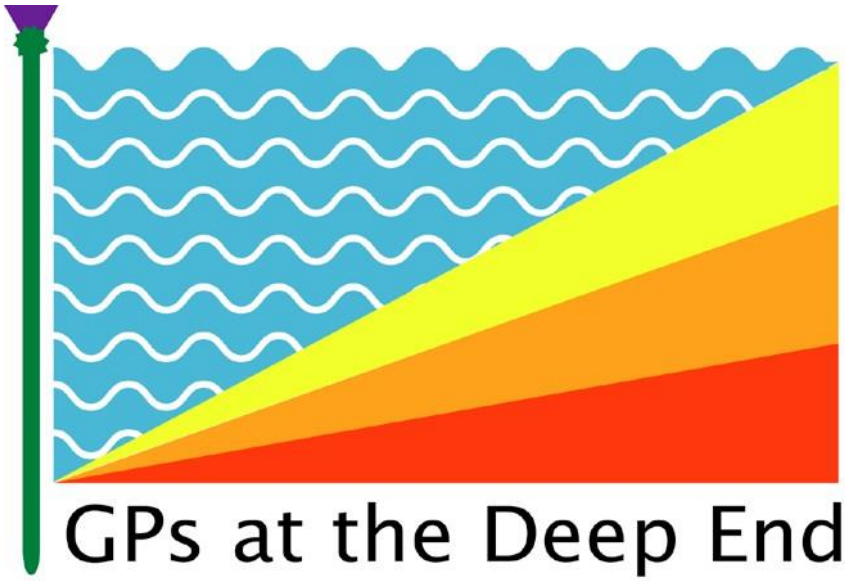

Deep End Report 32

8 years of the Deep End Project

This report summarises the shared experience, learning and plans of the Deep End Project, comprising the activities of General Practitioners at the Deep End, during 8 years following the initial meeting in September 2009.

The Inverse Care Law remains a major obstacle to what the NHS could and should achieve for and with patients in very deprived areas. However, the whole of general practice is now under threat due to underfunding and reduced levels of recruitment and retention of GPs.

To complement and counter the dominance of specialism and managerialism in NHS Scotland, a competing narrative is needed in which clinical generalism is developed and supported as the principal way of coordinating care, keeping patients in the community, reducing pressure on emergency services, improving health and narrowing health inequalities.

Based on learning from the Deep End Project, General Practitioners at the Deep End seek common cause with other General Practitioners in Scotland in protecting and developing general practice in NHS Scotland.

October 2017

SUMMARY

- The essential features of general practice are an unconditional approach to patients' problems, continuity and coordination of care, flexibility and population coverage
- General practice is essential for the future of the NHS but is in crisis due to underfunding, excessive workload and reduced GP numbers.
- Weakened general practice is less able to keep patients' problems in the community and puts hospital services under pressure.
- Generalist care provides an affordable and sustainable solution to fragmented care, especially for patients with multimorbidity, for whom the proliferation of specialist services has increased the treatment burden.
- Apart from a few examples, the exceptional potential of general practice has still to be imagined and realised. This can only be done by general practitioners working together and with others.
- Improving all kinds of relationships takes time and cannot be hurried
- More time is needed for consultations and case management, especially for selected patients with complex problems
- Re-assessment of individual patient needs (e.g. addressing uncoordinated care) should be the driving force for better integrated care, via multidisciplinary team meetings and improved links between services
- Continuity of care is a pre-condition and a quality marker for building patients' knowledge and confidence in living with their conditions and making good use of available services.
- Specialist services, including those in primary care, need to work more closely with general practice, via trusted referral links that are quick, local and familiar, including attached/embedded workers when justified
- Practices are best placed to assess local needs and can adapt quickly but GPs need protected time to lead service developments
- Practices must rise to the necessity of changing skill mix (e.g. the number, range and level of staff) to strengthen the generalist clinical function
- Better support is needed to allow sharing of experience, activities, information and plans between general practices.
- Better metrics are needed to monitor the effect of general practices, either singly or in groups, on patients' uses of emergency care.
- Better metrics are needed to monitor patient experience, especially patients requiring integrated care for complex combinations of conditions.
- GPs are needed for a role combining generalist clinical skills, leadership, capacity building, collegiality and advocacy.
- Further joint work is needed to develop shared understanding and expression of concepts of GP autonomy, mastery, purpose, leadership, collegiality and accountability.
- Imagining and developing the future of general practice must involve the next generation of GPs.

"General Practitioners at the Deep End" *work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Scottish Government Health Department, the Royal College of General Practitioners, and General Practice and Primary Care at the University of Glasgow.*

Full report available at www.gla.ac.uk/deepend

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GPs at the Deep End

CONTENTS

A. INTRODUCTION

Eight years after the first meeting of General Practitioners at the Deep End, this report takes stock of what has been achieved and looks ahead.

The Inverse Care Law, best understood as the difference between what general practices can do for and with patients in very deprived areas and what they could do if resourced more appropriately in relation to need, remains unresolved. (1)

A decade of preferential investment in specialist services in both secondary and primary care has unbalanced the NHS, reducing its capacity to contain patients' problems in the community, increasing pressure on emergency services and fragmenting care, especially for patients with complex multimorbidity, whose treatment burden has increased. (2)

At the same time the ageing population, increasing patient expectations and the transfer of work from secondary to primary care has increased workload in general practice, exhausting practitioners, making the job less attractive, reducing recruitment and increasing early retirement. The capacity of the NHS to deliver unconditional, personalised continuity of care has been seriously weakened. (3)

The over-riding challenge is to demonstrate that re-investment in generalist clinical care and GP leadership is essential in order to address key issues faced by NHS Scotland namely : an ageing population with increasing multimorbidity; fragmented care via multiple specialist services; increased pressure on emergency services and widening inequality. A key component of this challenge is to develop a role for GPs that attracts new recruits and retains experienced practitioners.

The Deep End Project has made a start, focusing on the problems of very deprived areas, but now seeks common cause and joint activity with other general practices seeking to define, protect and advance the role of clinical generalists in Scotland's National Health Service. (4)

NOTE As this is a long report, and sections might be read separately, some key statements are repeated throughout the report e.g. the emphasis on unconditional, personalised continuity of care for all patients as the basic function of general practice.

