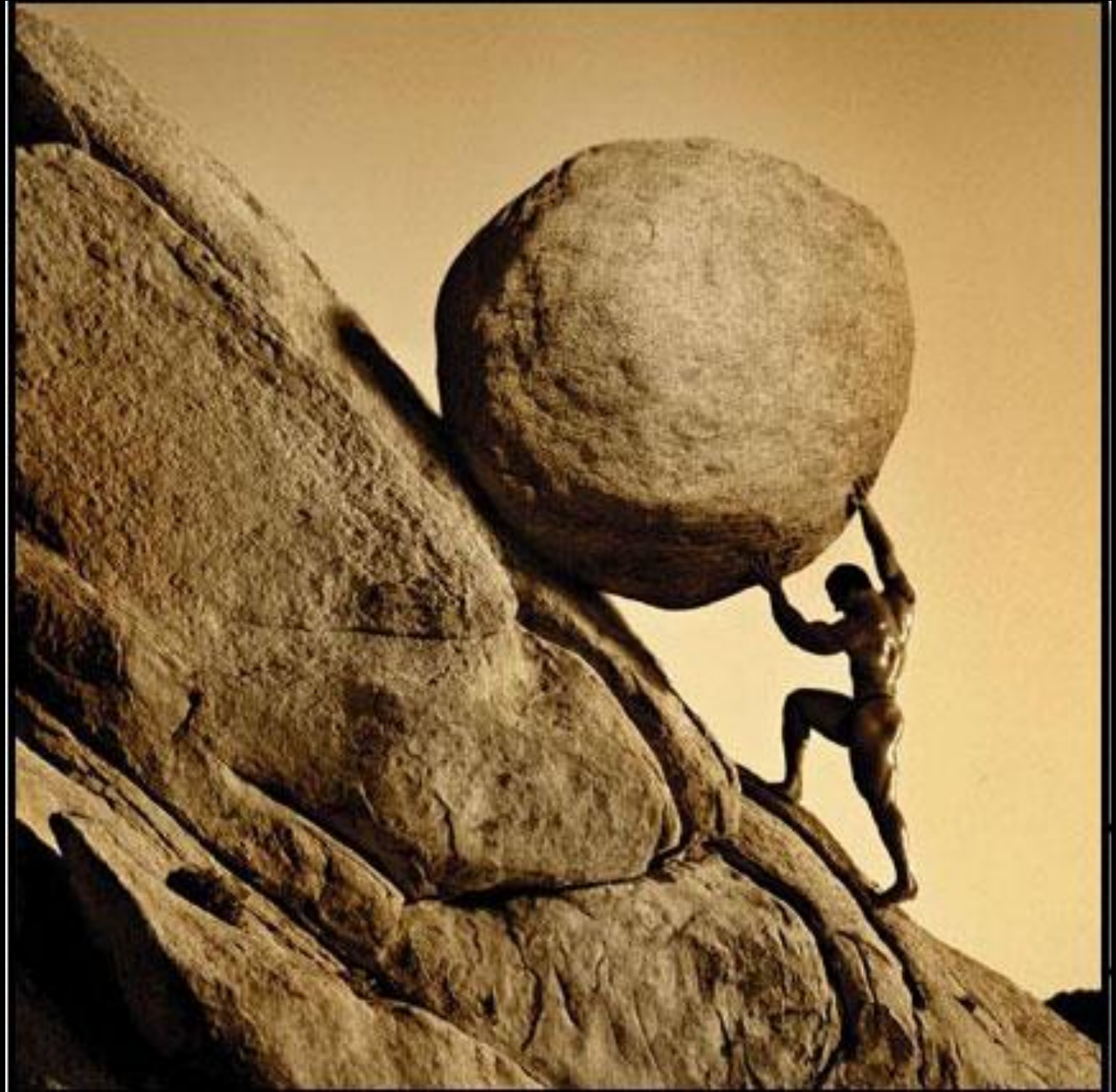
Attitudes are more important than abilities
Motives are more important than methods
Character is more important than cleverness
And the heart takes precedence over the head

