvantaged in the England where patients [consult more often](#) and where children grow up breathing the worst [air quality](#) in London. Many areas have been significantly affected by COVID-19.

The Faculty's mission is that it is a place where we care for doctors and patients. We have established collaborative relationships with NHS partners in North Central and East London around restoring cultures of gratitude; initiated scholarships for climate justice; and taken a stand on Black Lives Matter, fossil fuels and working internationally in the realm of human rights. And interest has grown in our Faculty.

Prompted by conversations with Chad Hockey in NW London and an opportunity to access a [Deep End Learning](#) and [Quality Improvement System Redesign](#) platform in West London, a position paper was brought to the Faculty Board with a vision for facilitating conversations to support leadership for health equity, building on the relationships already established in the Faculty. We have focused on [virtual face-to-face dialogue, trust building, and the development of commitment and shared understanding focusing on "small wins" that deepen trust, commitment, and shared understanding](#).

We have done this through an informal virtual, short life, thoughtful group which has GPs from each of the thirteen Boroughs who are committed to health equity. Some of these GPs have other roles in NHS Commissioning, Health Education England, both medical schools in the Faculty and in the NHSE Appraisal system. We have embraced all interested GPs including GPs who are not members of the RCGP.

Funding has been identified in some Boroughs to fund Health Equity Leads for a six-month period to cover GP time to harness the learning and QI platform and to bring this learning into conversations for health equity in their respective areas. Two out of thirteen boroughs have agreed to fund Health Equity leads: one GP has been funded for Newham and four for City and Hackney. These Health Equity Leads will be supported through a leadership action learning set with the aim of shaping a convention in February 2021. We hope to share the Deep End learning topics through support platforms established since Covid-19.

Conversations have started about [Marmot informed Primary Care Network](#) (PCN) data that captures the lived experience of clinicians and patients. There has been an initial exploration of reframing of safeguarding roles to focus on trauma informed care with localised PCN data to enable relationship building between GPs and Social care, police and other services. These roles, although resourced and centrally legitimised, are in reality frozen in governance, rooted in blame and weak on building local data and relationships.

We in our society do not know how to acknowledge, to measure the contribution of an ordinary working doctor. To take measure of a person doing no more and no less than easing – and occasionally saving – the lives of a few thousand of our contemporaries. To fully take the measure of it, we have to come to some conclusion about the value of these lives to us now’ [John Berger 1967. A Fortunate Man – The Story of a Country Doctor](#)

The overall aim is to build courageous system leaders who are informed by health equity and who can support the RCGP and our local NHS Partners in the retention of GPs and multi-disciplinary teams through an improvement of their lived work experience.

Dr Liliana Risi

Provost RCGP NEL Faculty

Contact: LRISI@nhs.net

OUTER NW LONDON

We are GPs working in deprived areas of outer NW London, at the initial UK epicentre of COVID. Apart from our clinical work, Amisha was spearheading her street mutual aid group and I was taking my students for walks to demonstrate the stark socio-economic divides in our communities. We experienced directly how important it was to have strong communication with other health, social, and third-sector organisations, and were looking for an accessible community of practice to build on this. These conversations led to us connecting practitioners, helping link medical students to electives on inequalities, and gaining interest from neighbouring Deep End groups in working together.

Our first Deep End event was at the end of October as part of RCGP NW London’s education series. Dr Anne Mullin and Dr David Blane eloquently described the origins and evidence from the Scottish Deep End project. Dr Dana Beale and Dr Natalie Miller, who run Great Chapel Street Medical Centre (a practice for homeless people) showed how they responded to the pandemic by reaching out to local authorities. They achieved incredible outcomes by mobilising people and trying out practical solutions rather than waiting for ideas. The audience were inspired by all of the speakers’ work.

Next, we aim to develop an active group of like-minded colleagues across the community. A key feature of our population is multi-ethnicity and one of the attendees at the inaugural event expressed interest in this. We have both been appointed co-clinical leads for domestic violence in our respective areas, which should lead to further holistic working. Together we will realise ideas for support, advocacy, education, and research. Inequalities and the challenges in dealing with them have no boundaries, so where possible we aim to share widely, be responsive, and keep events open to all interested.

Amisha Babla and Camille Gajria **Contact: deependONWL@pm.me**

VIEWS FROM ABROAD

LIFE IN ACADEMIC GENERAL PRACTICE IN AUSTRALIA

Liz

Sturgiss

Australia has, overall, had very few cases of coronavirus and low numbers of deaths. There are probably many factors contributing to this fact, with relative isolation on a large island not being the least of them. Australia closed its international borders early in 2020, and our Prime Minister has recently warned the population that they are likely to remain closed throughout 2021. Small numbers of international travellers are being accepted each week with strict hotel quarantine in place in most states.