B. BRIEF HISTORY OF THE DEEP END PROJECT

The Deep End Project (i.e. the collaborative activities of General Practitioners at the Deep End) is 8 years old. Achievements include:

- Increased identity, voice, profile, influence, camaraderie and collegiality for general practitioners serving the 100 most deprived general practice populations in Scotland
- Participation by 75% of Deep End practices
- Advocacy concerning the nature and impact of the inverse care law

- Affirmation that the principal contribution of general practice to addressing inequalities in health is via unconditional, personalised continuity of care for all patients, whatever problem or problems they present.
- Dynamic collaborative projects including the Link Worker Programme, Govan SHIP, the Pioneer Scheme, attached alcohol nurses and embedded financial advisors
- Additional capacity for some Deep End practices including GP locums (Govan SHIP), GP fellows (Pioneer Scheme), protected time for GPs (SHIP and Pioneer Scheme), community link practitioners (for all Deep End practices from 2018), attached workers (SHIP, alcohol nurses, financial advisors, mental health)
- Productive partnership between service and academic general practitioners
- A website with Deep End Reports, publications and news (www.gla.ac.uk/deepend)
- Parallel Deep End Projects in Ireland, Yorkshire/Humber, Manchester and Canberra, Australia

The main Deep Projects and their key features are listed below. More information is available on the Deep End website. (4)

Link Worker Programme

- 7 general practices hosted a full time community link practitioner (CLP)
- practice development funding
- funded by the Scottish Government and administered via the Scottish Health and Social Care Alliance
- CLPs identified, developed and used links to community resources for health
- CLPs helped patients via signposting, one to one consultations, sorting problems and supporting referrals
- CLPs met weekly as a group for joint learning
- strong central support including programme manager and GP lead
- independent evaluation by the Scottish School of Primary Care
- programme now being rolled out via 250 new CLP posts

Govan SHIP (Social and Health Integration Partnership)

- 4 general practices have additional clinical capacity (about 10% extra) via GP locums
- funded by the Scottish Government and supported by the Greater Glasgow and Clyde Health and Social Care Partnership South Sector
- protected time for host GPs, used mostly for extended consultations with selected patients
- initially, attached social workers, followed by social care workers working below existing referral thresholds
- 2 practices have attached community link practitioners (to be increased to 4 practices, as part of the national roll out of CLPs.
- monthly multidisciplinary team meetings (MDTs)
- protected time for a GP lead
- dedicated administrative and information support
- independent qualitative evaluation by the University of Stirling

- learning events to embed knowledge and develop a shared language across participating professional groups.

Deep End GP Pioneer Scheme

- 5 general practices have additional clinical capacity (about 10% extra) via GP fellows
- funded by the Scottish Government and administered via the GGC Health and Social Care Partnership and RCGP Scotland
- protected time for service development by host GPs, including a lead GP role representing the practice in inter-practice and extra-practice activities
- practice GP leads and GP fellows meet as a group to share experience
- regular day release sessions for GP fellows, with educational content and outcomes posted on Deep End website
- shared learning among participating practices via online Trello platform and more widely via engagement with GP clusters.
- Supporting recruitment of future GPs through engagement with medical students and the University of Glasgow REACH (widening access) programme
- coordination via Lead GP and academic GP coordinator

Parkhead Financial Advisor Project

- 2 general practices have an embedded financial advisor, working as part of the practice team with weekly sessions in the practice
- funded by the Wheatley Housing Group and Greater Glasgow and Clyde Health Improvement
- facilitated and evaluated by Building Connections and the Glasgow Centre for Population Health
- new referrals, new claims and claimant incomes have increased
- The embedded advisor had access to casenotes, with consent, and prepared draft letters for GPs to check and sign
- ongoing internal evaluation and development via attached researcher
- dedicated information support
- The project involved no additional work for the practice. GPs report that it released time for clinical issues.
- the scheme is being rolled out in the local GP cluster of 9 practices and evaluated by the Glasgow Centre for Population Health

Attached Alcohol Nurses

- 6 general practices shared 2 FTE alcohol nurses
- funded by Alcohol and Drug Partnership Glasgow
- specific evaluation not funded, used existing addictions resource to examine activity and outcomes
- despite widespread support from all stakeholders and evidence of limited positive outcomes pilot not continued or expanded due to addiction budget cuts and falling between service 'silos'

- conclusion of a ‘topic review’ for a Health Technology Assessment by Health Improvement Scotland- there is an evidence gap about the efficacy of attached alcohol nurses to general practices in high problem alcohol use prevalence areas.
- follow up research is being explored in partnership with Scottish Health Action on Alcohol Problems (SHAAP)
- lobbying renewed following recent addictions funding announcement

In summary, the **active ingredients** of Deep End Projects include:

- Increased clinical capacity, about 10% extra, via GP fellows and locums
- Uses of extended consultations, mainly to coordinate uncoordinated care
- Protected time for GP leadership and service development
- Uses of link workers
- Experience of attached/embedded workers
- Multidisciplinary team meetings
- Advocacy for the “unworried unwell”
- Practices working together in non-geographical clusters
- Dedicated leadership, coordination and support
- Shared learning events and knowledge dissemination

C. LEARNING SO FAR

This section reviews learning from the Deep End Project, in terms of agreed general precepts and experience of advocacy.

Precepts

If the NHS is not at is best where it is needed most, inequalities in health will widen. (1)

Countries with strong primary care systems have better health outcomes and lower health care costs. (6)

This observation pre-dates most quality initiatives, including the rise of evidence-based medicine, is based on primary care as a whole with all its variations and cannot be attributed to a minority of leading general practices.

Essential features of general practice in the UK National Health Service, which make the NHS highly efficient in international comparisons, include:

- universal patient registration via general practice lists, providing cumulative and consistent population coverage;
- the absence of financial barriers at the point of use, reducing issues of access;
- the gatekeeping role whereby access to specialist services requires referral by a general practitioner and is not driven solely by patient demand
- pragmatic, conscientious and well organised clinical care in the community preventing, postponing or lessening disease complications, and reducing pressure on emergency services

The NHS will continue to provide its traditional functions of emergency care and access to specialist investigations and treatments. It will try to give more children a better start in life and to care for more people at the end of their life with dignity and in comfort.

Increasingly, however, the challenge will be to enable people with multimorbidity to live long and well with their conditions in the community.