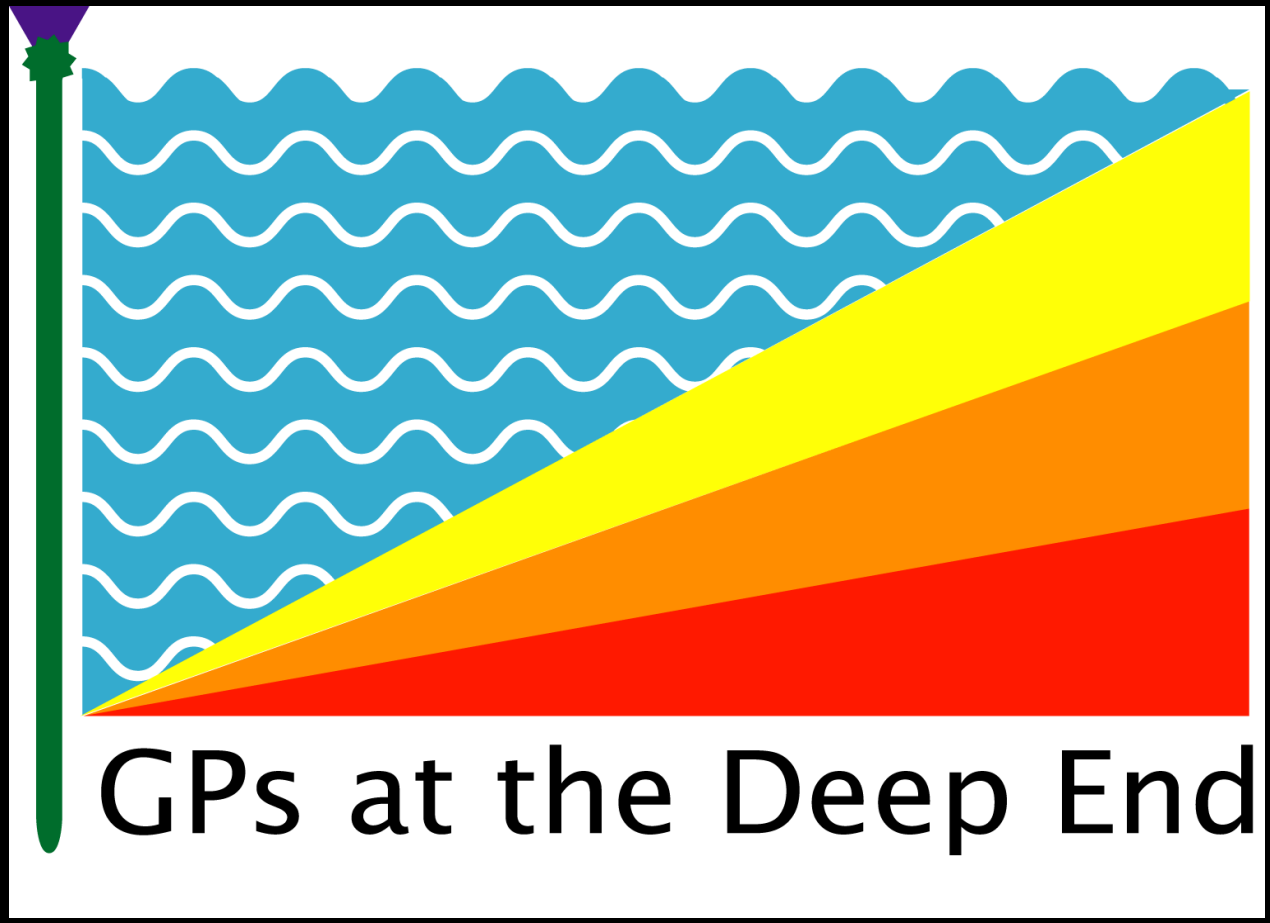
Perseverance is more important than pace.
(Not a long race - but many short races one after another)

Making the right choices at various junctions in life
can be of greater importance than outstanding ability.

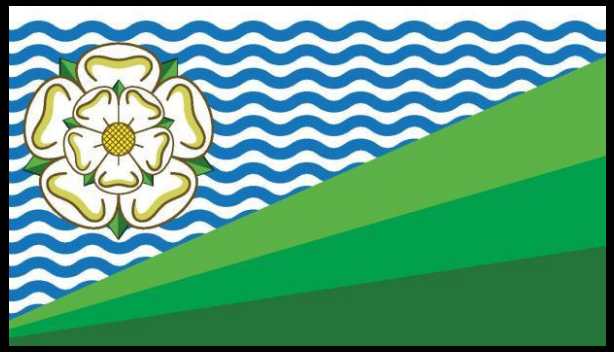
DENIS BURKITT

THE FUTURE OF GENERAL PRACTICE WILL NOT BE HANDED TO YOU ON A PLATE

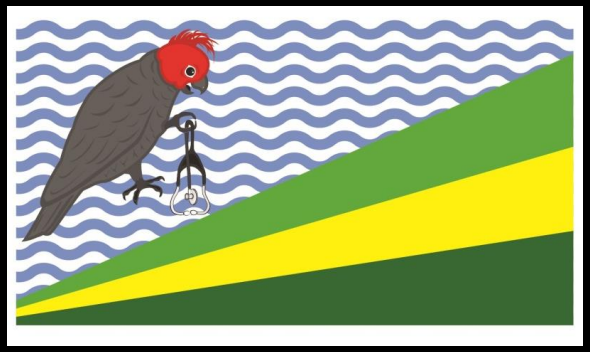



GPs at the Deep End

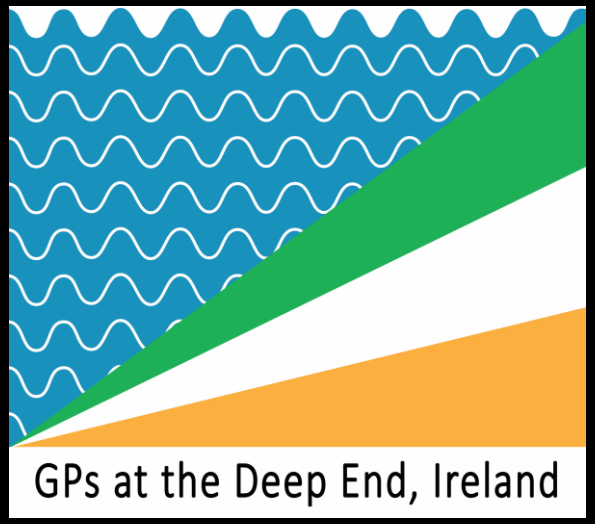
GENERAL PRACTITIONERS AT THE DEEP END



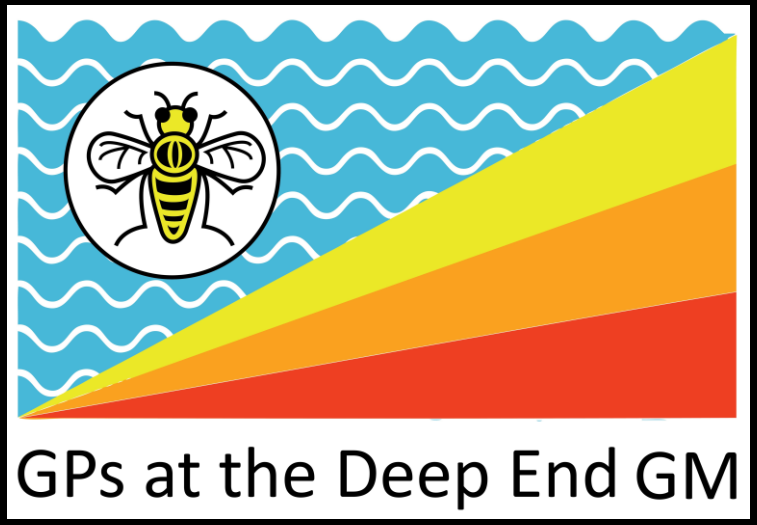
YORKSHIRE/HUMBER



CANBERRA



IRELAND



GREATER MANCHESTER

OUR COMMON CAUSE

to develop a compelling competing narrative
based on the importance of generalist clinical practice

