Learning from the Scottish Deep End GP Project: implications for health care, research, and medical education

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GP researcher, academic lead for the Deep End group

Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study

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Acknowledgements
Acknowledgements

Dr Julian Tudor Hart, 1927-2018

“Intellectual opposition to injustice is only the beginning of social understanding”
"The availability of good medical care tends to vary inversely with the need for it in the population served".

Julian Tudor Hart, The Lancet, 27th February 1971
Inverse Care Law today = “lack of time to address needs”

GENERAL PRACTITIONERS AT THE DEEP END
GPs at the Deep End = “blanket deprivation”

Patients in 15% most deprived areas

“Deep End” practices = top 100 most deprived
“Deep End” issues

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<tr>
<th>ISSUES AFFECTING DEEP END COMMUNITIES</th>
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<tr>
<td>• Unemployment</td>
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<td>• Benefits sanctions</td>
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<td>• Cuts to services</td>
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<td>• Drugs and alcohol</td>
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<td>• Child protection</td>
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<td>• Migrant health</td>
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<td>• Vulnerable adults</td>
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<td>• Bereavement</td>
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<td>• Higher cancer prevalence</td>
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<th>KEY POINTS ABOUT DEEP END ENCOUNTERS</th>
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<td>• Early multiple morbidity</td>
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<td>• Social complexity</td>
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<td>• Shortage of time</td>
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<td>• Reduced expectations</td>
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<td>• Lower enablement</td>
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<td>• Health literacy</td>
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<td>• Practitioner stress</td>
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<td>• Weak interfaces</td>
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Health inequalities = “shorter lives lived in poorer health”

1) Advocacy

2) Evidence

3) Service development

4) Professional development

www.gla.ac.uk/deepend
Advocacy

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

Not only what you say... but also what you do
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  LINK Workers, Care Plus, Welfare Advice, Govan SHIP, Pioneer Scheme, Alcohol

Scottish Deep End GP Project
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

Started as a pilot in 7 practices in 2014... now rolling out across Scotland

GP stress → “less empathy = less enablement”

Lessons from CARE Plus study

- High level of unmet need, in the face of the inverse care law, results in higher GP stress, less patient enablement and worse outcomes.

- ‘Reversing’ the inverse care law experimentally – by giving more time, better continuity, and more empathic, patient-centred care, appears to result in better outcomes in a cost-effective way.

Lessons from Advice Worker Project

Started as a pilot in 4 practices in 2015... now rolling out across Scotland

- “Embedded”, not just co-located

The Deep End Advice Worker Project:
embedding an advice worker in general practice settings

Jamie Sinclair
Glasgow Centre for Population Health
September 2017

276 referrals were made to an advice worker based in the two practices
85% of referrals had never previously accessed GEMAP's services (despite these services having been available in the area for 15 years)

Of the 165 people which engaged with the service:

£850,000 worth of financial gain was secured through supporting people to access social security payments

Successful applicants received an annual average of just under £7,000

The project identified and is now managing £155,000 worth of debt
Lessons from Govan SHIP (Social and Health Integration Partnership)

- Aim to improve collaboration / integration between GP, social work, other health services, and community and third sector organisations.

“Key ingredients”:
- Aligned Social Workers
- Structured MDT meetings
- Early career GP locums
- Additional time for GPs

Started as a pilot in 4 practices in 2016... watch this space

- Extended consultations
- Polypharmacy reviews
  - Case Review
- Outward facing / planning
Lessons from the Pioneer scheme

Aim to develop a ‘change model’ involving recruitment of early career GPs, retention of experienced GPs, and their joint engagement in strengthening GP as the natural hub of local health systems.

“Key ingredients”:

- 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.

Implications for health care?

- Inverse care law manifests as **lack of time and resource** in disadvantaged areas.
- There are particular issues in areas of ‘**blanket deprivation**’ (trauma-informed).
- Need for **protected time** for professional and service development.
- Extended consultations (and continuity) for **selected patients**.
- Bottom-up **integrated care** via MDT meetings.
- Team **wellbeing** was the first step of most projects (needs proactive support).
- Additional staff for community links, financial inclusion, mental health, addictions should be “**embedded**”, rather than just co-located.
- **Shared learning** within and between practices.
- Advocacy (health equity lead in each practice?).
- Involvement of the **next generation** of GPs.
Supporting the GP workforce

Anderson et al. “Securing a sustainable and fit-for-purpose UK health and care workforce”, Lancet May 2021

https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(21)00231-2.pdf
Implications for research?

- Holistic care needs holistic research.
- Marginalised groups often excluded from research.
- Needs to include patients’ voice as well as practitioners’ voice (co-production approach).
- Takes time and understanding
  - Often not valued by Universities and mainstream funders.
Implications for medical education?

- **Widening access**
  - ‘Getting ready’ (e.g. REACH programme)
  - ‘Getting in’ (e.g. selection process, GAP)

- **UG teaching**
  - New GP curriculum
  - Increase quantity and quality of time in general practice (e.g. COMET) **8 to 25%**
  - Social determinants
  - Inter-professional learning

- **PG training**
  - Tailored GP training (e.g. North Dublin, Greater Manchester)
  - Rotation through different practices
  - FY placements in GP
  - ‘Near peer’ teaching

- **Lifelong learning**
  - Protected time!
  - Fellowship schemes
  - ‘Coalition of learning’ (e.g. WoS early career GP DIG)
  - PBSGL, peer support

Tudor Hart on medical education

- 3 tasks for which GP > hospitals

1. **Correction of social ignorance**
   - Real respect/concern for real people

2. **Coping with uncertainty**
   - Understanding limitations of knowledge

3. **Developing disciplined anger**
   - Not against people, but against attitudes/situations that impede care

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Medical Education

**RELATION OF PRIMARY CARE TO UNDERGRADUATE EDUCATION**

**JULIAN TUDOR HART**

Glyncorrwg Health Centre, near Port Talbot, Glamorgan

Nearly everyone reaching our hospital and specialist service has undergone some prior sorting by a primary doctor, generally referring 4-10% of consultations to hospital.¹ Primary care is in this precise sense the foundation of the National Health Service, and in its absence hospitals may become inhumane, ineffective, and wasteful, as American experience has shown.² It would seem obvious that it should always have played a part in undergraduate teaching, and if this has not been the case we should seek reasons for this anomaly.

*Lancet, 1973*
Attracting practitioners

Individual Factors

Autonomy
Mastery
Purpose

System factors

Leadership
Collegiality and shared learning
Accountability
“Sir Geoffrey Vickers described the history of public health as ‘a record of successive redefinings of the unacceptable’. In medical education we should be redefining the intolerable, helping new generations to reject what we have bent to, and to express their rejection in great deeds and short words.

Departments of primary care could, and in a few cases will, be innovators of an education of this new kind.”

*Lancet, 1973*
Thanks for listening!
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“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