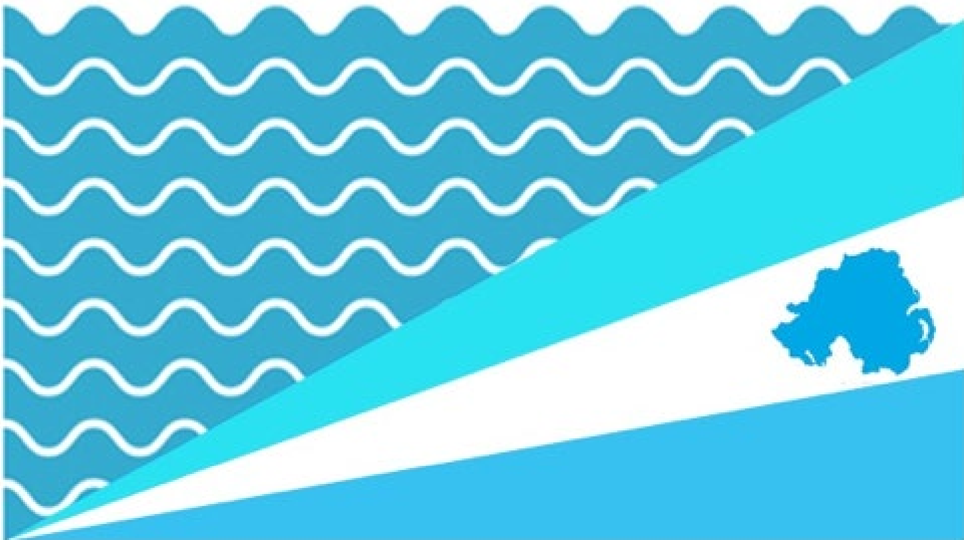
GENERAL PRACTITIONERS AT THE DEEP END
INTERNATIONAL BULLETIN NO 7
JULY 2022

Welcome to the 7th Deep End International Bulletin – 36 pages of experience and views from an increasing number of Deep End Projects around the world.



INTRODUCTION

The 6th Deep End International Bulletin included annual reports from nine Deep End Projects in five countries at various stages of development.

The 7th Bulletin includes news and reports from 5 projects which are just beginning, and starting not only from different places geographically but also different places in terms of size, situations and opportunities. Size is not important. The common thread is the belief that inclusive health care delivered by general practitioners and primary health care teams can improve the health of even the most deprived and poorest local populations.

The starting ingredients may be considered as :

1. Engagement with front line practitioners
2. A central coordinating role providing continuity and momentum
3. Moving forward via shared activity and learning
4. Communication within the network
5. Independence from established institutions

On page 5 Makoto Kaneko describes the new Deep End Project in Kawasaki and Yokohama, with its brilliant new logo.

Having recently published their scoping review of how to start a Deep End Project (Page 20)Daniel Butler and Nigel Hart describe the new Deep End Project in North Ireland (Page 7). Their review also features in a workshop at the forthcoming conference of the European Forum for Primary Care in Ghent, Belgium in September (Page 19)

On page 6 Judit Konya gives a short news report fom the first Deep End meeting in Cornwall. A fuller report is promised for the 8th Bulletin in December.

On page 9 Mogens Vestergaard reports exciting new developments for the Deep End Project in Denmark, including unprecedented interest and support from central insitutions.

Finally, on page 11 Hina Shahid and Camille Gajria report on Deep End developments in North West London.

On page 15 Khairat Al-Habbal reports on how she is finding ways of applying Deep End values and principles in the very different situation and climate of Abu Dhabi.

On page 21 Carey Lunan, chair of the steering group of the Scottish Deep End Project, reports not only on the conclusions and recommendations of the Scottish Government Short Life Working Group on Health Inequalities but also on the novel ways in which community interests were represented and included. After years of knocking on the door, we have finally entered the building and are being listened to.

We congratulate David Blane, academic coordinator of the Scottish Deep End Project on his being awarded the 2022 Outstanding Early Years Researcher Award of the UK Society of Primary Care and Royal College of General Practitioners. (Page 24)

Page 26 highlights the brilliant short book on *Recovery. The Lost Art of Convalescence* by Gavin Francis.

On page 27 there are links to four talks given earlier this year under the auspices of the Royal Institution of South Wales in which his former colleagues remembered Julian Tudor Hart.

Finally there are two longer reads - a reflection on pages 29-33 by Kathy Owens on her experience of leading the roll out of Community Link Practitioners in Deep End General practices in Glasgow, and an article "*If we do not change direction"* from the *Herald* newspaper's series on the future of the NHS (Pages 34-35).