I was involved in an [editorial for the International Journal for Equity in Health](#) which outlines the response of countries to the pandemic with a focus on socially disadvantaged communities. This was written prior to the second wave in Melbourne which resulted in the lockdown of the city. The city managed to reduce cases from over 700 per day, to less than 5. It was an achievement based on the population largely complying with severe restrictions on work, schooling and movement. The editorial is an interesting read with common issues across many countries in the world.

The recent cases in Australia have highlighted the gaps within our social system – for example, those people working in “casual” jobs without sick pay or job certainty, were at higher risk. This was particularly evident in cleaning staff and security guards who were all involved in the outbreaks of cases from hotels looking after international travellers. Our most essential workers in the pandemic, have also been the most at-risk due to job conditions, higher use of public transport, and sometimes more crowded living conditions.

As seen in many countries, our aged care sector has been particularly affected. Aged care has had funding reductions over the past decade resulting in fewer registered nurses and more reliance on casualised, lay assistants. A lack of personal protective equipment added to the perfect storm. At the height of the second wave, more than 3500 healthcare workers were infected in Melbourne and at times this was 20-25% of the new daily cases. Many of the healthcare workers were from the aged care sector.

Housing has been a key factor for socially disadvantaged populations. In the Melbourne wave, people who were infected lived with on average many more people than the state average for households. It really hit home for me when government advice stated that people with COVID should have a “separate bedroom where they can recover without sharing an immediate space with others” and should use their own bathroom. This was not something I could achieve in my own Melbourne home and my patients living in crowded public housing apartments were even less able to follow this advice. My friend and colleague Dr Jason Agostino was intensely involved in the response of Aboriginal and Torres Strait Islander communities and housing was identified as a critical issue. We authored a blog on housing that might be of interest to the Deep End community – [“For pandemic control, housing is the best medicine”](#).

Watching the healthcare response unfold in Australia, I have been disappointed at the lack of coordination between primary and secondary care. Perhaps my surprise is naive. The default position has been hospital-centric and excludes the community health sector. It has been disheartening to see the reluctance of public health physicians and policy makers to include general practice in the COVID response. It has been frustrating to see little understanding of how and why general practice works, and therefore programs are put in place that don't draw on the strengths of primary care. The pandemic has really shone a spotlight on all the cracks in every system.

Personally, I have moved with my husband and kids back to live with family in Canberra. We decided to do this when the internal state borders of Australia closed and we would have been separated from family. We have only lived in Melbourne for 12 months and we had the intense feeling that we had been "locked on the wrong side" of the border. It has been a humbling, and at times anxiety provoking, experience. I did not imagine I would ever drive through military borders and have to apply for travel documents within our own country. It is not something I am going to forget in the near future.



Graham Watt and Liz Sturgiss at the International Conference on Quality in Primary Care in Toronto, November 2019

HET STORMT IN DE GEZONDHEIDSZORG

Jessica Fraeyman

(Translated as 'stormy weather', referring to turbulent times in health care these days in Belgium due to the Covid-pandemic. Everyone is affected, but differently)

Towards more capitation

We were already convinced that the capitation system is a good way of financing integrated primary health care, but the Covid-19 crisis has highlighted the essential qualities of the system.

Community health centers (which work on a capitation basis) very swiftly made the switch to a different organisation of care, more telephone consultations, more triage of health care questions by the receptionist and engaging staff in contacting those patients who disappeared from the radar (the unworried unwell). All this without losing any income, adapted to the needs of the population they serve and no rigidly slow fee-for-service administrative system that needed a new 'classification in the list of services' in order for general physicians to prescribe without losing income.

For some of you this might be 'business as usual', but in Belgium only 5% of patients have access to capitation-financed primary health care. We already knew the advantages, now many others have – hopefully - realised the need for change.



Keep looking people in the eyes

Since March 2020, many social workers from all regions saw the same problem in their neighbourhood, social services closed their doors, switched to telework and as such minimized their accessibility. For some clients, the consequences were harsh.