(i.e. unconditional, personalised continuity
of care for all patients, whatever problems they have)

THE
DOMINANCE
OF
SPECIALISM
AND
MANAGERIALISM
OVER
GENERALISM

POSSIBLE EXPLANATIONS OF THE WEAKENING OF GENERALISM

Traditional disdain

The most important work of generalists is “out of sight, out of mind”

Effective generalist care is hard to document as it mainly results in non-events.

The most powerful and influential institutions tend to be specialist-based

Most research and evidence is specialist-based

Practice-based research is complicated by small numbers and many sources of variation

The arguments that bigger and better general practice is the solution to pressure on A&E departments, health care fragmentation and widening health inequality tends to be rhetorical rather than evidence-based

There are men and classes of men that stand above the common herd : the soldier, the sailor and the shepherd not infrequently; the artist rarely; rarelier still the clergyman; the physician almost as a rule. He is the flower (such as it is) of our Civilisation, and when that stage of man is done with and only to be marveled at in history, he will be thought to have shared as little as any in the defects of the Period and most notably exhibited the virtues of the race.

Generosity he has, such as is possible to those who practise and art, never to those who drive a trade; discretion tested by a hundred secrets; Tact tried in a thousand embarrassments and what are more important, Heraclean cheerfulness and courage. so that he brings air and cheer into the sick room and often enough though not as often as he wishes, brings healing.

ROBERT LOUIS STEVENSON

Out of Hours

Discretion is the better part of general practice

I shadowed a GP working in one of Glasgow's most deprived areas. She arrived at 7.20 am on a Monday morning to deal with 38 items of correspondence, all needing to be checked and prescriptions altered, a patient phoned, or arrangements made, before the day even started. The telephone calls to patients all began the same way: 'This is Dr xxxxx, Hello John, Hello Helen etc'.

As the on-call doctor on a busier day than usual, she completed seven house visits that morning, each taking 30 minutes. It took an hour to enter all the details back in the practice and make the necessary arrangements, leaving 5 minutes for lunch. A colleague who took over the on-call for the afternoon made three more home visits, dealt with 22 telephone consultations and six emergency appointments.

The afternoon surgery ran for 3 hours, and would have lasted longer if all the booked patients had attended. Problems addressed included: cancer, depression, agoraphobia, asthma, self-harm, bereavement, domestic violence, heart failure, alcohol abuse, dementia, social neglect, and so on, often in combination. She left for home after a 12-hour day, with 61 items of correspondence yet to deal with.

I didn't see any short or trivial consultations. There were no 'worried well' patients, but a worried doctor leaving no loose ends when dealing with a series of patients with complicated health issues and other problems, all of whom she knew well. One patient said 'Dr xxxxx' is the only person I can relate to'. Another came in grim-faced, avoiding eye contact, almost in tears, but left 15 minutes later, beaming a smile.

I was struck by the intensity of the day, every patient getting the same attention. The doctor was too busy to put on an act: 'We have to focus on every single patient and listen. A lot feel they bother us and we cannot fob them off by being stressed or not dedicating time'. The practice has learned from experience that it is unsafe to assume that if problems are serious, patients will consult in time.

There are three GP partners and none work full-time: 'You cannot work fully concentrated for a whole day without recovery time'. The practice is wondering whether it might attract more students to their list to dilute the clinical load. Burn-out

> "'We have to focus on every single patient and listen. A lot feel they bother us and we cannot fob them off by being stressed or not dedicating time'."

is an ever-present hazard. The level of work is hard to sustain.

The consultations I observed showed a GP at the top of her game. Previous contact, shared knowledge, and trust were fundamental to what could be achieved in a short space of time. Despite the pressures of practice in a deprived area,[1] the GP was ambitious for what she could achieve with, and for, her patients.

One seldom gets the opportunity to observe a GP through a whole working day. What I saw in Glasgow reminded me of working with Julian Tudor Hart at Glyncorrwg in South Wales. He is best known for research on high blood pressure, but his daily practice and long-term achievements were characterised by his unconditional approach to all patients, whom he came to know well, whatever problems or combinations of problems they had. In the BBC documentary series on the NHS *Pioneers*, Mary Hart said 'Many people sentimentalise us, but we were just doing our job, for which we were paid, providing the NHS for our patients.'[2]

In an article with Paul Dieppe, Tudor Hart described the poisonous effects which can arise when, for whatever reason, health professionals become indifferent to what happens to the patient in front of them.[3] I remember him talking of the importance of finding something to like about every patient. There was no-one about whom there wasn't something to like.

In the 1950s, Collings described poorly-resourced areas of general practice as 'sufficient to turn a good doctor into a bad doctor in a short period of time.'[4] Such gross effects are less common today. A more subtle effect is whether practitioners set the bar high or low when dealing with patients.

ADDRESS FOR CORRESPONDENCE

Graham Watt
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E-mail: graham.watt@glasgow.ac.uk

The incentives of the Quality and Outcomes Framework, involving only 12.7% of GP consultations,[5] have little to do with this aspect of practice. Professionalism and caring for patients are what matter, and both are at the discretion of individual practitioners.

Consultation rates are used as crude measures of practice activity and proxy indicators of health need. Such data convey nothing of the duration, content, quality, or consequences of consultations, and their use sustains the inverse care law.[6] What I saw in 1 day in one practice in one part of the country goes unrecorded in the scheme of things, reflects poorly on the NHS commitment to equitable resource distribution, but spoke volumes for the professionalism of one GP.