Graham Watt graham.watt@glasgow.ac.uk **July 2022**

Like Pegasus the Deep End is flying

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REPORT FROM DEEP END KAWASAKI/YOKOHAMA

We have just joined this excellent project from Japan. Kawasaki city and Yokohama city are next to the capital city Tokyo and are located in the bay-side area. Historically, many dock labourers live in the cities. Also, in recent years, immigrants who can not speak Japanese are facing difficulty with medical care access due to barriers to language and insurance schemes.

Now, Deep End Kawasaki/Yokohama consists of 4 GP clinics and 1 hospital. Because there is no deprivation index which is publicly available in Japan, we included medical institutions which provide“the Free/Low Cost Medical Care Program” in the area. The program supports people in financial poverty who need medical care. There are 673 medical institutions which provide this support overall in Japan. Two clinics in our team do not provide the support. However, the clinics play a key role in our project. One of the clinics locates in the most deprived areas in Yokohama city. Another clinic pays special attention to vulnerable migrant communities. Part of the clinics/hospital in the team offers not only clinical care but also outreach activities and social relationship with people in the areas. We are going to collaborate with other urban family medicine programs in Japan to obtain the skills for community assessment and empowering the community around our workplace.

Our team started an urban family medicine fellowship: Yokohama-Kawasaki Urban Primary Care and Social Medicine Fellowship in 2021.

https://upcare-fellow-yokohamakawasaki.studio.site/1 Moreover, now, we are developing a new family medicine residency program to learn urban primary care including marginalized populations. We have held regular meetings to read "*The Exceptional Potential of General Practice*" and share complex cases and experiences. Also, we have collaborated with members of Yokohama City University and the Yokohama city government.

Our Deep End logo uses Japanese traditional colours and patterns. Moreover, we combine the logo with ukiyo-e by Katsushika Hokusai who is a famous painter. The ukiyo-e describes the wave near Kawasaki and Yokohama city. The Kanji in the logo, "川崎/横浜", means Kasawaki/Yokohama.

We are looking forward very much to participating in the Deep End project. Equity in healthcare is our common goal and sharing the knowledge and experience among the Deep End GPs is really important for improving our practice.

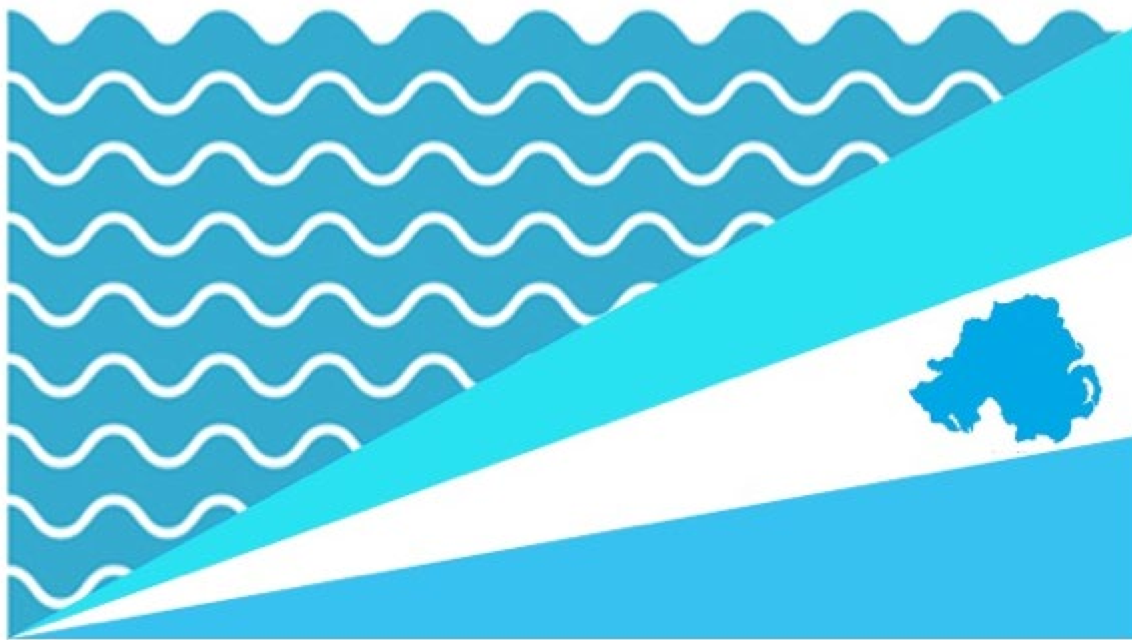
Makoto Kaneko

DEEP END CORNWALL STIRRING

In Cornwall, we are in the very early phases of establishing our Deep End group. Deep End GP practices were identified by the Index of Multiple Deprivation 2019 score, to account for blanket deprivation. Kernow CCG provided a small pot of funding that made it possible for us to meet virtually and lay down the foundations of our group.