When providing care for all patients according to their needs, general practice reduces pressure on emergency services, reduces fragmented care, improves health and narrows health inequalities.

General practice achieves this via unconditional personalised continuity of care, building long term relationships based on mutuality and trust.

The “silver bullets” of primary care are long term relationships.

Not all patients need such care. Patients who do include the sixth of patients, mostly with complex multimorbidity, who account for half of all GP consultations.

Patients with complex multimorbidity have different combinations of problems but similar needs in terms of generalist care provided by a small team whom they know and trust.

With intrinsic features of contact, continuity, coverage, flexibility, long term relationships and trust, general practices are the natural hubs of local health systems but need effective links to secondary care, community health services and community resources for health.

All kinds of relationships, whether between individuals or services, take time to develop and should not be deterred by slow progress or false starts.

While the active ingredients of general practice and primary care may be prescribed, their combination in local health systems, taking into account such factors as geography, history, culture, personality, resources and premises, can only be imagined, led and developed locally.

For general practice to be effective as a whole system, and not hundreds of separate, unconnected practices going their own way, new infrastructure is needed for the sharing of information, experience, views and activity. The success of the cluster model will partly depend on the arrangements made to deliver this function.

Based on activities of General Practitioners at the Deep End, there is no simple solution to primary care transformation, only a direction of travel and a commitment to share experience, evidence and learning along the way.

Joint working between practices implies that “the best anywhere should become the standard everywhere”. Experience, views, information and evidence need to be shared across the front line of the health service.

In the absence of research studies, practitioner experience and views are important sources of evidence. The Deep End Project has shown that roundtable discussions, involving GPs from 6-10 practices, are an effective way of capturing information that is representative of most practices serving deprived areas.

Advocacy

Despite many Deep End Reports, research papers and advocacy at many levels, the Inverse Care Law (i.e. the mismatch between health needs and GP funding) has still to be identified and addressed in either an official report of any of the central agencies of NHS Scotland or a policy of the Scottish Government.

Following publication of a research paper on the Inverse Care Law in Scotland in the British Journal of General Practice (5), both the First Minister and Cabinet Secretary for Health stated in the Scottish Parliament their intention that the issue should be addressed via the revised Scottish GP contract.

The revised Scottish GP contract provides an opportunity for BMA Scotland and the Scottish Government to show strong leadership in addressing the Inverse Care Law, instead of continuing to ignore it. Little progress has been made, however, partly because of BMA Scotland's concern not to "de-stabilise" other general practices, but also opposition from civil servants and NHS managers, on the basis that the GP contract provides no guarantee as to how additional funding would be spent.

Additional funding for primary care has been announced by the Scottish Government, without clarifying how much is to be earmarked for general practice to strengthen the generalist clinical function. The funding is to be administered by the Integrated Joint Boards of local Health and Social Care Partnerships which have little experience of funding general practice and which are generally preoccupied (as can be judged from IJB minutes) by the management and resourcing of community health services.

A culture shift is required, with change on both sides. IJBs have the power and resource. General practices have local knowledge, population contact and coverage, plus continuity, flexibility and the ability to adapt quickly. The new general practice clusters provide a testing ground for joint working.

The majority (i.e. 80%) of general practices serving very deprived areas continue to work in circumstances which are similar or worse than those pertaining in 2009, addressing higher levels of premature mortality and morbidity with no extra GP funding, resulting in shorter consultations, reduced expectations, less patient enablement, poorer outcomes and greater practitioner stress. (7) Preventable complications are less likely to be prevented. Greater pressure is put on emergency services.

Exceptions are the 20 Deep End practices which have had their situations partially relieved by involvement in government-funded programmes such as the Link Worker Programme, Govan SHIP and the Deep End GP Pioneer Scheme.

The ineffectiveness of advocacy concerning the Inverse Care Law has not been for the want of evidence or effort and may be considered as part of a more general phenomenon in NHS Scotland whereby power and resource are configured around specialism and managerialism rather than generalism. There are many associated explanations.

- the most important work of general practitioners, with patients with complex muiltimorbidity, is "out of sight and out of mind";
- effective generalist care is hard to document as it mainly results in non-events (e.g. fewer disease complications, less use of emergency services)
- the effects of a general practice on population health and patient's use of unscheduled care are difficult to demonstrate because of small numbers, the many sources of variation between practices and the lack of resource applied to this type of research
- the convention of grouping general practices for review and analysis by geographical area misses the information that could be obtained by grouping practices serving similar types of population (e.g. very deprived areas) or with similar operating characteristics e.g. practice size, type of premises etc.
- most evidence-based medicine, and associated clinical governance (such as the Quality and Outcomes Framework), is based on the management of single conditions, rather than the generalist approach required for multimorbidity

- over 90% of health research and academic funding supports specialism, via biomedical and clinical research
- the most powerful and influential medical institutions tend to be specialist-based
- the contractual independence of GPs, keeps them at arm's length from NHS managers, who are mostly involved in the management of hospital services and specialist services in the community
- variation between general practices can result in the majority of practices being perceived in terms of the performance of a few e.g. high earning and/or high referring practices

In consequence, neither specialists nor managers, nor the politicians and civil servants they influence, have seen general practice as an important or manageable solution to the problems commanding their attention (e.g. rising elderly admissions, pressure on emergency services, fragmented care). A competing narrative is needed, with evidence, to show the cohering benefits of generalist care.

D. **THE CHANGING CONTEXT**

This section describes major issues affecting NHS Scotland in addition to the Inverse Care Law, such as increasing pressure on emergency services and the manpower crisis in general practice, but begins by addressing the challenge of multimorbidity.

Multimorbidity

In a review of the 40 commonest chronic conditions in Scottish general practice, patients with only one condition and no other were a minority, and usually a small minority of patients. Most patients had two or more other conditions. (8)

The study took no account of social and financial problems, either of individuals or their families, which are steeply socially patterned and add to the complexity of multimorbidity, especially in deprived areas.