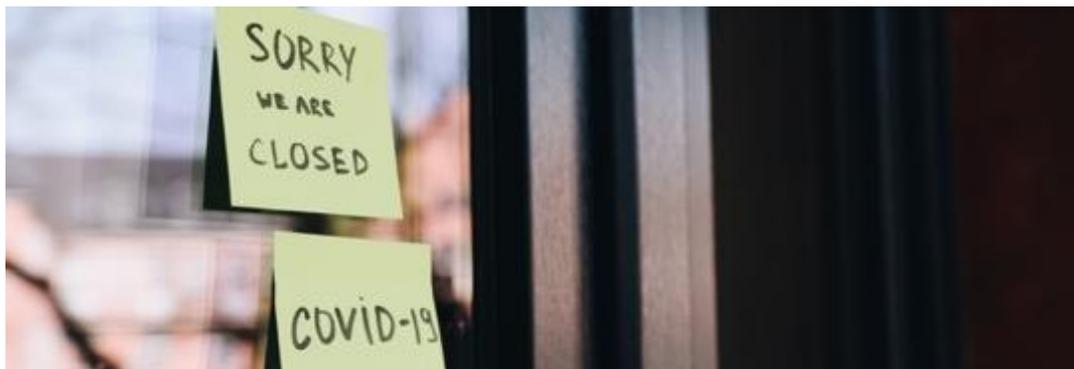
"Ilya knows how it feels. She has been working in catering for a long time. The corona-crisis caused her to lose her job and apply for an unemployment"

fee. She had never done it before. She had to wait 3 hours on the phone. When she finally had someone on the phone, she has to hear someone would call her back. The colleague that was qualified for this issue was working from home and could not be reached at the time. For Ilya, this uncertainty was unbearable, she got ill and called the community health center.”

They say we are all in the same situation, the same boat, in the corona-storm. The truth is more nuanced, some face the storm in a luxury yacht, others in a soap box with improvised oars.

“Norbert has been ill for a long time. At the beginning of March, he received an invitation for a meeting with the advising physician from the sickness fund to start the re-integration process. Norbert was pleased he could finally look forward to getting back to work. Unfortunately, the appointment was cancelled. He had to wait 6 long months for a new invitation.”

All social workers from the community health centers call out to their colleagues from all kinds of social services to be creative, to find ways to maintain a certain level of physical accessibility and to keep looking people in the eyes! Because this is so essential for so many.



Note: Jessica Fraeyman, who led the Belgian visit of primary care workers to Glasgow in March 2020, works for the association of community health centres in Flanders and Brussels.

ADDRESSING SOCIAL NEEDS IN A PANDEMIC ST. MICHAEL'S HOSPITAL ACADEMIC FAMILY HEALTH TEAM, TORONTO, CANADA

Gary Bloch, Noor Ramji, Deborah Kopansky-Giles and Katie Dorman

The COVID-19 pandemic brought social and health inequities into stark relief. Challenges to health posed by poverty, racism, a lack of adequate housing, and insecure employment quickly became evident to front line health providers. The lockdown exhausted many patients' social supports, and they were left struggling to maintain housing and find adequate food.

Primary health care teams, while central to helping individuals maintain their health and wellbeing, also felt the impact of the lockdown. The St. Michael's Hospital Academic Family Health Team (SMHAFHT), which serves 50 000 rostered patients in downtown east Toronto, was forced to rapidly reduce its in-person clinical services to a fraction of previous levels.

SMHAFHT's health providers immediately recognized the need to ensure their most socially marginalized patients were not lost to the pandemic response. The team is a national and global leader in creating innovative primary care models to address the health and social needs of socially marginalized patients. This work, coordinated by a [Social Determinants of Health \(SDOH\) Committee](#), has been integrated into a sophisticated infrastructure of leadership in education, research, and quality improvement.

A SDOH-COVID Working Group was created within two weeks of the World Health Organization's declaration of a pandemic, to ensure patients' health and social needs would not be neglected. This group aimed to apply a data-informed health equity lens to clinical operations, teaching, research, and quality improvement, while coordinating initiatives to address social needs and engaging the broader community in care provision and advocacy.

The SDOH-COVID Working Group's approach addressed three major priorities: individual patient needs, equity assessments of health team operations, and social policy advocacy. Here's how we did it:

Individual Needs

Patients were systematically identified for Wellness Check-ins using electronic health record searches and outreach to primary providers. Nurses, resident physicians and other staff conducted over 2000 checks from March to August 2020. They identified patient health and social needs and connected them to team and community resources.

The Working Group also developed a robust real-time resource known as the [Marginalized Populations and COVID Resource Drive](#). This set of documents, accessible to health team members, contains a list and description of local social support agencies and programs, and is updated on a regular basis.

The team's income security-focused health promoters supported over 70 patients with income-related concerns. Some patients received grocery cards and other necessary items such as cloth masks, phones and tablets.

The working group also created a COVID-19 Management toolbar in its electronic health record to provide FHT providers with one-click access to social resources for patients. Wellness Check-ins are now integrated into routine nursing workflows.

Equity Lens

The Working Group ensured a focus on equity at FHT operations and leadership meetings. Through a real-time equity-focused review of clinical operations, and regular consultation with leadership, the needs of the most socially marginalized patients were kept at the centre of

pandemic planning.

A lived experience perspective is essential to ensure patients' social needs are identified and addressed. The FHT's Patient and Family Advisory Council provided substantive input in shaping the team's SDOH-oriented initiatives and helped the FHT to develop mechanisms to communicate resources directly to patients.