We are working on identifying the priority themes in Cornwall. We are engaging with stakeholders and designing our logo to mark the establishment of Deep End Cornwall. With great anticipation, we look forward to becoming part of the Deep End movement.

Judit Konya
on behalf of Deep End Cornwall



Hello from Northern Ireland! We are in the formative stages of establishing a group here and have been inspired and empowered by the work and updates of colleagues across the international Deep End network. Like many things, COVID-19 has disrupted our progress to date.

In Northern Ireland more than 1 in 3 (37%) of the population live in socioeconomic deprivation compared to approximately 1 in 5 in rest of the UK[1]. The reasons, as with most Deep End populations, are complex and multi-factorial, but in part due to the recent civil conflict. Twenty years on from 'the Troubles', a 30-year civil conflict in which 3500 died and 30,000 people were injured, has left a legacy. Four in 10 adults in Northern Ireland experienced at least one conflicted-related traumatic event. This legacy is referred to as the 'diseases of despair' epidemic, such as substance misuse and alcohol dependency, alongside the highest suicide rates in the UK.

The 'Deep End' imagery of a swimming pool, and the notion having to work hard to keep treading water and provide the same service to sicker, younger patients with significant levels of multimorbidity rings so true for GPs at the 'Deep End' in the Northern Ireland. It is no great surprise to learn of mismatches in time demands, staffing levels and funding.

Our first steps have been to access the data which has allowed us to quantify Practices with 'blanket deprivation' in Northern Ireland; this data has not been freely published. Being constrained during the Pandemic to move forward with establishing our own Deep End network we have used the time to look at representation of these 'Deep End' Practices in both undergraduate medical teaching and post-graduate training; the

‘Inverse’ teaching and training laws. We have also sought to build support from colleagues in the health board, BMA and GP federations.

Our work to date, has focused on building the case and developing evidence for a Northern Ireland Deep End group. Daniel, who is an academic GP training has been working on this as it is forming part of his MPhil, under the supervisor of Prof Nigel Hart. Part of that output has been the recently published scoping review (see abstract on page 20) on how to establish a Deep End group[2]. Ironically, given these findings, we have faced challenges in securing funding to reimburse GPs’ time to allow representative participation of Deep End GPs.

As we emerge from the Pandemic our hope is to establish a formal group soon, as preliminary conversations and meetings have shown great interest in a Deep End NI group, and this is in no small part due to the example and successes of Deep End groups that have gone before us.

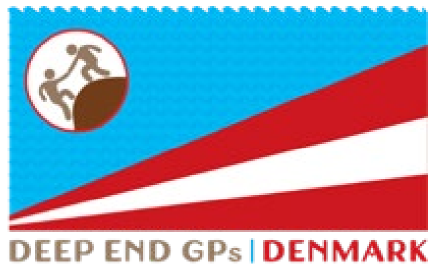
Daniel Butler and Nigel Hart

[1] https://bmjopen.bmj.com/content/bmjopen/6/11/e012750.full.pdf
[2] https://bjgpopen.org/content/early/2022/04/27/BJGPO.2021.0230

SLOWLY TURNING WHEELS – 1

> There are also aspects of the GP contract that need urgent reform. Deficiencies are particularly acute in the least affluent areas of the country, yet funding for these surgeries does not adequately take into account social deprivation, where care is more expensive to provide.
>
> **Editorial in *The Observer*, 3rd July 2022**

REPORT FROM DEEP END DENMARK



On 24th of May 2022, we launched the Deep End in Denmark officially. In collaboration with the Alliance Against Social Inequality, we had arranged a meeting with participants from the Danish Cancer Society, The NovoNordic Foundation, the Ministry of Health, the Danish Health Authorities, the Organisation of General Practitioners, the College of General Practitioners and the four Research Units of General Practice.

The meeting was a great success primarily because Professor Graham Watt and Professor Susan Smith gave outstanding talks about the lessons to be learned from the Deep End in Scotland and Ireland. All participants at the meeting supported the establishment of the Deep End Denmark and understood that it is supposed to be an independent organization who gives identity, voice, and shared learning to a previously neglected group of general practitioners.

DAGENS Medicin

Nyheder Karriere Kultur

ALMEN PRAKSIS

»Når man går sammen, får man en stærkere identitet og stemme«

The most important news media in Denmark on health care entitled 'Dagensmedicin' brought two fine articles about the Deep End initiative in the days following the meeting. The picture below covered the frontpage of the printed version of the magazine and the text says: "When you stand together, you have a stronger identity and voice".

Although we look very serious on the picture taken in front of the National Opera House, I think we had a lot of fun and many great discussions in Copenhagen.

Our main task for the next months is to apply for money to secure network meetings, locums, and a research group. We look optimisticly at the future since we have already been promised support for half of our budget and have a strategy on how to try to get the other half.