Graham Watt,
Nanie Miller Professor of General Practice, University of Glasgow, Glasgow.

DOI: 10.3399/bjgp15X685357

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2. *Pioneers: The Blood Doctor*. BBC2. 7 Oct 1996.
3. Tudor Hart J, Dieppe P. *Caring effects. Lancet* 1996; **347(9015)**: 1606–1608.
4. Collings JS. General practice in England today: a reconnaissance. *Lancet* 1950; **i**: 555–585.
5. NHS National Services Scotland. Information Services Division. *Practice team information (PTI). Annual update (2012/13) 29 October 2013*. http://www.isdscotland.org/Health-Topics/General-Practice/Publications/2013-10-29/2013-10-29-PTI-Report.pdf (accessed 7 Apr 2015).
6. Watt G. The inverse care law today. *Lancet* 2002; **360(9328)**: 252–254.

Ubiquitous, endemic complexity

The value of previous encounters

Empathy and trust

A “worried doctor”

Setting the bar high

Every patient matters

BJGP, June 2015

GENERAL PRACTICE IMPROVES HEALTH

NOT ONLY

Evidence-based medicine (QOF, SIGN)

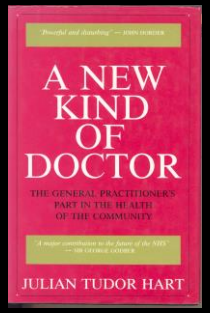
BUT ALSO

Unconditional, personalised, continuity of care, provided for all patients, whatever problems they present.

With great effort any doctor can get to know all his patients, even in a city with a high migrant turnover. Only then can he learn to think of a responsibility, not only to the patient sitting in the surgery, but to the whole population for whose care he is paid and for whose health he is responsible. He can then see his role as the ultimate custodian of the public health on a defined section of a world front against misery and disease.

The greatest rewards in primary care are going to be found in those areas that most need good doctoring, but which at present are least likely to get it. to do this one must discard the sorts of ambition still encouraged by some teaching hospitals. We need more liberty, more equality, but above all more fraternity; the doctor living and working within a community, sharing as much as he can of the common experience, is better able than any other to discard privilege and stand on two firm legs of earned respect.

Julian Tudor Hart
Lancet Career Guide for Medical Students 1973



Intellectual opposition to social injustice, even when present, is only the beginning of understanding.

If students are to retain patient-oriented rather than disease oriented motivation, they must learn to identify in complex, concrete, detailed terms with people they know only as crude stereotypes, and of whom they are usually afraid.

Julian Tudor Hart

ADVOCACY

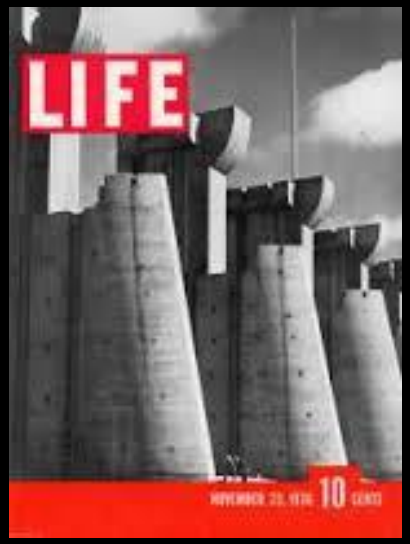
The social causes of illness are just as important as the physical ones.

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

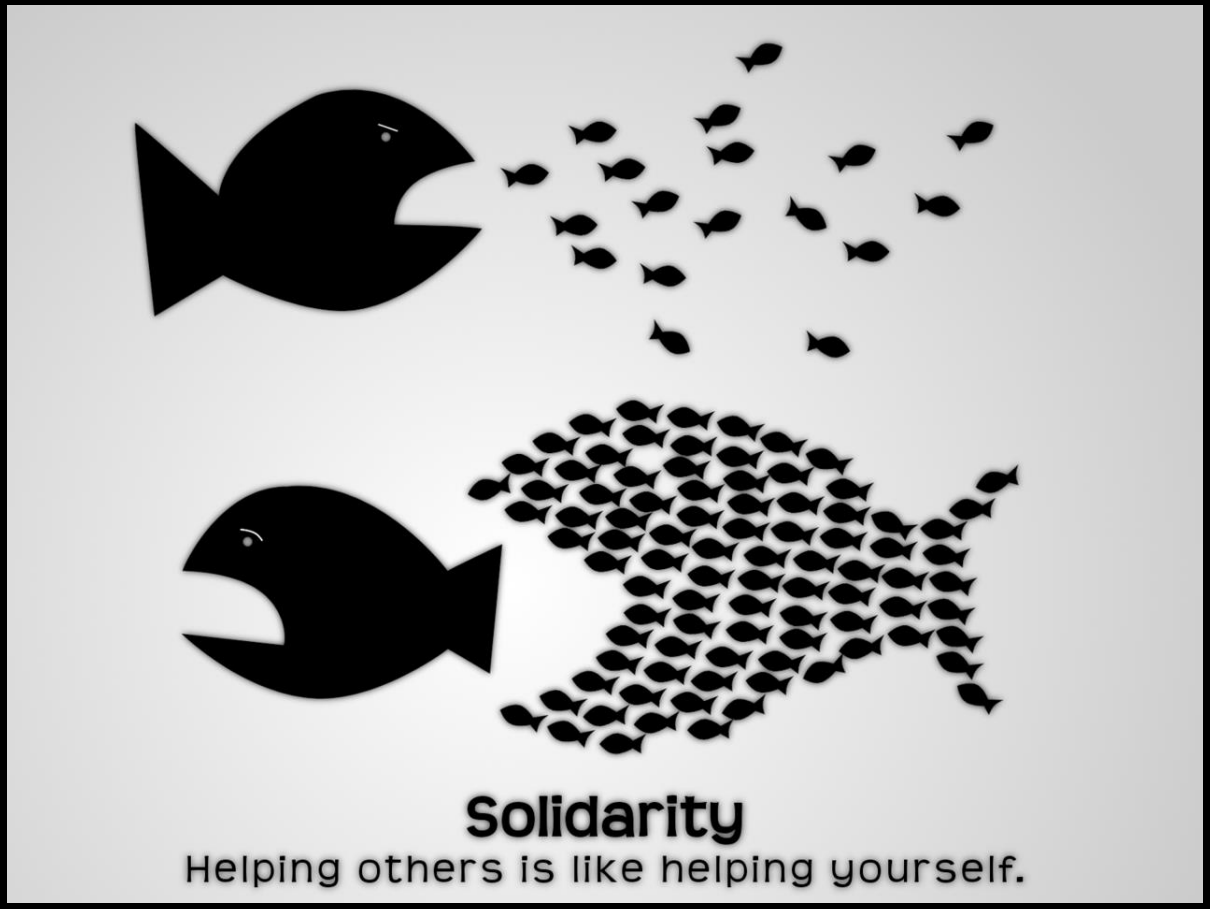
They well know the factors that paralyse all their efforts.

