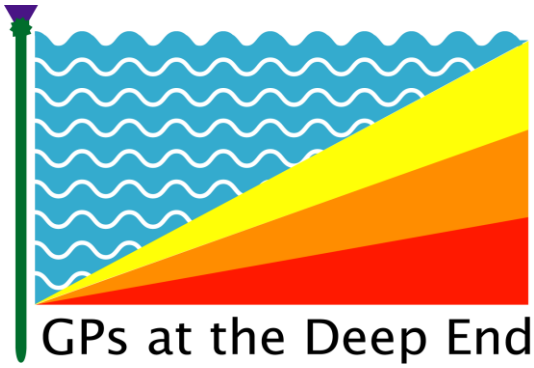

DEVELOPING A DEEP END PROJECT

Graham Watt

When asked whether a new group can call themselves a Deep End Project, we thank them for their courtesy, ask that they use some quantitative method to identify general practices serving areas of blanket deprivation and encourage them to adapt a local version of the Deep End logo.

This is a description of how the Scottish Deep End Project developed over a decade. It is not a prescription for how other Deep End Projects should develop, but a reflection on Scottish circumstances and opportunities.

At its heart, the Deep End Project encourages and supports GP leadership at several levels to address the difference between what general practices serving very deprived areas can and could do to improve the health of their patients (i.e. realising the exceptional potential of general practice, following and building on the example of Dr Julian Tudor Hart).

In general, the steps have included :-

1. Initial engagement with general practitioners, capturing their experience and views to establish legitimacy, identity, voice and an agenda
2. Shared activity, addressing parts of the agenda, whether collecting information, advocacy or service development, usually starting small, to establish and build momentum, collegiality, profile and example
3. Coordination and communication within the network, usually, but not necessarily, from an academic base.
4. GP ownership and leadership via regular meetings of a steering group
5. Flexibility, allowing survival and progress despite frustrations, disappointments and competing pressures
6. Alliances and joint activity with partner groups and organisations

7. Advocacy based on evidence, argument and practical example
8. Shared learning
9. Involvement of general practitioners at every stage of their careers.

Defining blanket deprivation

Deep End practices had first been identified as part of the Primary Care Observatory Project, which was similar in intention to Public Health Observatories with the key difference of using general practice list denominators rather than geographical denominators and grouping practices serving similar types of population irrespective of their geographical relationships.

Practices were ranked, therefore, according to the proportion of patients on their lists living in the 15% most deprived Scottish datazones – an arbitrary criterion based on the Scottish Government's targeting of deprived areas. Practices were then divided into ten groups of equal population size. As practices serving deprived areas tended to be smaller, the most deprived tenth of practice populations involved more general practices than other tenths.

The first meeting

When RCGP Scotland set up a working group to look at what general practitioners could do to address inequalities in heath, it was decided not to produce a report on health inequalities nor to provide general practitioners with a tool kit but rather to listen to what general practitioners serving the 100 most deprived general practices, and covering the most deprived 8% of the Scottish population, had to say.

A similar initiative two years earlier had started with the Scottish Government asking the Greater Glasgow and Clyde Health Board Public Health Department to convene a meeting on health inequalities. GPs were invited and sat in the audience listening to a range of high profile experts on health inequalities. At the end of the meeting, little had been achieved and the meeting was soon forgotten. In planning the new meeting, it was decided not to repeat this format.

The first meeting of Deep End practices took place after several months of advertising the conference and inviting GPs to attend. RCGP Scotland offered a whole day locum fee, worth about £420, for one participating GP per practice to provide clinical backfill on the day. The Scottish Government then offered to meet 50% of this expense. About two thirds of Deep End practices were represented, plus colleagues from a few remote and rural practices.

From the outset it was decided that there would be no formal presentations at the first meeting. Plenary sessions involved circular seating so that every participant was in the

first row. The assembled company was made up almost exclusively of general practitioners so that there would be no outside focus or distractions.

The conference split up quickly into groups of 10 GPs including a chair and a rapporteur. Each group sat round a table in a separate room to avoid background noise and distraction. Their task was to identify issues facing general practitioners serving very deprived communities. Each participant had a pen and post-it notes, so that issues could be written down and stuck on an A1-size poster.

While a plenary session and discussion followed, the posters and post-it notes were reviewed, organised and displayed on the walls of the main conference room. Participants then toured and inspected the posters, using adhesive coloured dots to indicate which issues they considered most important. The number of dots per issue was counted and issues ranked in terms of the numbers of dots. A second session of roundtable discussions addressed the issues which had been highlighted

In this way the contributions of every conference participant were captured for inclusion in the conference report, which became Deep End Report 1, summarising the experience and views of Deep End Practitioners.

Next steps

The next step was a first meeting of the Deep End Steering Group, about 6 weeks later, to which all conference participants were invited. About 30 attended. It was decided to hold a series of roundtable discussions on the top issues identified in the conference report.

Most of these meetings involved 8-10 Deep End GPs in a half-day meeting, divided in two halves; first addressing problems and then suggesting solutions. Through good fortune, a budget was available which allowed locum payments to be paid, allowing GPs to take part in the first series of meetings. The Scottish Government provided funds to meet locum payments for subsequent meetings.