Mogens Vestergaard
On behalf of Deep End Denmark

DEEP END REPORT RCGP NORTH WEST LONDON FACULTY

The RCGP NWL Deep End project started in March 2022 to respond to the needs of GPs in outer North West London (NWL) Deep End practices to create a peer support network. Led by two local GPs with support from the RCGP NWL Faculty Administrator, the project aims to create a community of practice, spotlight innovation, support joined up working and promote wellbeing and resilience among colleagues in outer NWL working in areas of deprivation and superdiversity characteristic of Deep End practices. Supporting colleagues working in challenging conditions to address inequalities (or more accurately, inequities) in health and healthcare is at the core of this project through providing a safe space for rich, meaningful and deliberative discussions and inspired action.

Once a month, primary care colleagues come together to hear about and discuss a themed topic with a range of speakers which may include a combination of practitioners and service providers, commissioners and system leaders, academics, champions, lived experience experts, community organisations and advocates. The themes have been selected to reflect local priorities and include spotlighting innovation in outer NWL boroughs. To date three sessions have been held with approximately 50 delegates. Each session ends with a reflective question on how colleagues will change their practice after the session. Each session is recorded and uploaded on to a private MS Teams space for colleagues to join and continue learning and building connections.

Session 1- Deep End, population health and health inequities

In the first session we were delighted to be joined by Professor Graham Watt, founder of Deep End, who delivered an inspiring talk on the principles and development of the Deep End project, starting in Scotland and spreading globally. He discussed the importance of advocacy, accountability and the active ingredients of pioneer schemes and what can be learnt from them to deliver on the wider determinants of health and close the gap. We were also joined by Dr Nilesh Bharakhada, RCGP NWL Faculty co-chair and NWL Personalised Care clinical lead who spoke about the role of personalisation and population health approaches, in particular, targeted outreach, integrated services and multi-dimensional support.

3 top tips

- Deep End is a resistance movement requiring political and central support
- Engagement and listening is a first step but only a start
- Unconditional personalised continuity of care is essential to reduce health inequities

Session 2- Personalised care and making each contact count

What was your main "take away" from this event?

Selfishly? Good tips on how to set the group up - and the inspiration!!

There are others who care too! (but also a bit sad I only recognised 2 local names on the call). However, there are others, and movements start with small steps and mutual encouragement

It is clinically and economically effective as well as ethically more appropriate to prioritize resources to care for the populations that need them most for the good of all.

Joining group of learning practice

Look at the Glasgow Uni Deep End website

I learn more about the deep and project and how these areas affected.

Like minded people coming together

Healthcare service should be at its best where it is needed most.

.

The theme of personalisation was explored further in the second session. We were joined by Lianna Martin, a programme manager from the Healthy London Partnership who discussed ways of working at the interface between primary care and communities through the NHSE personalised care workforce. Dr Bogdan Chiva Giurca, Founder and Chair of the NHS Social Prescribing Champion Scheme, highlighted the important role of social prescribing in addressing health inequities and the need for advocates in the primary care workforce. Dr Ed Pooley, a GP and communications skills expert demonstrated how a personalisation approach can be brought into patient consultations with patients who may be experiencing socio-medical complexity by presenting an excellent mix of thought-provoking scenarios.

3 top tips

- Social prescribing is an important practical way of addressing the social determinants of health that create health inequities
- The personalised care workforce are important bridge builders between primary care and underserved communities
- Asking “what matters to you?” is an powerful way to support more meaningful conversations with patients

What was your main "take away" from this event?

Interested in Deep End how it can improve my practice and trainees practice

Get all practice team educated on social prescribing and utilise it locally. How to communicate with patient especially in deep end practice very useful

Think about what I'm really saying to the patient.

a lot information how t access social prescribing

Session 3- From the crade to the grave: life course approach and trauma-informed care

In the third session, we explored the high prevalence and impact of trauma on health across the life course and the principles of trauma informed care. We heard from Dr Sarah Heke, a trauma psychologist currently working with Grenfell survivors who spoke about the need for improved access to trauma services across NWL (and beyond) through better awareness of trauma-informed approaches, training, funding and resources. We also heard from Dr Neda Bazegar, a GP trainee and trauma survivor who gave us a moving and powerful account of her lived experiences and her tips for how health professionals can better support patients who are trauma survivors.

3 top tips

- Trauma can manifest in multiple ways; behavioural, psychological and physical experiences
- Asking patients "what happened to you?" removes blame and affirms the normality of a response to an abnormal event
- Every consultation, practice and organisation can take steps to be trauma-informed and the creation of a safe environment is vital to this

What was your main reason for attending this event?