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



A COUNTRY DOCTOR


Solidarity
Helping others is like helping yourself.

KEY FEATURES OF GENERAL MEDICAL PRACTICE IN THE UK
(Structure determines Function)

Free at the point of use, paid for by taxation

Complete registration with a GP (i.e. population coverage via clinic populations)

Continuity of contact

High levels of public trust

Gatekeeping to secondary care

Independence

Variation

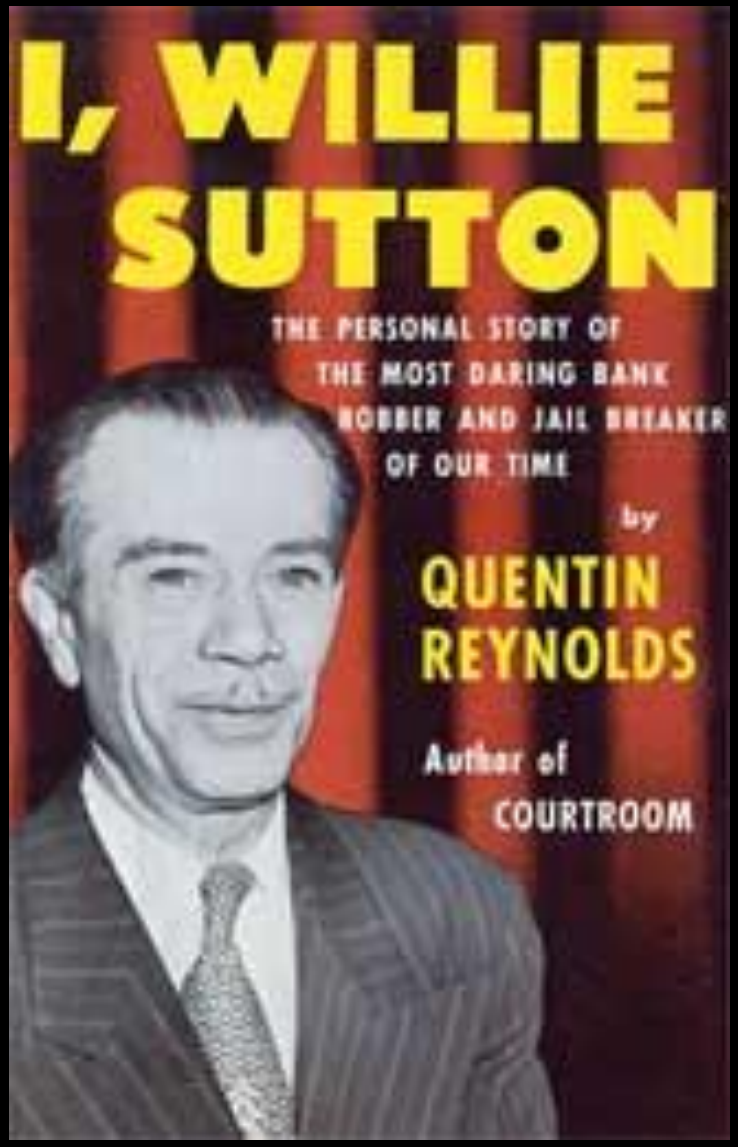
Dealing with emergencies (big and small)

Access to specialist diagnosis and treatment

Getting a good start in life

Dying with in dignity and comfort

Living with (several) long term conditions



QUESTION

WHY DO YOU ROB BANKS ?

ANSWER

BECAUSE THAT'S WHERE THE MONEY IS

WILLIE SUTTON

WHERE ARE THE MOST DEPRIVED POPULATIONS ?

BLANKET DEPRIVATION

50% are registered with the 100 “most deprived” practice populations
(from 50-90% of patients in the most deprived 15% of postcodes)