Simple multimorbidity involving two conditions may not be challenging for either the patient or for their health professionals e.g. a patient with high blood pressure and one other condition

Complex multimorbidity, defined either as 5+ conditions, or the combination of physical and mental health problems or the combination of three physical conditions in different clinical specialties, is more prevalent and occurs 10-15 years earlier in deprived areas, where the commonest co-morbidity is a mental health problem. (5,8)

The patient's treatment burden comprises the work required to live successfully with a condition, including understanding the condition and its treatments and accessing and making good use of available services and resources. (9)

Patients with discordant multimorbidity (i.e. several conditions spanning different clinical specialties) have the greatest treatment burdens, yet are often the least able to overcome them in terms of health literacy, personal agency and family resources.

Such patients need specialist attention on occasion but what they need most is continuity of care from a small generalist team whom they know and trust. Adequate consultation time and continuity of care are the keys to “Realistic Medicine”, addressing fragmented care and over-treatment. Self-help and self-management are important objectives, but are often destinations rather than starting points in deprived areas where the “unworried unwell” need a “worried doctor” to start the process.

This aspect of care needs to be strengthened but has been weakened in the last decade.

Since 2004, consultant medical staffing has increased by over 50%, while the community health service share of the NHS budget increased by a similar amount. Over the same period, the general practice share reduced by a sixth. (2)

Specialist services in secondary and primary care typically work with referral criteria, waiting lists to control demand, evidence-based protocols and discharge back to general practice when they are done. Such work is usually done to a high standard, based on internal criteria, but leaves a lot for general practice to do, with patients who do not meet the criteria, are poor at accessing unfamiliar services, who have other conditions or who are not made better by treatment. Weakened general practice is less able to absorb such work.

Fragmentation of care occurs:

- when consultations are too short to cover patients’ problems
- when patients with multimorbidity attend different clinics for different conditions
- when professionals have little or no previous knowledge of the patient
- when there is poor communication between services
- when waiting times are long
- when patients do not attend appointments and are “dropped” by services

By focusing on the patient in addition to the patient’s conditions, generalist care is better placed to provide the continuity and coordination that most patients with multimorbidity require.

NHS Scotland has been slow to recognise, respond and prepare for the challenge of multimorbidity. Many of its institutions and ways of working are no longer fit for purpose.

Pressure on emergency services

Although the gatekeeping function of general practice is usually considered in terms of patient access to specialists, another aspect concerns patients’ use of emergency care (i.e. out of hours, A&E, acute hospital admissions). In this context there is no gate, only a gateway that patients can go through at any time. What keeps patients in the community is satisfaction with the care they receive and the prevention, postponement or lessening of complications from their conditions. If patients cannot access care, are dissatisfied with the care they receive or complications have not been prevented, they fast-track to emergency services.

The NHS neglects this aspect of gatekeeping at its peril but this is what it has done over the last decade, by choosing to increase investment in specialist services in both secondary and primary care, thus reducing the general practice share of the NHS budget, disturbing the balance between generalist and specialist care, and relying on expensive emergency services to deal with the consequences. The answer to this problem is neither more A&E consultants nor the placing of general practitioners in A&E departments.

Weakened general practice is not the only factor driving the increase in emergency elderly hospital admissions. Reductions in the capacity of district nursing and social work services have also contributed. (2)

The manpower crisis in general practice

The effects of a decade of underfunding of general practice have been compounded by increasing workload due to the ageing population, increased patient demands and the unfettered transfer of work from hospitals.

Many general practices are working 11-12 hour days. GPs are opting in increasing numbers for early retirement. General practice is struggling to recruit young doctors. Recently qualified GPs are choosing to work as peripatetic locums, or in out of hours services while others are leaving to work abroad. The intensity of clinical work in general practice has led to many GPs working part-time.

The current business model of general practice may not survive as the risks and costs (including premises and indemnity costs) become unattractive to GPs.

The GP landscape will increasingly be marked by “sinkholes”, as vacancies cannot be filled, practices become unsustainable and Health Boards make stop-gap arrangements.

Adjustments to skill mix (i.e. the combination of health professionals and higher-skilled administrative staff working together in a practice) will be a major transitional feature of the next decade and must preserve a strong generalist function.

Inequalities in health

The most important public health function of general practice is to provide unconditional, personalised continuity of care for all patients, whatever problem or combination of problems they have.

There are other aspects of public health, whereby the population contact of general practice is used to deliver public health programmes, such as immunisation, and screening, but these should not detract or take the place of the public health role of clinical activity.

General practice can either narrow or widen inequalities health, depending on whether it is delivered equitably in relation to need. Continued emphasis on the Inverse Care Law is necessary for several reasons

- The greater patient burden in very deprived areas from premature mortality and complex multimorbidity, including combinations of physical and mental health problems
- The higher prevalence of specific problems such as mental ill health, drug and alcohol misuse, vulnerable families etc
- The lower levels of health literacy and personal agency (the “unworried unwell”) which increase the time needed to engage and work with patients
- The flat distribution of GP funding per patient, especially in the 40% most deprived section of the Scottish population (i.e. the Inverse Care Law)
- Widening of health inequalities if the Deep End is neglected and left behind

It is important to note that the 100 Deep End general practices only address the challenge of “blanket deprivation”, with 44-88% of their patients living in Scotland’s 15% most deprived data zones.

About one third of people living in the 15% most deprived data zones are registered with Deep End practices. The other two thirds are registered with about 600 other general practices throughout Scotland, dealing with “pocket deprivation”.

Many of the solutions which have been developed in the Deep End Project need to be rolled out on a pro rata basis to other practices.

Conclusion

Recent trends have taken the NHS to the brink, weakening the ability of general practice and primary care to keep patients in the community, flooding emergency services with patients and threatening to capsize the system. An alternative narrative is needed in which generalism is seen as the answer to three problems :- keeping care in the community, addressing fragmented care and reducing health inequalities. In generating such a narrative, the Deep End Project seeks common cause with other general practices in Scotland.

E. **FUTURE CHALLENGES**

The strengths of general practice, sometimes called the “essence” of general practice, are contact, continuity, population coverage, an unconditional approach, flexibility, long term relationships and trust. (10)

These features are not exclusive to general practice and are displayed variously between practices, but no other part of the public service has these features in such large degree.

Trust is not an intrinsic feature of services but earned on the basis of positive experiences and confidence. Future arrangements must not undermine such trust, or the activities on which it is based.

Generalist care is the antidote to inefficiency caused by health care fragmentation and dysfunction (e.g. as provided by multiple separate specialist services).

Specialist care needs to work more effectively with generalist care by bringing care, whenever possible, closer and more quickly to the patient.