To improve my knowledge and care for self /staff and patients

To hear the experiences of trauma from GPs

Never attended an event on trauma, but see it a lot in practice

Interest and exposure in working with many patients who have experienced multiple traumas.

Feedback and future plans

The sessions have received excellent feedback with an average score of 9.4 out of 10 and 100% of delegates across the sessions stating that they would recommend the sessions to colleagues.

Further sessions are planned around the care of specific marginalised and health inclusion groups in North West London and spotlight events across outer NWL boroughs.

We are grateful to the RCGP NWL Faculty for supporting this project and for making each session open access and free to join. The recordings of the session, however, are only available to colleagues who have signed up to be part of the community of practice.

For more information please contact nicola.husbands@rcgp.co.uk

Hina Shahid and Camille Gajria

SLOWLY TURNING WHEELS – 2

The following motion was adopted by the BMA Conference of Local Medical Committees in May 2022

HEALTH INEQUALITIES

22. That conference is deeply concerned by the rise in health inequalities in our communities and calls upon GPC t

(i) conduct a review into the impact of current national and local general practice funding models includi funding formulae and outcomes payments

(ii) negotiate enhanced funding for GP practices serving areas of significant deprivation to resource addressing the additional workload

(iii) negotiate a requirement for a health impact analysis to be carried out by commissioners when any ne housing or care homes are located in these areas of deprivation

(iv) negotiates for fairer funding of vaccinations which does not financially discriminate against practices with low vaccine uptake.

Carried
Proposed by Lisa Harrod-Rothwell, of Kensington, Chelsea and Westminster LMC

Readers may remember a session at the 2019 conference in Glasgow on *“The Exceptional Potential of General Practice”* which was chaired by Khairat Al-Habbal, a family doctor from Beirut in Lebanon.

Khairat (pictured above in the Scottish winter) had also contributed to the book of the same name, describing family medicine in Lebanon, and before that had visited Scotland on a medical student elective, including visits to the Scottish Deep End Project.

Now based in Abu Dhabi, and looking for ways to apply Deep End values in a local context, she has written the following article.

RESHAPING THE DEEP END IN ABU DHABI

My approach to the Deep End in the United Arab Emirates (UAE), namely in Abu Dhabi, the largest emirate and capital of the country, differs from approaches that have been used thus far. The UAE has a very diverse population, with UAE nationals comprising only 11% of its residents. The remaining population is mostly expatriates from India, Pakistan, Sri Lanka, Bangladesh, Philippines, the Middle East, Europe and North America (WHO 2012). A sizable percentage of these residents are from areas of deprivation and have started their lives at a disadvantage.

The UAE is an accepting environment where individuals are treated with respect and fairness. Although there are differences in the wages of workers depending on specialty, rank and experience, many individuals choose to work in the UAE because they earn higher incomes than in their home countries. Employers are mandated to provide health insurance to all employees and dependents who reside in the country, regardless of pay or job duties. Securing insurance is a prerequisite for applying for a work visa to be able to travel to and reside in the UAE. Even workers in the lowest paying jobs have access to Basic Daman (the Arabic term for insurance). This policy, which is provided to most of the labourer population, functions through a gatekeeping system, where GPs initially

assess patients and refer to specialists as needed. If tertiary care is needed, all patients have access to public hospitals, which provide high quality care, have a diverse pool of healthcare workers and are the major teaching institutions in the country. Expatriates with higher paying jobs have access to private insurance and UAE nationals are insured by the government. Both groups have the choice to access healthcare through either public or private clinics. Abu Dhabi implements an electronic medical record system (EMR) called Malafi that is shared by all public clinics and hospitals. Even though there is no specified catchment area per primary healthcare centre (PHCC), the fact that the EMR is shared by all the public centres allows easy access of patients to any PHCC and makes Abu Dhabi as a whole one big catchment area. The private GP clinics have their own EMR. Health information can be accessed by the central health authority of Abu Dhabi, Department of Health (DOH), when needed. DOH also has access to all the insurance information which enables better understanding of population parameters and needs.

In this area of mainly social advantage, there is a need to adapt the Deep End approach for interventions that support the government in achieving its vision of a healthy population. We are starting at Horizon A with a need to define the Deep End through the lens of the social determinants of health (SDH). This can be done through risk stratification of patients through their insurance records or EMRs looking into indicators from each of the SDH domains. Identifying the groups that may be at risk of vulnerability allows us to determine whether these groups exist in certain pockets and frequently visit specific practices or if they are dispersed throughout the emirate. Then the questions of how to catch them, how to reach them and what interventions would help support them become more pertinent. On the other hand, I think of the Deep End in Abu Dhabi as grassroot work that is done at the level of medical education in order to prepare a workforce that understands and speaks a common language and has the awareness of the impact of SDH on the health of individuals, communities and populations. This is why my current work focuses on educating medical students about the relationship between the one-on-one interactions that they will have with their patients, to identify issues of importance at the community level, and then move to the macro level of policy making to improve the health of the population.