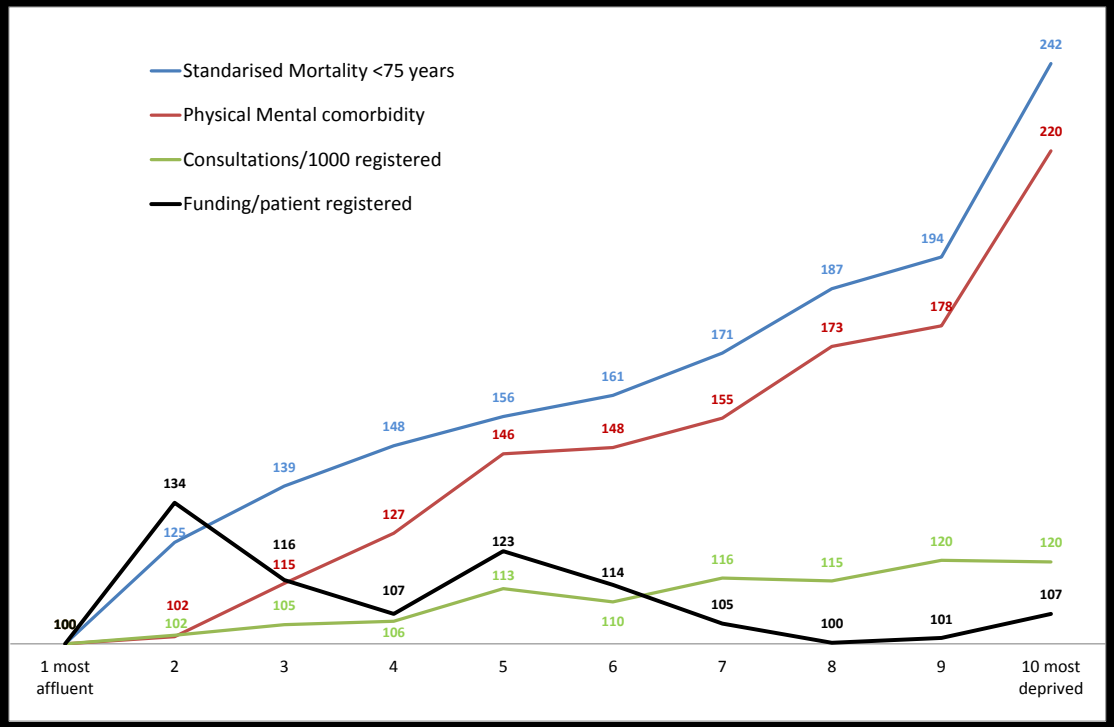
POCKET DEPRIVATION

50% are registered with 700 other practices in Scotland
(less than 50% in the most deprived 15% of postcodes)

HIDDEN DEPRIVATION

200 practices have no patients in the most deprived 15% of postcodes

Percentage differences from least deprived decile for mortality, comorbidity, consultations and funding




The Herald

SCOTLAND'S POWER 100
Your essential 20-page guide to the leading individuals who shape our daily lives
INSIDE TODAY

Postcode lottery hits GP surgeries in poorest areas

Labour bid to question minister over 'illegal' surveillanc

Murray seals historic Davis Cup win

Fathers in palace roof protest

Arrest: I trust only three Scots lawyers

Pay for a pint with 'Scotcoin'

Inside

"Over 2 million Scots in the most deprived 40% of the population received £10 less GP funding per head per annum than over 3 million Scots in the most affluent 60%"

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

Health literacy

Practitioner stress

Mercer SM, Watt GCM
Annals of Family Medicine 2007;5:503-510

INVERSE CARE LAW

"The availability of good medical care tends to vary inversely with the need for it in the population served".

Julian Tudor Hart

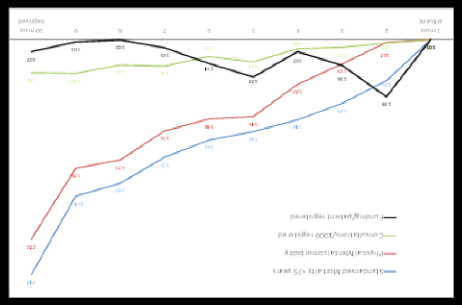
Not the difference between good and bad care, but between what general practices can do and could do with resources based on need.

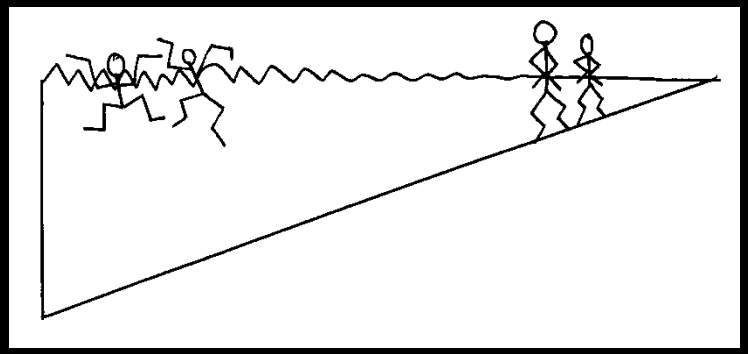
IS THE NHS FAIR?

i.e. equitable based on need

In providing emergency care	YES
In providing specialist care	NO
In providing access to primary care	YES
In providing needs-based care	NO

