LEARNING FROM THE SCOTTISH DEEP END PROJECT

Graham Watt
Emeritus Professor
General Practice and Primary Care
University of Glasgow, UK
graham.watt@glasgow.ac.uk
% DIFFERENCES FROM LEAST DEPRIVED DECILE FOR MORTALITY, COMORBIDITY, CONSULTATIONS AND FUNDING

CONSULTATIONS IN DEPRIVED AREAS

Multiple morbidity and social complexity

Shortage of time

Reduced expectations

Lower enablement (especially for mental health problems)

Poorer outcomes after 12 months

Higher practitioner stress

GENERAL PRACTITIONERS AT THE DEEP END
GPs at the Deep End
THE DEEP END PROJECTS 2021

GPs at the Deep End
SCOTLAND

GPs at the Deep End, NE/Ireland
NORTH-EAST AND NORTH CUMBRIA

GPs at the Deep End, Plymouth
PLYMOUTH

GPs at the Deep End, Greater Manchester
GREATER MANCHESTER

GPs at the Deep End, Nottinghamshire
NOTTINGHAMSHIRE

GPs at the Deep End, NW London
NW LONDON

By excluding exclusions and building relationships, inclusive health care is a civilising force in an increasingly dangerous, fragmented and uncertain world.
GPs at the Deep End

General Practitioners at the Deep End

Final report of a special meeting held on 16 September 2009 at Erskine Bridge Hotel
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
28. GP recruitment and retention in deprived areas
29. GP use of additional time as part of the SHIP project
30. A role for members of the Scottish parliament in addressing inequalities in health care in Scotland
31. Attached Alcohol Nurse Deep End Pilot
32. 8 years of the Deep End Project
33. Increasing undergraduate education in primary care in areas of socio-economic deprivation
34. The Deep End Project for 2019-22
35. Plans for advocacy and engagement by the Scottish Deep End Project
36. General practice in the time of COVID-19
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

A SCATHING report from the Deep End Steering Group and authorised by 260 GPs in deprived areas says the bed tax and work capability assessments are damaging the health and lives of the country’s most vulnerable people.
Our health service should be at its best where it is needed most

SCOTLAND has an admirable record of providing comprehensive health care which is free at the point of use, and has been steadfast in protecting its NHS from the ravages of market competition, which continue to threaten the NHS in England.

However, as the continuing statistics on health inequality show, NHS Scotland has still to address the inverse care law, whereby the availability of good medical care tends to vary inversely with the need for it in the population served.

While NHS resource distribution formulas and general practitioner contracts have recognized for a long time the increased health problems, multiple morbidity and needs for care of elderly populations, they have been much less effective in providing resources to meet the increased health problems, multiple morbidity and social complexity of younger patients living in very deprived areas.

As general practitioners working in the 190 most deprived general practices in Scotland, we are the frontline of the NHS in Scotland as it battles with health inequality. We are in daily contact with large numbers of patients, with unrelieved levels of disability and coverage, and have substantial experience and knowledge of the health problems of people living in Scotland’s poorest communities, including vulnerable children, and those struggling with mental health and addiction problems, in addition to physical ailments.

The inverse care law in Scotland is not a matter of good medical care in affluent areas and bad medical care in deprived areas. It is the difference between what general practice and primary care can currently achieve, in meeting the needs of patients in very deprived areas, and what could be achieved if the service were better resourced to address levels of need.

The major issue which must be addressed, and whose solution requires political action, is the shortage of time within consultations to address a patient’s needs in very deprived areas. Although other modellers are needed, without this essential building block, the NHS will continue to fail in its attempts to narrow health inequalities.

 Longer consultations are needed to work with patients on their problems, to take a preventive approach and to instigate links to other services. The NHS has many challenges to face, but should be at its best where it is needed most. We call on political parties contesting the forthcoming election to commit themselves to eliminating the inverse care law in Scotland. Their first step should be to provide general practices in the front line with additional time for patient consultations.

Members of the Deep End Steering Group:
- Georgina Brown, GP
- Springfield Health Centre
- John Budd, GP
- Edinburgh Homeless Practice
- Peter Giggins, GP
- Drumchapel Health Centre
- Bloody Mary, GP
- Fous and Springfield
- Stewart Longbridge, GP
- Penicuik Health Centre
- Stewart Mercer, Professor of Primary Care Research
- University of Glasgow
- Cathrina Morton, GP
- Craigshill Health Centre
- Anne McInnes, GP
- Govan Health Centre
- Jim O’Hall, GP
- Lighthouse Medical Centre
- Euan Peterlinson, GP
- Govan Health Centre
- Petra Sambells, GP
- Keppoch Medical Centre
- Graham Watt, Professor of General Practice, University of Glasgow
- Andrew Williamson, GP, Glasgow Homeless Health Services.
THE DEEP END MANIFESTO

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)
HOW DO DEEP END GENERAL PRACTITIONERS SEE THEIR ROLE?
ADVOCACY

not only what you say

but also, what you do
THE CARE PLUS STUDY

- RCT of longer consultations for selected complex patients
- CARE Plus prevents decline in QOL
- Cost-effective (<£13,000 per QALY; NICE threshold is £20,000)