Each discussion was recorded by a rapporteur, often a young GP, who captured the elements of the discussion in bullet points. Some of the initial meetings involved more than one group discussing the same topic but it quickly became apparent that a single group of 8-10 Deep End GPs was sufficient to generate experience and views considered representative of Deep End practice.

The bullet point summaries were quickly edited and converted into coherent reports of each meeting both as full reports and as executive summaries which were checked with participants before being posted on the Deep End website at Glasgow University.

In this way, the engagement and enthusiasm of the first conference was maintained, while developing identity, views and voice. E-mail communication and coordination from an academic base facilitated these arrangements. At the end of the first year, when 12 Deep End Reports had been produced, the British Journal of General Practice agreed to publish a monthly series of Deep End Reports during 2011 (subsequently collated as RCGP Occasional Paper 89, with forewords by Richard Horton and Julian Tudor Hart).

Throughout this early period, and thereafter, meetings of the steering group, with never less than ten attending, provided continuity and shared understanding. It also established a network of GPs who could be called upon to represent GPs at the Deep End to outside bodies. For example, when opportunities arose to speak to parliamentary committees at Holyrood, to civil servants or Government Ministers, the Deep End group was usually represented by one academic GP and two frontline practitioners, presenting a combination of evidence-based argument with coal-face observations based on daily contact with patients.

Members of the steering group often responded to invitations to make presentations at meetings hosted by other organisations, drawing not only their own experience and interests but also the shared, coherent arguments and proposals which the group had developed via the Deep End Reports and Manifesto. Several members of the steering group were interchangeable in carrying out this role, depending on their expertise in a variety of areas e.g. child welfare, homeless health, addictions, local health management.

The second and third national Deep End conferences were held in 2012 and 2015, using the same venue and similar formats to the first conference. The Scottish Government provided funding for these conferences and also smaller meetings, including locum funding for clinical backfill. As the Deep End group had no official status and had no administrative infrastructure, these funds continue to be handled on behalf of the group by RCGP Scotland.

Another consequence of the Deep End Reports and associated networking activity was a state of readiness for responding to funding opportunities as they arose, usually from the Scottish Government. The main Deep End projects (described in more detail on the Deep End website www.gla.ac.uk/deepend) were :-

- Link Workers
- Govan SHIP
- Pioneer Scheme
- Embedded Financial Advisors
- Attached Alcohol Nurses

The projects had variable timescales from proposals to implementation but all had the same purpose of developing solutions to longstanding problems experienced by frontline practitioners

The Link Worker theme began with a simple survey of social prescribing in Deep End practices, followed by the Links Project (funded by the Scottish Government) and then the Bridge Project (funded by the Scottish Chief Scientist Office). Eventually, the Link Worker Programme was established, developing the community link practitioner role in 7 Deep End practices in Glasgow with another 8 Deep End practices as "controls" for an evaluation carried out by the University of Glasgow with NHS Health Scotland funding. Central administration, including the employment and continuing development of the community links practitioners, was based at the Scottish Health and Social Care Alliance. The Scottish Government now has a scheme for establishing 250 Link Worker posts throughout Scotland.

Govan SHIP was originally a local proposal for attaching social workers to general practices at Govan Health Centre in Glasgow, but with Scottish Government, local NHS and Social Work encouragement, the proposal was expanded as an integrated care project including several elements of the Deep End Manifesto (Report 20) including additional clinical capacity (via GP locums), protected time for host GPs and administrative support, including support for monthly multidisciplinary team meetings in each of the four practice, two of which also had community link practitioners.

The Financial Advice Project had its origins in Deep End Reports recording the experience of austerity as it affected patients and general practices, followed by two symposia exploring the interface between general practice and the established financial advice services in Glasgow. After the second of these meetings, a senior officer of the Wheatley Housing Group in Glasgow volunteered end-of-year money to support a general practice-based project. Two practices at Parkhead Health Centre were quickly approached and agreed to take part, with a financial advisor provided by the Greater Easterhouse Money Advice Project. Other organisations were quick to join the steering group, helping to provide succession funding, including a roll out of the project to include 7 other general practices in the local GP cluster.

The Pioneer Scheme, involves GP fellows attached to Deep End practices, adding clinical capacity, releasing the time of host GPs and supporting service developments by both the fellows and host GPs, plus shared learning within the scheme as a whole and also as part of a day release programme for fellows at Glasgow University,. This integrated project was developed as a proposal at least two years before funding became available and was obtained from the Scottish Government's GP Recruitment and Retention Scheme.

The attached alcohol nurse project was originally suggested at a joint meeting for Deep End GPs and local alcohol services in Glasgow in 2010 but it took several years of lobbying before local funding was provided, the scheme launched, then withdrawn and then started again.

The Scottish Deep End Projects have been characterised by GP initiative and persistence both in developing proposals and seizing opportunities for funding. Initiation of Deep End Projects was generally possible in response to national policy directives and funding streams. Links with local NHS management structures helped with practical administration. A key step was to identify appropriate individuals in partnership agencies who were supportive of the Deep End objectives and to maintain such links as the basis of collaborative working.

All of this activity has been described in Deep End Reports and other materials posted on the Deep End website at Glasgow University (www.gla.ac.uk/deepend). Several Deep End GPs have also contributed to a book The Exceptional Potential of General Practice, which also contains accounts of Deep End Projects in Ireland, Yorkshire/Humber and Greater Manchester.

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