Key lessons from 10 years of the Scottish Deep End GP project

Dr Anne Mullin  
Chair, Deep End GP Group in Scotland  
Dr David Blane  
Academic lead, Deep End GP Group in Scotland

27th October 2020
• Deep End context and background

• Key lessons
Health inequalities = “shorter lives in poorer health”

Inverse Care Law = “lack of time to address needs”

GPs at the Deep End = “blanket deprivation”

Patients in 15% most deprived areas

“Deep End” practices = top 100 most deprived
‘Inclusion health’ in mainstream practice

“A research, service, and policy agenda that aims to prevent and redress health and social inequities among people in extremely poor health due to poverty, marginalisation, and multimorbidity”

Aldridge et al 2018

“By excluding exclusions and building relationships, inclusive health care is a civilising force in an increasingly dangerous, fragmented and uncertain world”

Watt et al 2019
**ISSUES AFFECTING DEEP END COMMUNITIES**

Unemployment  
Benefits sanctions  
Cuts to services  
Drugs and alcohol  
Child protection  
Migrant health  
Vulnerable adults  
Bereavement

**KEY POINTS ABOUT DEEP END ENCOUNTERS**

Multiple morbidity and social complexity  
Shortage of time  
Reduced expectations  
Lower enablement  
Health literacy  
Practitioner stress  
Weak interfaces

---


Since 2009…

A lot, quickly and cheaply

- Identity
- **Engagement**
- Profile
- Voice

Phase 1  Meetings
Phase 2  Publications, Presentations and Profile
Phase 3  Opportunities, Influence, Resources
Phase 4  Implementation, Lobbying

Projects  Govan SHIP, LINK Workers, Care Plus, Benefits, Alcohol, Pioneer Scheme
DEEP END REPORTS

1. First meeting at Erskine
2. Needs, demands and resources
3. Vulnerable families
4. Keep Well and ASSIGN
5. Single-handed practice
6. Patient encounters
7. GP training
8. Social prescribing
9. Learning Journey
10. Care of the elderly
11. Alcohol problems in young adults
12. Caring for vulnerable children and families
14. Reviewing progress in 2010 and plans for 2011
15. Palliative care in the Deep End
16. Austerity Report
17. Detecting cancer early
18. Integrated care
19. Access to specialists
20. What can NHS Scotland do to prevent and reduce health inequalities
21. GP experience of welfare reform in very deprived areas
22. Mental health issues in the Deep End
23. The contribution of general practice to improving the health of vulnerable children and families
24. What are the CPD needs of GPs working in Deep End practices?
25. Strengthening primary care partnership responses to the welfare reforms
26. Generalist and specialist views of mental health issues in very deprived areas
27. Improving partnership working between general practices and financial advice services in Glasgow: one year on
1) Advocacy
2) Evidence
3) Service development
4) Professional development

www.gla.ac.uk/deepend
‘Whole career’ approach

- **Getting ready** (e.g. REACH programme)
- **Getting in** (e.g. selection process, GAP)
- **New GP curriculum**
  - Increase quantity and quality of time in general practice (e.g. COMET) **8 to 25%**
  - Social determinants
  - Inter-professional learning
- **Tailored GP training** (e.g. North Dublin, Greater Manchester)
- **Protected time!**
- Fellowship schemes
- **Coalition of learning** (e.g. WoS early career GP DIG)
- PBSGL, peer support

- **Widening access**
- **UG teaching**
- **PG training**
- **Lifelong learning**

“Key ingredients” of the Pioneer scheme

- **Additional** clinical capacity.
- **Released time** of experienced GPs for service development.
- **Protected time** for Fellows for tailored day-release curriculum and service development.
- **Peer support**.
- **Engagement with others**, including students, policy makers.
- **Shared learning** across practices.
- **Shared ethos and values**.