Throughout the Medicine and Society course, students are exposed to the topics of SDH, health systems, systems-based practice and community medicine as early as their first year of medical school through an engaging workshop style approach where they are encouraged to explore these topics in both local and global contexts. This is supported by an experiential learning opportunity that starts during the second year of medical school, where students perform home visits to vulnerable older adults as part of a multidisciplinary healthcare team. The experience is augmented by stimulating them to reflect on the effect of the SDH on patients' conditions. Their capacity to think in terms of identifying SDH of older adult care and gaps in the healthcare system is facilitated through structured projects and group activities, that encourage them to move from

identifying problems to suggesting interventions (including social prescriptions) that are to be implemented with partners within and outside healthcare in order to address SDH and vulnerability. This is the second year I run this medical education program. The cohort of medical students that I started working with are already thinking about the Workforce, Education, Advocacy and Research, but, more importantly, how to tie all the elements of the framework to people's lives within and outside the healthcare system.

My hope is that if they learn the approach using older adults as a target population, they will be able to apply the same principles to any patient population that they will encounter throughout their practice. This cohort graduates in 3 years and I am eager to see what they will do as they progress through their clinical training and their practice. My Deep End focuses on planting the seeds so that future generation of doctors (GPs or specialists) can be the change.

Khairat Al-Habbal

NOTE

Six previous Bulletins are accessible on the Scottish Deep End website.

DEEP END INTERNATIONAL BULLETING NOS 1-6

News from : Scotland, Ireland, Yorkshire/Humber, Greater Manchester, Canberra, Australia, Plymouth, NW London, North-East and North Cumbria, Nottinghamshire, East of England, and Denmark

www.gla.ac.uk/deepend

There are now 12 variants of the original Scottish Deep End logo. From left to right they are :-

Top Row : Ireland, Yorkshire/Humber, Greater Manchester, Canberra

Middle Row : North East and North Cumbria, Nottinghamshire, North West London, Plymouth

Bottom Row : Kawasaki and Yokohama, Denmark, East of England, Northern Ireland

The imagery is largely self-explanatory. Of particular note is Nottinghamshire's inclusion of Robin Hood who robbed the rich to give to the poor. It was simpler in those days. All of the logos feature a swimming pool, but only the Japanese logo features a wave machine.

DEEP END WORKSHOP AT THE EUROPEAN FORUM FOR PRIMARY CARE CONFERENCE , 26-28TH SEPTEMBER 2022

Six colleagues from the Scottish Deep End GP Project are collaborating with Jessica Fraeyman (Association of Community Health Centers in Belgium) and Dr Daniel Butler (Academic GP trainee in Belfast) for a workshop at the EFPC conference in Ghent in September.

The workshop on "Joining the Deep End movement: primary care for those who need it most" will showcase primary care initiatives in areas of high deprivation from Scotland and Belgium, and discuss a practical framework for starting a Deep End group, based on Dr Butler and colleague's research. (see page 20)

The conference also provides an opportunity to re-visit some of the connections made when a delegation of Belgian primary care colleagues visited Glasgow in March 2020 (as described in International bulletin no. 3), and coincides with the retirement of our longstanding Deep End friend and colleague, Emeritus Professor Jan de Maeseneer, who was Head of the Department of Family Medicine and Primary Health Care at Ghent University between 1991 and 2017.

Even when walking on the Campsie Fells north of Glasgow
it is difficult to get away from world events

BJGP Open

Diving into the deep end: a scoping review on taking the plunge

Daniel Butler[1], Diarmuid O'Donovan[2], Jennifer Johnston[3], Nigel D Hart[4]
Affiliations expand

- DOI: 10.3399/BJGPO.2021.0230

Free article

Abstract

Background: General Practitioners working in deprived areas, where all-cause mortality rates are higher, face unique challenges. Despite 50 years passing since Tudor-Hart's seminal 'Inverse Care Law' paper, the health inequities gap is wide. 'Deep End GP' projects, are frontline General Practice led initiatives, working to close this gap, improving the health and lives of those most in need.

Aim: To use scoping methodology to map out the process of creating a 'Deep End' GP group.