In the 1970s a famous paper celebrated the “***exceptional potential of the GP consultation***” in terms of the opportunities provided to deal with acute problems, chronic problems, social problems and the prevention of future problems. (11)

However, consultations are also building blocks via serial encounters for a larger agenda.

The challenge is to imagine, realise and advocate the ***exceptional potential of general practice*** as the natural hub of local health systems and capable of:

- improving population health
- avoiding fragmentation of care
- boosting long term care in the community
- reducing pressure on emergency services
- narrowing health inequalities.

General practice can achieve this by delivering its basic clinical task:

- providing unconditional, personalised continuity of care for all patients, whatever problem or combination of problems they have while investing in three building programmes
- building patient's knowledge and confidence in understanding and living with their conditions and making good use of available services and resources
- building the hub function of general practice via the practice team and improved links to other services and local resources
- building general practice as a whole system in which individual practices are connected by shared purpose and learning

Section E describes the active ingredients of such care, as developed so far via Deep End Projects.

Section F addresses more strategic issues, including the recruitment and retention of general practitioners and the infrastructure and support required for general practices to operate as a whole system.

Section G speculates on next steps for general practice.

F. **PRIMARY CARE DEVELOPMENT**

This section draws on experience, audits, evaluations and research in several Scottish Government-funded projects involving general practices serving very deprived areas. The conclusions and recommendations have wider relevance, however, and may be applied to general practice throughout Scotland.

No masterplan or blueprint is proposed. Rather, the paper attempts to identify active ingredients, whose combination in local packages can only be determined by professionals who know their situation and community well.

A King's Fund report described the active ingredients of coordinated care for a variety of schemes including palliative care at home, mental health services, home care for people with dementia, care for older and frail people and complex case management to reduce unnecessary hospital admissions. (12)

The report questioned the need for defined care packages, arguing that protocol driven approaches lack the flexibility that patients with complex needs require. Such schemes are weaker without GP engagement, knowledge and leadership. Bottom-up developments are needed to develop "the building blocks of effective partnership working" rather than "top down approaches, no matter how well they may have worked elsewhere". Most of the projects took six to seven years to achieve the desired changes.

Active ingredients

1. Additional clinical capacity
2. Consultations
3. Cumulative knowledge and experience
4. Population coverage
5. Information

6. The practice team
7. Integrated care
8. Referral links within primary care
9. Referral links to secondary care
10. Community links
11. Quality improvement
12. Protected time for GP leadership
13. Research and development
14. Advocacy

1. Additional clinical capacity

It has been crucial that projects involving GPs in primary care development have included some additional clinical capacity to address unmet need and to release GPs from the pressures of clinical work in a Deep End practice.

In the Govan SHIP project, 4 practices hosted a half-time GP, employed as a long term locum, releasing the time of host GPs so that each can have one weekly session of protected time.

Subsequently, two of the locum doctors became NHS principals in Govan general practices.

In the GP Pioneer Scheme, 5 practices host a GP Fellow, working 6 clinical sessions per week in the practice, 3 sessions as additional capacity and 3 sessions to release the time of host GPs.

In both cases, the additional clinical capacity amounts to about a 10% increase which, although modest, has been sufficient to reduce pressure, raise morale and enable GP involvement in other aspects of the projects.

Other Deep End Projects have not involved additional clinical capacity although the Link Worker Programme was reported by some practices as enhancing the generalist function, based on link workers being able to accept patient referrals from GPs and to help sort out patients' problems via one to one encounters.

A key aspect of the Parkhead project involving an embedded financial advisor is that benefits for patients were increased without adding to practice workload.

2. Consultations

Consultations between practitioners and patients who are ill or who believe they are ill are the cornerstone of clinical practice, from which almost everything else flows. (11)

The initial aim of the consultation is to address the problem or problems presented by the patient. The medium to long term aim is to help build patient knowledge and confidence in understanding their condition(s), making good use of available services and resources and living long and well with their conditions.

It is axiomatic that practitioners must be competent clinical generalists able to respond unconditionally to whatever problem(s) a patient may present.

The generalist role must be protected, and not weakened by the development of specialisms within general practice (including the specialism of only seeing complicated cases).

Relevant patient outcomes are improved health status; satisfaction with the advice and care received; prevention, postponement or lessening of complications; and infrequent use of emergency care services.

The pace and route by which such aims are achieved are partly determined by the patient's starting position on a spectrum from "worried well" to "unworried unwell". In the latter case the "worried doctor" has an important role.

Research on consultations shows that while patients may report practitioner empathy (e.g. the practitioner knowing and caring for the patient) without being enabled (i.e. better able to cope with their conditions and life in general), patients never report enablement without also reporting practitioner empathy. (13) Relationships are key.

Vacant (or "catch-up") slots in booked surgeries provide flexibility to give more time to patients who need it on an ad hoc basis. (14)

Extended consultations/case-management (e.g. for 30-45 minutes) for selected patients can help to re-plan and coordinate their care. Deep End Report 29 highlights the complexity of many of the patients' problems which GPs selected to address via extended consultations. (15)

In the Care Plus study, extended consultations were a cost-effective way of increasing patients' quality of life over a 12 month period. This was achieved partly by improvements in the quality of life of patients receiving longer consultations but was also explained by the decline in quality of life in patients not receiving the intervention. (16)

3. Cumulative knowledge and experience

Continuity of contact builds shared knowledge, experience and trust. (17)

Shared knowledge, experience and trust from previous contacts increases what can be achieved within consultations, especially short consultations where there is less time to address issues. (18)

Serial contact provides opportunities for building patient's knowledge and confidence in understanding and living with their conditions, accessing relevant services and avoiding complications.

In general, little is known about best use of the "serial encounter", comprising all the contacts which a patient has with services, in order to build patient's knowledge and confidence.

While record review is an important first step in identifying categories of patient, such as frequent attenders, and patients with complex multimorbidity, practitioner's cumulative knowledge and experience of patients can help to refine the selection of patients for special intervention (e.g. not all patients with multimorbidity are complex; frequent attenders may attend for good reason). Not all patients will benefit from longer consultations.

In both the Govan SHIP Project and the Care Plus Study the patients selected for extended consultations were patients whom practitioners knew and for whom they considered that an extended consultation would be useful.