1. Inverse care law manifests as **lack of time and resource** in disadvantaged areas

2. Particular issues (e.g. premature multimorbidity) in areas of ‘**blanket deprivation**’

3. First step is **engagement with practitioners**

4. GP Recruitment and retention issues require a **whole-career approach**

5. Need **protected time** for professional and service development – **particular needs** in Deep End (e.g. trauma-informed care)
Lessons from Links Worker Programme

• High % of consultations related to social adversity
  • Poverty, violence, trauma, addictions, etc.
• Lack of time / barriers to accessing community resources
• “Fully integrated” practices:
  • More collective leadership
  • Enabling team relationships
  • Continuity of CLW support
  • More engagement in practice development
• More proactive community networking
Lessons from Links Worker Programme

- “Key ingredients”/capacities to develop in primary care teams:

  1. Team wellbeing
  2. Sharing learning
  3. Awareness of social context
  4. Intelligence/knowledge management
  5. Signposting
  6. Problem solving
  7. Network building

GP stress → “less empathy = less enablement”

1. Extra TIME for consultations (INVERSE CARE LAW)

2. Best use of serial ENCOUNTERS (PATIENT STORIES)

3. General practices as the NATURAL HUBS of local health systems (LINKING WITH OTHERS)

4. Better CONNECTIONS across the front line (SHARED LEARNING)

5. Better SUPPORT for the front line (INFRASTRUCTURE)

6. LEADERSHIP at different levels (AT EVERY LEVEL)
Shared ethos and values

Social Inclusion
We actively promote a socially inclusive society where all people feel valued, their differences are respected, and their basic needs are met so they can live in dignity. We do this through service provision in areas of severe socio-economic disadvantage and through a commitment to professional and service development that supports marginalised groups.

Advocacy
We believe the evidence base that health is socially determined. To address the early death and illness burden in our patients those involved in this scheme will advocate with vigour on behalf of those patients affected by social inequality.

Commitment to Excellence
We recognise the importance of basing our clinical decisions about our patients on the best available current evidence. We value learning as a process that we engage with throughout our medical career. We have a holistic educational philosophy that promotes developing clinical skills and knowledge; effective communication skills; personal and professional development.

Respect and Honesty
We respect and esteem ourselves, our patients and our colleagues. This involves taking feelings, needs, thoughts, ideas, wishes and preferences into consideration. It means taking all of these seriously and giving them worth and value.

Accountability and Responsibility
We can be relied upon to do our utmost on behalf of our patients and to fulfil our promises. We are industrious and work hard on behalf of our patients. We fulfil our responsibilities fully to our patients, staff and colleagues.

Inspired by North Dublin City GP Training Scheme
RELATIONSHIPS ARE THE SILVER BULLETS OF GENERAL PRACTICE AND PRIMARY CARE

Especially for the 15% of patients who account for 50% of the workload
The social causes of illness are just as important as the physical ones.

The medical officer of health and the practitioners of a distressed area are the natural advocates of people.

They well know the factors that paralyse all their efforts.

They are not only scientists but also responsible citizens, and if they did not raise their voices, who else should?

Henry Sigerist, John Hopkins University
Doctors warn austerity is damaging patients’ health

Large city hospitals ‘are hubs for MRSA’

Welfare cuts could see further 60,000 Scots kids being dragged into poverty, warn doctors

Cases of concern

Patients and doctors in the report are anonymous to protect confidentiality.

E.ON to freeze its prices

Advocacy
6. Additional **staff** for community links, financial inclusion, mental health, addictions should be “**embedded**”, rather than just co-located.

7. Most **projects began with team wellbeing** as the first step.

8. Need to **share learning** within and between practices.

9. Joint working with others takes time to **build relationships**.

10. And **advocacy** takes different forms – be ready when opportunities arise…
“You have to **expand reactive care** and make it richer and more imaginative…

If you really care about people you **care about their future**, not just about the immediate reason they have come to see you…

You’ve got to do more than meet expectations – **expectations in deprived areas are very low**; you’ve got to raise them…

You have to get immersed in their story, take their story seriously, give them the feeling that they are valuable people…

Including those **people who are losing confidence that they are of value**, you’ve got to show that you really care about them.”

---

Dr Julian Tudor Hart, 1927-2018

---

@dnblane
@ddeependgp

Contact details
David.Blane@glasgow.ac.uk