GENERAL PRACTITIONERS AT THE DEEP END





GPs at the Deep End

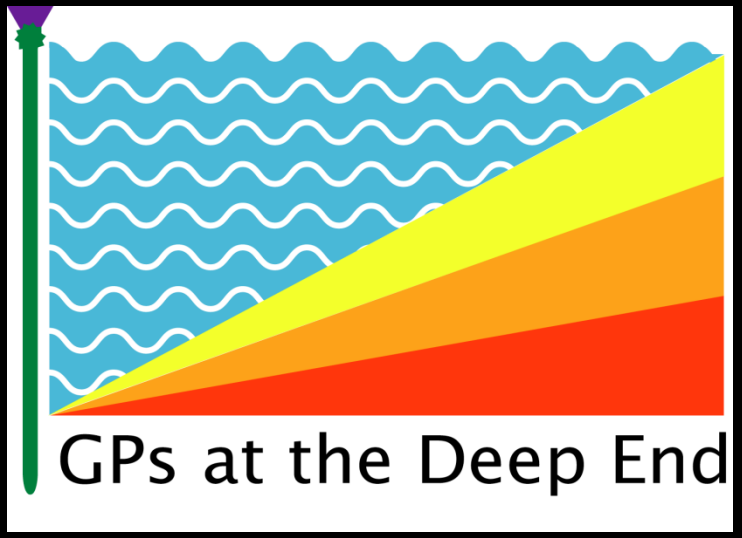
ACHIEVEMENTS

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

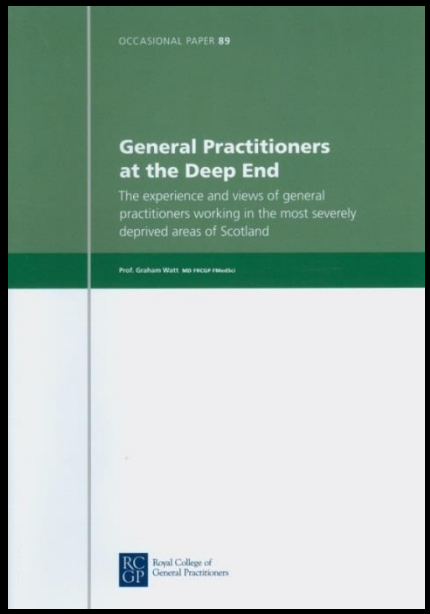
Projects Govan SHIP, LINK Workers , Care Plus, Benefits, Alcohol, Housing



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
13. The Access Toolkit : views of Deep End GPs
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 heath 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

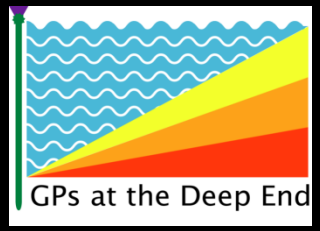
GPs at the Deep End



www.gla.ac.uk/deepend

ISSUES ESPECIALLY PREVALENT IN THE DEEP END

Mental health problems
Drugs and alcohol
Material poverty
Vulnerable children and adults
Migrants, refugees and asylum seekers
Fitness to work
Sexual abuse history
Homelessness



GENERIC ISSUES

How to engage with patients who are difficult to engage
How to deal with complexity in high volume
How to apply evidence

DEEP END REPORT 24

ADVOCACY

THE HERALD TUESDAY 15.05.2012 PAGE 9 NEWS

Doctors warn austerity is damaging patients' health

GPs in deprived areas see sharp rise in social issues

STEPHEN NAYSMITH
SOCIETY EDITOR

GPs working in the most deprived communities in Scotland have warned of increasing levels of mental and physical health problems among patients affected by austerity.

The Deep End group of GPs, representing 360 doctors in 100 practices, said job losses, welfare reform and cuts to social services were all affecting the health of their patients.

The 100 Deep End group of general practices that serves the most socio-economically deprived areas of the country was set up in 2009. It is backed financially by the Scottish Government.

In a new report, the group says austerity measures are causing increased distress and poverty among their patients, and an increased workload for family doctors.

The GPs add that the growing impact of benefit cuts mean much of their time is taken up with social issues rather than patients' underlying health problems.

In February, the group surveyed members to ask about their experiences of austerity. Doctors responded that patients were suffering deteriorating mental health, and also physical problems.

The report says: "GPs report less time to deal with physical problems, as these are no longer a priority for the patient."

Benefit changes were also a concern for many GPs, because they felt patients were wrongly being declared fit to work in medical tests on behalf of the for work was particularly frustrating.

She said: "So may people who are clearly unfit for work are being assessed as capable of work after a cursory assessment.

"We see people with uncontrolled chronic conditions, who are physically quite disabled or have significant mental health problems. The system seems to maximise their distress.

"The majority appeal and the majority of them win."

The report draws attention to the impact of cuts in other public services, such as education, social work and addiction support. Dr Craig added: "The minimum pricing of alcohol is a great thing, but addiction services are falling by the wayside. Austerity measures also affect children, but social work only have the resources to get involved in the most disturbed and difficult situations."

Dr Graham Watt, professor of General Practice at Glasgow

> **So many people who are clearly unfit for work are being assessed as capable of work after a cursory assessment**

University, helped compile the report. He said: "These GPs are absolutely on the front line. Many of them are frustrated that they can see all this happening but people don't know about it."

Aberdeen South MP Anne Begg chairs the work and pensions select committee at Westminster, and has written to

ON THE FRONTLINE: GPs Margaret Craig, left, and Petra Sambale are part of the Deep End group of GP practices. Picture: Colin Mearns

Cases of concern

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

- A doctor saw a 40-year-old woman who had been sexually abused as a child and had struggled with alcoholism. "She was found to be capable

worry that her mental health will deteriorate. Her benefits were stopped. She was diagnosed with type 2 diabetes ... instead of working with her setting goals for her diabetes I wrote a letter for an appeal and referred her to the benefit

- Another reports seeing a former labourer in his early fifties who was out of work due to osteoarthritis. His disability allowance had been cut and he was unable to afford his mortgage. "This patient's mental health problems have escalated and he is being seen

psychologically cope with retraining."

- A third case reads simply: "Eastern European pregnant lady with no money or food. Living in squalor with approximately eight other adults. *No money available or*

Large city hospitals 'are hubs for MRSA'

HOSPITALS in large cities act as "breeding grounds" for the superbug MRSA, which then spreads to smaller regional hospitals and health centres, according to a new study.

Researchers from Edinburgh University found evidence that shows for the first time how the superbug spreads between different hospitals throughout the country.

The study involved looking at the genetic make-up of more than 80 variants of a major clone of MRSA found in hospitals.

Scientists were able to determine the entire genetic code of MRSA bacteria taken from infected patients.

They then identified mutations in the bug that led to the emergence of new MRSA variants and traced their spread around the country.

Dr Ross Fitzgerald, of The Roslin Institute at Edinburgh University, who led the study, said: "We found that variants of MRSA circulating in regional hospitals probably originated in large city hospitals.

"The high levels of patient traffic in large hospitals means they act as a hub for transmission between patients, who may then be transferred or treated in regional hospitals."