GOVAN SHIP

Social Health Integration Partnership

4 general practices in one health centre

Added clinical capacity (via long term GP locums)

Protected time for extended consultations

Monthly Multidisciplinary Team (MDT) Meetings

Attached social care workers

Administrative support

Targeting 8% of patients reduced practice workload overall
THE COMMUNITY LINK WORKER PROGRAMME

The Community Links Practitioner + The GP practice adopting the Links Approach

The Patient Journey
- Community Links Practitioner
- Discusses patient's situation
- Provides specialist 1:1 support
- Patient identifies goals
- They identify appropriate community assets
- Patient supported to access assets

The Practice Journey
- Community Links Practitioner
- Joint GP practice team
- Facilitates GP practice development
- They build on GP practice capacities
- Practices are aware of community assets
- Patient supported to address social situations
- Patients signposted to community assets

Patient are supported to live well in their community

GPs at the Deep End

ALLIANCE HEALTH AND SOCIAL CARE
ALLIANCE SCOTLAND
people at the centre
THE PARKHEAD FINANCIAL ADVICE PROJECT

- Engagement of practice
- Increase in new referrals, made mostly by GPs
- 65% uptake
- Median financial benefit per claimant of £7,000 per annum
- 68% of people engaging with the service stated they had a mental health condition
- About a half of people were referred to additional forms of community support
- More time for GPs to address clinical problems
- Now being rolled out to 150 other local practices
THE DEEP END GP PIONEER SCHEME

Additional capacity via GP fellows

Protected time for host GPs (as in SHIP)

Shared learning based on service developments

Day release scheme for GP fellows

Recording of shared activity via website
ACTIVE INGREDIENTS OF THE SCOTTISH DEEP END PROJECT

Additional capacity
Leadership at a local level
GP protected sessions
Extended consultations for selected patients
Bottom-up integrated care via multidisciplinary team meetings
Embedded community link practitioners acting as generalists
Embedded financial advisors
Associated evaluation and research
Shared learning between practices
Advocacy
Involvement of the next generation of GPs
THE EXCEPTIONAL POTENTIAL OF GENERAL PRACTICE
Making a difference in Primary Care

14-15th February 2019, Glasgow
YES, this is what I do

YES, that’s what I want to be part of

YES, that’s the direction I want to go
News from:
Scotland
Ireland
Yorkshire/Humber
Greater Manchester
Canberra, Australia
Plymouth
NW London
North-East and North Cumbria
Nottinghamshire

www.gla.ac.uk/deepend
A DAY IN THE LIFE ……

Ubiquitous, endemic complexity

The value of previous encounters

Empathy and trust

A “worried doctor”

Setting the bar high

Every patient matters

BJGP, June 2015
SHEHEREZADE

TELLING 1001 TALES
Building

KNOWLEDGE

CONFIDENCE

AGENCY
RELATIONSHIPS WITH PATIENTS

“Initially face to face, eventually side by side”

Julian Tudor Hart
A NEW KIND OF DOCTOR
10% of patients with 4 or more conditions accounted for
34% of patients with unplanned admissions to hospital and
47% of patients with potentially preventable unplanned admissions

Payne R, Abel G, Guthrie B, Mercer SW. The impact of physical multimorbidity, mental health conditions
and socioeconomic deprivation on unplanned admissions to hospital: a retrospective cohort study.
RELATIONSHIPS ARE THE SILVER BULLETS OF GENERAL PRACTICE AND PRIMARY CARE
INTRINSIC FEATURES OF GENERAL PRACTICE

Contact

Coverage

Continuity

Coordination

Flexibility

Relationships

Trust
INTEGRATED CARE DEPENDS ON MULTIPLE RELATIONSHIPS
PRACTICE-BASED BUILDING PROGRAMMES

1. A COMPENDIUM OF PATIENT STORIES

2. STRONG LOCAL HEALTH SYSTEMS
Solidarity
Helping others is like helping yourself.
BUILDING PROGRAMMES

1. A COMPENDIUM OF PATIENT STORIES
2. STRONG LOCAL HEALTH SYSTEMS
3. NETWORKS OF LOCAL SYSTEMS
POLITICAL AND CENTRAL SUPPORT NEEDED FOR …..

- Resources commensurate with need
- Information systems to measure omissions and monitor progress
- Educational opportunities to share learning
- Research and Evaluation to establish what works
- Career opportunities to attract, sustain and retain practitioners
What can NHS Scotland do to prevent and reduce health inequalities?

Proposals from General Practitioners at the Deep End

March 2013
PREVENTING AND POSTPONING CRISSES

FOR EMERGENCY CARE THERE IS NO GATE

ONLY A GATEWAY

(that patients can go through at any time)
...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.

John Berger
“By excluding exclusions, keeping everyone on board, and building three types of relationship, inclusive health care can be a civilizing force in this increasingly dangerous, fragmented and uncertain world.”

The Exceptional and Equitable Potential of General Practice