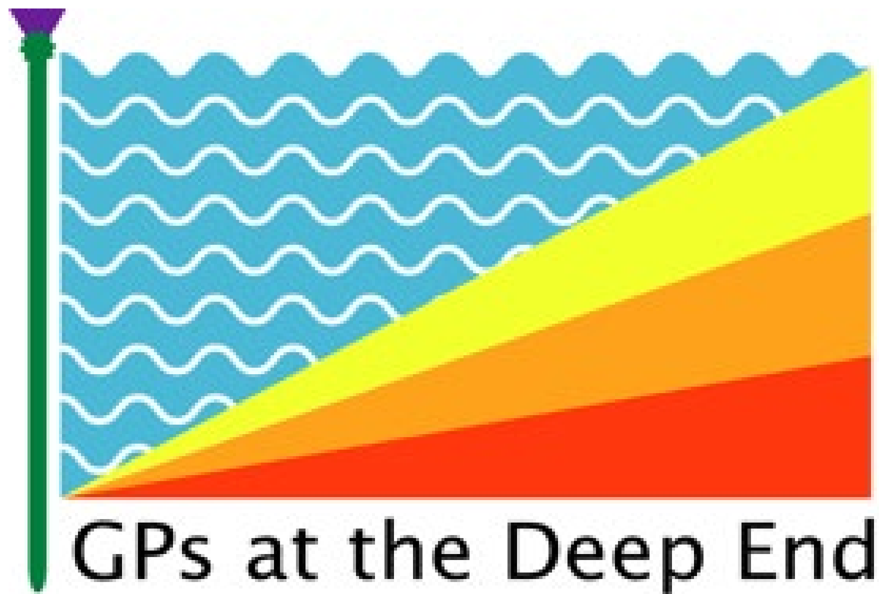
Design & setting: A scoping review using Arksey and O'Malley's framework.

Method: MEDLINE, EMBASE, Web of Science and CINAHL databases, as well non-peer reviewed publications, were searched and articles extracted, reviewed and analysed according to iterative inclusion criteria.

Results: From an initial search number of 35 papers, sixteen papers were included in the final analysis. Key steps in starting a Deep End group are: quantifying patients and practices in areas of deprivation; establishing GP led objectives at an initial meeting; regular steering group meetings with close collaboration between academic and frontline General Practice, as well as the wider multi-disciplinary team; adopting a local Deep End Logo.

Conclusion: Deep End GP groups have made advances to reduce health impacts of systemic health inequities. Starting a Deep End group involves a multidisciplinary approach, beginning with the identification of patients and Practices in areas of highest need. The findings and key themes identified in this scoping review will guide interested parties start the journey to do the same in their locality and to join the Deep End movement.

SCOTTISH SHORT LIFE WORKING GROUP ON HEALTH INEQUALITIES



The Covid19 pandemic both shone a spotlight on, and worsened, pre-existing health inequalities. High-level meetings being held within Scottish Government in 2020 about how to remobilise and recover the NHS quickly highlighted the unique and exceptional potential that primary care, and in particular, general practice, holds in relation to tackling and mitigating health inequalities. In response to this, in autumn 2020, a Primary Care Health Inequalities Short Life Working Group (SLWG) was established, its purpose to build on existing learning and evidence to identify and recommend clear actions that could be implemented and sustained to deliver meaningful and lasting improvements in health equity. I was initially involved as the Chair of the RCGP in Scotland, but more importantly was able to bring my experience as a frontline GP, working in the Deep End. Ultimately not so 'short-life', the group concluded in January 2022. We had covered a lot of ground, had a lot of difficult discussions, and worked hard between meetings to keep the momentum going, amidst the ongoing crisis of the pandemic and associated workload and workforce pressures.

Two reports were published at the conclusion of the group: a report with recommendations on next steps, and an accompanying report from our expert reference group.

The SLWG were clear from the outset that the voices involved in agreeing on recommendations should not simply be those of professionals and policymakers but also of individuals with lived experience of the issues being discussed. Chance to Change (C2C) is an established community peer support group in Glasgow, with historical links to Garscadden Burn GP practice but hosted and supported independently by Drumchapel Life / Yoker Community Campus. The group is led by a peer facilitator who was one of the founding group members.

Their remit was to help identify specific service improvements and actions for primary care to help reduce health inequalities and improve health equity, with the expertise of the group being grounded in their own experiences of living with the issues being discussed. Those who attend C2C all have lived experience of long term health conditions and of living with the issues being addressed by the SLWG, such as social disadvantage, discrimination or economic exclusion. They were asked to respond to the SLWG working papers outlining the themes and the draft recommendations as these developed. The group's peer facilitator, played a key role in enabling the group to contribute in this way, drawing on both her training in community development and her own life experiences. She used a variety of methods to ensure that the group felt comfortable with the topics and able to contribute to them. The discussions took place naturally as part of the regular weekly meetings of the group over a period of approximately nine months. The comprehensive report by the C2C group, authored by the peer facilitator, collates all the feedback from these meetings. The opinions, words and format captured in their final comprehensive C2C report are those of the group. The feedback and contributions from the group were pivotal both in developing the themes for discussion, and in the final recommendations of the SLWG, offering an honest and often critical voice to the group. In many ways the work of C2C has main one of the main achievements of the process, and I hope that this model of co-production will be replicated in other SLWGs within Scottish Government, with the voices and the experiences represented having the influence they deserve in shaping a fairer and more just Scotland. The story of C2C can also be viewed in this YouTube video