4. Population coverage

General practice only contributes substantially to public health when effective care is provided for all patients.

Cumulative contact with patients over time provides a large measure population coverage (typically two thirds of patients in a year, 90% over 5 years), which can be increased by special measures to increase coverage rates further.

High rates of population coverage for specific issues have repeatedly been shown to be possible, but require dedicated effort.

Screening is generally less efficient, in terms of population coverage and the generation of false positive cases.

The practical consequence of the way that general practices acquire population coverage is that presenting complaints always have to be addressed before other issues can be raised.

Information systems that allow the “measurement of omission” are the key to increasing the population coverage of effective care. (19) This aspect of care was developed to a high level in most practices to reach the targets set by the Quality and Outcomes Framework.

Routine consultations, message alerts and reminders to patients are the main mechanisms whereby general practices generate and maintain population coverage. Special measures to increase coverage rates are required for relatively few patients.

5. The practice team

Protected time is needed to promote team wellbeing. A team that doesn’t look after itself is less likely to be effective in looking after others.

Practice teams work to the generalist ethos that the patient’s problem is the practice’s problem and that decisions will be taken promptly to deal with it, either within the practice or via referral.

Specialist inputs to the practice team can relieve pressure on the generalist function but cannot replace it.

As GPs are in short supply, roles within the practice team (e.g. GPs, nurses, practice manager, administrative staff, link worker etc.) should be clarified and developed, with responsibilities allocated and taken according to needs, aptitudes and circumstances.

6. Information

Health systems only improve when performance can be reviewed, problems identified and solutions developed.

Progress in general practices is assessed by comparing either current performance with past performance, or by comparing practice performance with the performance of similar practices.

Some uses of routine information have been developed to inform such comparisons, but much more needs to be done, allowing practices to interrogate their data and make useful comparisons with other practices, taking account of important variables such as practice size, clinical capacity, demography and socioeconomic status.

Such development work needs to be supported centrally, in partnership with practices, giving them opportunities to ask the questions and determine priorities.

Govan SHIP is the only Deep End project to have had such dedicated support.

7. Integrated care (20)

Assessment and/or re-assessment of patients' needs (or, more accurately, their uncoordinated care), was achieved in the Govan SHIP Project, the Care Plus Study and the GP Pioneer Scheme via extended consultations, which have helped reset the agenda, establish priorities and drive integrated care.

Regular multidisciplinary team (MDTs) meetings within the practice, and involving key external staff (e.g. district nurses, health visitors, social workers) provide important opportunities to share information (e.g. from different information systems), review cases, plan care and involve new colleagues.

In this way, integrated care is driven "from the bottom up", with local services and joint working arrangements being put to the test of addressing patients' problems.

Govan SHIP has had additional administrative support to service MDT meetings, ensuring that agendas are planned, meetings arranged and records kept.

8. Referral links within primary care (21)

Experience shows that referral links to other primary care services in the community should be quick, reliable, flexible and familiar.

In developing the hub role of general practice within local health systems, the challenge is to shorten the links to other services, bringing them closer to patients, especially patients with multimorbidity, via attached worker arrangements.

Attached worker arrangements have been developed with social workers (22), alcohol nurses (23), financial advisors (24) and mental health workers. Co-location on its own is not a guarantee of joint working. Attached workers who are embedded within practices are more likely to be effective.

9. Referral links to secondary care

Current arrangements provide little opportunity for generalist and specialist clinicians within localities to share experience, problems, views, information and activity.

10. Community links (25)

A major but largely underdeveloped resource for helping patients to live well and long in the community is linkage with community resources for health and healthy living. Voluntary and third sector organisations are an important component of this landscape but need secure funding.

Every general practice needs accurate and up to date information about other community resources for health.

Link workers are an important new addition to the practice team, forging links with community resources, signposting and helping patients to access relevant resources and keeping other members of the team informed.

Link Workers who engage with patients are also an important addition to the generalist role, responding unconditionally to patients' problems, linking with relevant community resources, sorting out fragmented care and building knowledge and confidence in patients.

While link workers are a valuable addition to the general practice team, they are not a solution to the lack of clinical generalist time in very deprived areas as a result of the inverse care law.

11. Quality improvement

Daily experience and team contact provide frequent opportunities to identify and share ways in which local services can be improved.

GPs have an important role in initiating, piloting and authorising change within practices, but should hand over leadership and responsibility within the practice team as soon as feasible, to remain catalysts of change.

GPs can also take a lead role for changes involving other services and colleagues, for which protected time is required to establish and develop the necessary relationships.

Many new service developments need to be customised to local circumstances, learning by trial and error and informed by regular rapid feedback from all involved. The Parkhead project had additional support for this type of ongoing internal evaluation.

Practice development is more likely to occur when there is bespoke information on practice performance including:

- Measurement of omission – information systems which allow identification of tasks not done, non-responders, patients who have fallen out of review, etc.
- Significant Event Analyses (SEA) – learning from adverse events
- Internal evaluation – learning and responding quickly to problems in service delivery, based on the knowledge, experience and views of patients and staff (e.g. Plan, Do, Study, Act)
- Data comparing practice activity and performance with similar practices

12. Protected time for GP leadership

Remote management can support general practice and primary care development but is limited in its ability to drive local change.

GPs have the cumulative knowledge, experience and authority, but not the time or opportunity to lead local change.

The Govan SHIP and Pioneer Scheme have shown the value of protected time for GP leadership, enabling experienced GPs to address issues which they normally do not have time to address.

Deep End Report 29, based on GPs' use of protected time over a fortnight, showed that extended consultations and case note reviews were the main uses of protected time, but several other types of activity were recorded, including attendance at case conferences, special audits and liaison with other services. (15)

In the Pioneer Scheme, protected time for lead GPs is being used for service development, with experience and findings shared between practices.

For both projects, the protected time has been generated via additional clinical capacity, involving long term GP locums in Govan SHIP and GP Fellows in the Pioneer Scheme.

Experience of protected time is evolving, and it is not yet clear how such time is best provided, used and shared within practices.

Protected time is standard for consultants in secondary and primary care and needs to be normalised within general practice.

13. Research and development

External evaluations of practice developments need to take account of their emergent developmental nature. A problem with research designed to evaluate a specific model of practice is that the model may evolve while the research is taking place (e.g. as happened with the external evaluation of the Link Worker Programme).