Community Support

The Resource Drive was made publicly available online to help other health teams and community providers. The Wellness Check-in protocol was shared with other Family Health Teams and working group members supported the development of an Ontario [provincial tool](#) for the identification and management of social needs during COVID.

The team also created partnerships with COVID recovery sites for people experiencing homelessness to connect persons in need of a primary care team to ongoing care.

Social Policy Impact

COVID highlighted significant gaps in social support programs, such as income security and housing and systemic contributors to social inequities, such as racism. In order to ensure the social policy response to these issues was informed by health expertise, FHT members engaged in social policy commentary and advocacy, including a press conference on paid sick days, community actions on anti-Black racism, petitions advocating for basic income, and targeted initiatives to support indigenous health.

COVID-19 offered a perfect test of the ability of a social needs-oriented primary care team to draw on its expertise and non-hierarchical collaborative capacity to address urgent social risks to health. Through a multi-faceted, and multi-level response, the St. Michael's Hospital Academic FHT leaned on existing infrastructure for intervening in social determinants of health to address the specific needs of socially marginalized patients and community members.

- Gary Bloch is a family physician and co-Chair of the SMHAFHT's SDOH Committee;
- Noor Ramji is a family physician and the SMHAFHT's quality improvement lead;
- Deborah Kopansky-Giles is a chiropractor and co-lead of the SMHAFHT's interdisciplinary health committee;
- Katie Dorman is a family physician with the SMHAFHT.

OVERLEAF

Finally (next page), there is the summary of a MSc dissertation by Caitlin Whyte, a student at Strathclyde University, looking at the Scottish Deep End Project from a management change perspective. She characterises Deep End GPs as "institutional entrepreneurs" and "political navigators" – concepts that may prove useful in future discussions of Deep End strategy, leadership and advocacy. Full report at :- https://www.gla.ac.uk/media/Media_665716_smxx.pdf

'POLICY PIONEERS: NAVIGATION OF COMPETING LOGICS BY INSTITUTIONAL ENTREPRENEURS IN ADDRESSING HEALTHCARE INEQUALITIES IN SCOTLAND'

C Whyte BA (Hons)

The study is driven by the following research questions:

1. What are the forms of institutional work undertaken by actors in a micro-foundational policy initiative?
2. How do these manifest themselves as strategies which support navigation of competing objectives?

Research Context and Methods:

This study explores the case of the GPs at the Deep End project, a micro-foundational healthcare initiative driven by frontline and academic General Practitioners (GPs) with the objective of narrowing healthcare inequalities in Scotland. The study presents a single case study, triangulating interview, archival and observation to explore the forms of institutional work carried out by micro-foundational actors within the initiative and forwards a model of strategic directions to manage tensions in a pluralistic institutional field.

Theoretical Background:

Institutional work carried out by institutional entrepreneurs can be understood as the alteration or complete transformation of already well-established institutions that may be resistant to change as a result of their embeddedness in a particular field (DiMaggio, 1988). Prior literature emphasises that this behaviour is commonly the product of managing tensions between different stakeholder groups. Institutional logics is an example of this work which sees actors navigating the pluralistic dimensions that are within their field.

Findings:

Through analysis of incidents of institutional work carried out by the Deep End project, two aggregate dimensions emerged that pertain to two key sets of behaviors.

The first being the anatomy of the Deep End project which is characterised by its flexibility, adaptability and the fact that it is driven by micro-foundational or 'on the ground' actors. These behaviors refer to the design and ethos of the project that has allowed it to spearhead innovative ideas as a result of its autonomy from the medical political system.

The second dimension of behaviors is the careful navigation of the wider political system. This behavior is characterised by themes of political shrewdness, unconventional resource acquisition and legitimacy leveraging. These are the forms of work that have been undertaken by the Deep End as they attempt to navigate the political system whilst simultaneously pursue their own goals.

These behaviors were found to be the result of the competing logics within the field that the Deep End operates between the Deep End and the wider political system.

The study found that the Deep End adopt a hybrid strategy to manage these competing logics, suggesting that an autonomous strategy has a finite lifespan before integration with other institutions is inevitable. The hybrid strategy allows the Deep End to maintain its revolutionary nature by being flexible, adaptable and led by micro-foundational actors whilst also integrating with the political dimension in order to access resources and opportunities to address healthcare inequalities.

References: DiMaggio, P. (1988) 'Interest and Agency in Institutional Theory', in Zucker, L. (eds.) *Institutional Patterns and Organizations Culture and Environment*. Massachusetts: Ballinger Publishing, pp. 3-21.

1.the forms of institutional work undertaken by actors in a micro-foundational policy initiative?