E.ON to freeze its prices

ENERGY giant E.ON reassured its five million customers after it pledged *to keep residential energy*

Daily Record AND SUNDAY MAIL

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News ▸ Politics ▸ Con-Dem cuts

By Chris Clements | 16 Nov 2013 00:01

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 360 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.

Tweet 122 Like 406 Send

DEEP END REPORTS 16, 21, 25 and 27

The Herald
FOUNDED ON MONDAY JANUARY 27, 1783

Give care services more resources

GPs at the Deep End

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 formulae and general practitioner contracts have recognised 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 100 most deprived general practices in Scotland, we are the front line of the NHS in Scotland as it battles with health inequality. We are in daily contact with large numbers of patients, with unrivalled levels of continuity 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 measures are needed, without this essential building block, the NHS will continue to fail in its attempts to narrow health inequalities.

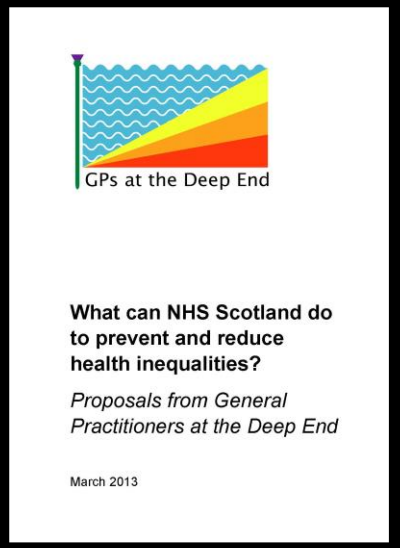
Longer consultations are needed to work with patients on their problems, to take a preventive approach and to instigate links to other services.

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, Springburn Health Centre; John Budd, GP, Edinburgh Homeless Practice; Peter Cawston, GP, Drumchapel Health Centre; Margaret Craig, GP, Possil and Springburn; Susan Langridge, GP, Possilpark Health Centre; Stewart Mercer, Professor of Primary Care Research, University of Glasgow; Catriona Morton, GP, Craigmillar Health Centre; Anne Mullin, GP, Govan Health Centre; Jim O'Neill, GP, Lightburn Medical Centre; Euan Paterson, GP, Govan Health Centre; Petra Sembale, GP, Keppoch Medical Centre; Graham Watt, Professor of General Practice, University of Glasgow; Andrea Williamson, GP, Glasgow Homeless Health Services.

SIX ESSENTIAL COMPONENTS

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)



BUILDING PROGRAMMES FOR INTEGRATED CARE

PATIENT STORIES

LOCAL HEALTH SYSTEMS

NETWORKS OF LOCAL SYSTEMS

SERIAL ENCOUNTERS

BRIEF ENCOUNTERS

SCHEHEREZADE

TELLING 1001 TALES

RELATIONSHIPS WITH PATIENTS

Initially face to face, eventually side by side

Julian Tudor Hart
A NEW KIND OF DOCTOR

RELATIONSHIPS

ARE THE

SILVER BULLETS

OF GENERAL PRACTICE AND PRIMARY CARE

Especially for the 15% of patients who account for 50% of the workload

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.

CMAJ 185 (e-publication ahead of print): E221-E228, 2013, doi:10.1503/cmaj.121349

INTRINSIC FEATURES OF GENERAL PRACTICE

Contact

Coverage

Continuity

Coordination

Flexibility

Relationships

INVENTING THE WHEEL

HUB

Contact
Coverage
Continuity
Comprehensive
Coordinated
Flexibility
Relationships
Trust
Leadership

SPOKES + RIMS

Keep Well
Child Health
Elderly
Mental Health
Addictions
Community Care
Secondary Care
Voluntary sector
Local Communities

INTEGRATED CARE DEPENDS ON MULTIPLE RELATIONSHIPS

PRIMARY CARE AS A WAGON TRAIN

THE DEEP END GP PIONEER SCHEME

Additional capacity via GP fellows

Protected time for host GPs

GP lead for service development

Day release scheme for GP fellows

Recording of shared activity via website

DEVELOPING A GP ROLE WITH THE FOLLOWING FEATURES

Generalist expertise in addressing the needs of patients in very deprived areas, and especially those with complex multimorbidity.

GP leadership and protected time for extended consultations and service development.

Building links with local communities

Collegiality based ion joint working, per review and shared learning with other practices.

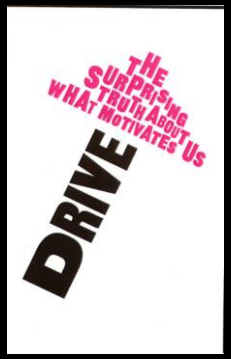
Advocacy based on collective experience and common cause

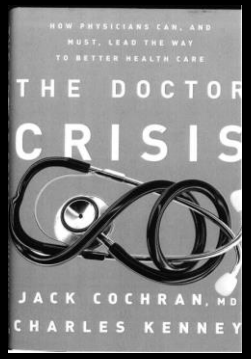
Involvement of the next generation of GPs in all of the above.

ATTRACTING PRACTITIONERS

Individual Factors

Autonomy
Mastery
Purpose



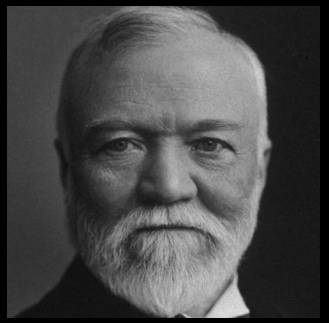


System factors

Leadership
Collegiality and shared learning
Accountability

Perhaps the most tragic thing about mankind is that we are all dreaming about some magical garden over the horizon, instead of enjoying the roses that are right outside today.

Andrew Carnegie



A COALITION OF LEARNING

Committed to the principle :

that “the best anywhere should become the “standard everywhere”

SHARING

Knowledge

Information

Evidence

Experience

Values

It is better to travel hopefully than to arrive

and the true success is to labour.

Robert Louis Stevenson