Co-design involving researchers and practitioners is often needed at the initial stage of studies (as in the Care Plus Study), so that both are aware of what is desirable, necessary, likely and possible.

For research studies to reflect the nature of generalist clinical work, case definitions should exclude as few patients as possible. It follows that health outcomes need to be measured in general terms (e.g. quality of life) in addition to disease-specific indicators.

Case definitions based on routine data (e.g. frequent attenders, complex morbidity) may need to be refined (as happened in the Care Plus Study) with practitioner knowledge of patients.

Developmental work is needed on:

- Measures of “general practice impact assessment” whereby NHS policy proposals are considered in terms of their impact on continuity of care, coordination of care and population coverage.
- Measures of patient experience, especially trajectories of integrated care, including how such information can be collected routinely, including the “measurement of omission”.
- Measures of the strength of local health systems, based on the sum of working relationships between individuals and between services.
- Better use of routine data, including aggregates of practices serving similar types of population to assess their contributions to health improvement and patients’ use of emergency services.
- Filling the evidence gaps caused by research which excludes particular types of patient and place.
- A mixed method research framework that fits better with the complexity and messiness of real life situations.

14. Advocacy (26)

A practice team’s cumulative knowledge of patients, their problems and recent experience of policies and services gives them huge authority in advocating on behalf of patients for

changes in policy, health care organisation and delivery at national, area (Health Board) and local (cluster) levels.

In this way, GPs may act as proxy representatives of their practice populations, especially for groups of patients who tend not to be represented.

The effectiveness of advocacy is increased when GPs can convey the coherent view of many practices, when points can be illustrated with references to individual patient stories and when arguments are based on practical solutions rather than negative criticism.

In this way the Deep End Project, comprising the various activities of General Practitioners at the Deep End, has served as a spearhead project, providing an example of collegiate working between practices and showing the value of general practice with a particular focus on patients and families with premature multimorbidity and social complexity.

G. ATTRACTING AND RETAINING GENERAL PRACTITIONERS

General practice can only survive to realise its exceptional potential if it attracts new recruits and retains experienced GPs.

The Deep End Project has shown that highly motivated GPs have an appetite for improving care and can be supported to deliver improvements on a collegiate basis.

The key to GP recruitment and retention is that the role of GPs in the NHS is an attractive career choice. The current model is not proving to be attractive.

For many general practitioners getting to the end of a very busy day is the limit of their current ambition. Many older GPs are “hanging on” until retirement. Recently qualified GPs are choosing to be peripatetic locums, with limited engagement in the challenges facing general practice. Some are moving abroad. Many are favouring part-time options.

These are understandable personal reactions to current circumstances, but are essentially negative responses, offer little hope for the future and consolidate a situation in which practitioners are drained rather than energised by their work.

A precondition for imagining an alternative future is to address the issues which have brought about the current situation, especially the shortage of time within consultations to address patients’ needs, perceived practitioner isolation, the overflow of work from secondary care and the increase in administration work, including electronic correspondence.

Potential solutions to restoring a sustainable balance to the work of general practitioners include increased nursing, pharmacy, physiotherapy and administrative support. Such support has had a transformative effect in other health systems experiencing a “doctor crisis”. (27)

In each case, the new roles need to be integrated within practice teams and evaluated in terms of their effectiveness, value and contribution, including whether and by how much they release the time of general practitioners (i.e. support generalist clinical care)

Professional drive

Professional work that is energising rather than draining has three characteristics – autonomy, mastery and purpose. (28)

Autonomy implies the ability to make choices about the content and direction of work. GP autonomy is important not only for morale, but also because the best local arrangements can only be determined on the basis of local knowledge.

GPs' cumulative knowledge and experience of patients' needs provides them with authority in identifying problems which need to be addressed in service organisation and delivery.

Autonomy is expressed as the distinctive entrepreneurial and organisational skills that allow general practice to adapt quickly to new challenges. Autonomy does not imply license or lack of scrutiny, however, and needs to be accompanied by mechanisms of accountability.

Mastery implies personal satisfaction and external approval for tasks well done. For GPs, the type of mastery that is of most value to the NHS is not expertise in specialist or technical tasks, nor the achievement of QOF targets (mostly involving the work of practice nurses) but rather the ability to respond unconditionally, and in a flexible but sustained productive way, to patients' problems, especially the minority of patients with complex multimorbidity who account for over half of GP consultations. The nature and content of such work tends to be unrecorded, undervalued and under-supported.

Purpose implies long term direction. Three building programmes are required: first, the traditional task of building patients' knowledge and confidence so that they can live longer and better with their conditions; and second, the new challenge of building the capacity of local health systems to respond promptly and effectively to patients' needs. Both programmes require a sustained, flexible approach, undeterred by short term obstacles and disappointments.

While autonomy, mastery and purpose are essential for making the work of general practitioners attractive, they are insufficient as a basis for general practice as a functioning whole system. This requires a third building programme with three key features – leadership, shared learning and accountability.

Leadership

In "*The Doctor Crisis: How physicians can, and must, lead the way to better health care*", Dr Jack Cochran, executive director of the Permanente Organisation in the United States, writes: (27)

> *Solving the doctor crisis means removing the many barriers between doctors and their patients. But it also means demanding that physicians step up and take stronger leadership roles on behalf of their patients.*

Relevant experience in Deep End projects includes:

- Protected time for GP leadership roles in the Govan SHIP Project, Link Worker programme and Deep End GP Pioneer Scheme, coordinating the activities of participating practices and representing practices in relationships with project partners.
- In both cases the authority of the GP lead role was enhanced by also being involved in a participating practice. Their authority was based on experience and relationships rather than position.

Collegiality and shared learning

Protected time and administrative support is needed to create opportunities for sharing experience, views, information, evidence and activity, so that the "best anywhere becomes the standard everywhere".

Relevant experience from Deep End Projects includes the GP Pioneer scheme:

- A fortnightly day release programme for GP fellows, including sessions with relevant specialists, capturing key points for general practitioners and recording this learning on the Deep End website for use by colleagues
- Regular protected sessions for practice GP service development leads, reporting and sharing experience of practice development projects

In the Link Worker Programme, community links practitioners met weekly to share their experience and views.

An important aspect of collegiality and shared learning should be the involvement of secondary care colleagues.

Accountability

The corollary of autonomy in spending public funds is accountability for their use. The lack of such accountability is a major obstacle to the use of the GP contract as a mechanism for targeting additional resources to practices serving very deprived areas.

In addition to external accountability to the funding body, there is also internal accountability between general practices working together, either in geographical clusters sharing local resources or non-geographical groups addressing similar challenges.

In this context, weak performance by one practice is a problem affecting all practices in the cluster or group.

Supporting the next generation of GPs

All of the above themes are "works in progress". There is no blueprint or logic plan, only a direction of travel and a commitment to share learning.

The challenge is to imagine and develop a role for GPs which meets patients' needs, provides professional satisfaction and offers a better solution to the problems of the NHS.

This challenge must be addressed ***with*** the next generation of GPs (e.g. medical students, FY1 doctors, GP registrars, GP fellows and newly qualified GPs) ***and not for them***.

GPs' future roles need to be imagined, tried and tested, in a collegial environment that protects against professional isolation and burnout.

H. NEXT STEPS FOR GENERAL PRACTICE

Don Berwick, former CEO of Medicare and Medicaid in the US, wrote "in the future health professionals must ask themselves not only what do I do but also what am I part of?"

General practice will continue in some form, influenced partly by external factors but also by the actions of general practitioners. This section focuses on the latter, as a way of influencing the former.

Rhetoric is weak by itself and much strengthened by facts on the ground.

If GPs do not themselves imagine and work towards a future of general practice that retains and builds on its best features, it is doubtful that others will instead.

While a focus on deprived areas is necessary to address inequalities in health, the next steps described below apply to almost all general practices in Scotland and can be seen as a common cause.

Basic premises and aims:

- to provide unconditional, personalised continuity of care for all patients, whatever problems or combination of problems they have
- to build patients' knowledge and confidence in living with their conditions and making good use of available services and resources
- to drive local arrangements for integrated care based on the needs of patients with complex multimorbidity
- to strengthen the hub function of general practice via links with other services and community resources
- to strengthen general practice as a whole system via collegiate working with other practices

Actions within general practices include:

- making the best use of practice resources for the benefit of patients (i.e. access and range of services)
- maintaining the health and morale of the practice team
- adjusting skill-mix and responsibilities within the practice team, to make best use of everyone's abilities, including the time and skills of general practitioners
- integrating embedded and attached workers as part of the practice team
- increasing patient use of community resources for health (via community links practitioners where available)
- strengthening practice links with other services in primary and secondary care

The Deep End Project can help by sharing learning and examples e.g.:

- experience of GP protected time for extended consultations (Govan SHIP Project and Pioneer Scheme)
- experience of GP protected time for service development (Govan SHIP Project and Pioneer Scheme)
- experience of GP locums and GP fellows to provide additional clinical capacity and protected time for host GPs (Govan SHIP and Pioneer Scheme)
- experience of attached workers (financial advisors, alcohol nurses, social care workers, mental health workers)
- practice experience of working with community links practitioners in the Link Worker Programme

- experience of GP leads in coordinating projects involving groups of practices (Govan SHIP, Link Workers, Pioneer Scheme)
- experience of working with an enhanced multidisciplinary team (Govan SHIP)

The principle mechanisms for alerting practices to Deep End practice experience are:

- website (www.gla.ac.uk/deepend)
- social media (e.g. twitter @deependgp)
- Deep End reports (in short and long forms)
- education and training materials from the GP Pioneer day release scheme
- newsletters
- meetings

New roundtable meetings are needed to capture and report practice experience and views of:

- changing skill mix
- uses of GP protected time
- service developments
- working with community link practitioners
- balancing GP autonomy and accountability

The Deep End Project continues to advocate and lobby on the following issues:

- the Inverse Care Law
- the needs of patients and families in very deprived areas (including the “unworried unwell”)
- protected time for GP leadership
- best use of community link practitioners
- embedding of attached workers (e.g. financial advisors, alcohol nurses, mental health workers)

Advocacy for general practice will only be successful if general practice can be shown:

- to coordinate and lead high quality care in the community, especially improving the experience of patients with complex multimorbidity
- to prevent, postpone and lessen disease complications
- to lead developments in changing skill-mix
- to reduce pressures on emergency services
- to develop and establish norms which reduce variation between general practices
- to improve health and narrow health inequalities

Evidence of such effects will require collaboration with information specialists and researchers e.g. the Scottish School of Primary Care. Research is needed to develop:

- Measures of “general practice impact assessment” whereby NHS policy proposals are considered in terms of their impact on continuity of care, coordination of care and population coverage.
- Measures of patient experience, especially trajectories of integrated care, including how such information can be collected routinely, including the “measurement of omission”.
- Measures of the strength of local health systems, based on the sum of working relationships between individuals and between services.
- Better use of routine data, including aggregates of practices serving similar types of population to assess their contributions to health improvement and patients’ use of emergency services
- Filling the evidence gaps caused by research which excludes particular types of patient and place
- A mixed method research framework that fits better with the complexity and messiness of real life situations

The contribution of these activities to the recruitment and retention of general practitioners is based on 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 on joint working, peer review and shared learning with other practices
- Advocacy based on collective experience and common cause
- Involvement of the next generation of GPs in all the above.

Involvement of the next generation of GPs in Deep End activities has included:

- Protected time for GP Pioneer Fellows, including time for shared learning, service development projects and joint meetings with practice GP leads
- Undergraduate Student Selected Courses (SSCs), elective placements and intercalated degree projects in Deep End practices
- Briefing sessions for medical students (e.g. medical student conference on 7th October 2017, reported on the Deep End website)
- GP locums in the Govan SHIP project have progressed to full partnership in two participating practices.
- Engagement with the University of Glasgow’s REACH programme, supporting pupils from schools in the most socio-economically deprived areas to get into medical school.

The Deep End Project comprising the collective activities of General Practitioners at the Deep End, continues to include:

- Participation at Deep End meetings – open to all
- Participation in Deep End projects (e.g. Govan SHIP, Pioneer Scheme)
- Lead advocacy roles on specific themes (see www.gla.ac.uk/deepend)

- Membership of the Steering Group (quarterly afternoon meetings, open to any Deep End GP on one-off or continuing basis, locum payments available for clinical backfill, new members welcome)

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