The recommendations in the final SLWG report, published in March 2022, are the result of collaboration across different professional groups, sectors, and interests. Group members from a wide variety of backgrounds brought evidence, challenge and experience to the group. The SLWG built on a significant body of existing work and reports, and sought to identify clear and tangible actions which were informed by existing evidence. The recommendations recognise that while tackling health inequalities requires broad action on social determinants well beyond health services, primary care does have a key role to play – but needs enabled and supported to achieve this. The recommendations combine practical actions which are achievable in the short term, with others which are undoubtedly aspirational reflecting the SLWG's philosophy that without ambition there is no change. Of the report's 23 far-reaching recommendations, five were identified as 'foundational', laying a bedrock for the others. A Development Group has now been established to support planning and implementation of its recommendations, and this met for the first time in May 2022. The Deep End continue to be well represented on this group.

Prior to the publication of the two reports, I met with the Cabinet Secretary for Health and Social Care Humza Yousaf, and the Minister for Public Health, Women's Health and Sport, Maree Todd, along with the Chair of the SLWG, Lorna Kelly, and fellow Deep End GP and SLWG member, Peter Cawston. We discussed the work of the group, its

context, and the rationale for the recommendations that were being made. In particular, we singled out three of the recommendations for early priority development: an Inclusion Health Enhanced Service to offer additional proportionate resource to GP practices in areas of deprivation to address the persisting inverse care law and allow different ways of working; a Fairhealth Fellowship for healthcare professionals working in areas of deprivation to address issues around recruitment, retention and specific unmet training needs; the creation of a new national leadership role, such as a Health Inequalities Commissioner, to work across all policy areas to facilitate collaboration, consistency 'joined up' thinking, and progress. It was a productive and positive meeting.

It is always hard to know in advance which discussions and groups we get involved with will ultimately 'make the difference'. The aspirations, values and commitment of this particular group, the leadership shown, the contributions made by members, the courageous recommendations made, were a ray of hope for me at a time when it was difficult to feel hopeful. I would like to offer my personal thanks to three people in particular – Naureen Ahmad (Head of General Practice Policy Division and who had the vision for the group and made it happen), Lorna Kelly (Chair of the SLWG) and Peter Cawston (GP in Drumchapel, and the link to Chance to Change).

Carey Lunan

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CONGRATULATIONS

are due to David Blane, academic coordinator of the Scottish Deep End Project, as joint winner (with Oliver van Hecke at Oxford University) of the SAPC/RCGP Awards for Outstanding Early Career Researcher 2022

This award recognises the contribution of early career researchers to advancing primary care theory and practice.

Both winners gave presentations at the SAPC ASM 2022 on Wednesday 6th July in the Award winners session.

Reproduced below is a Q&A with David on the SAPC website

Q: What is your main area of interest, and how did that develop?

My main area of interest is in the role – and potential – of primary care in mitigating health inequalities. We live in a society that is deeply divided, with increasing 'social distance' between the haves and have-nots. Inequalities in power, wealth and income drive this divide, but the distribution (and quality) of health care resource is an under-appreciated determinant of health (and health inequalities). I became involved in the 'GPs at the Deep End' group in 2010, while I was doing a Health Inequality Fellowship in Glasgow.

The group, which involves GPs serving the most socio-economically deprived communities in Scotland, has been an incredible source of inspiration for me and many others – there are now 11 Deep End GP groups across the UK and internationally.

Q: What does your research involve?

Like most GPs, I consider myself a generalist, so my research uses mixed methods and has spanned a range of topics related to general practice and primary care. My PhD was

about access to NHS weight management services and showed that, although people from the most deprived postcodes had higher levels of obesity (with co-morbidities), they were least likely to access NHS weight management support.

More recently, I have been involved in research related to Long COVID: a CSO-funded study examining the epidemiology of Long COVID in Scotland; and an NIHR grant testing whether a remotely delivered weight management intervention can improve symptoms of Long COVID for people with overweight/obesity. I'm also leading a project investigating responses to the inverse care law in primary care in Scotland (funded by the Health Foundation).

As academic lead for the Scottish Deep End Project, I'm keen to support other Deep End initiatives and to build the evidence base for integrating best practice from inclusion health into mainstream primary care.

Q: What will the RCGP / SAPC Early Career Award enable you to do?

The award will enable me to meet and collaborate with international researchers from Deep End groups around the world. My plan is to arrange a workshop with primary care researchers from these groups at the annual meeting of the North American Primary Care Research Group (NAPRCG) in 2023.

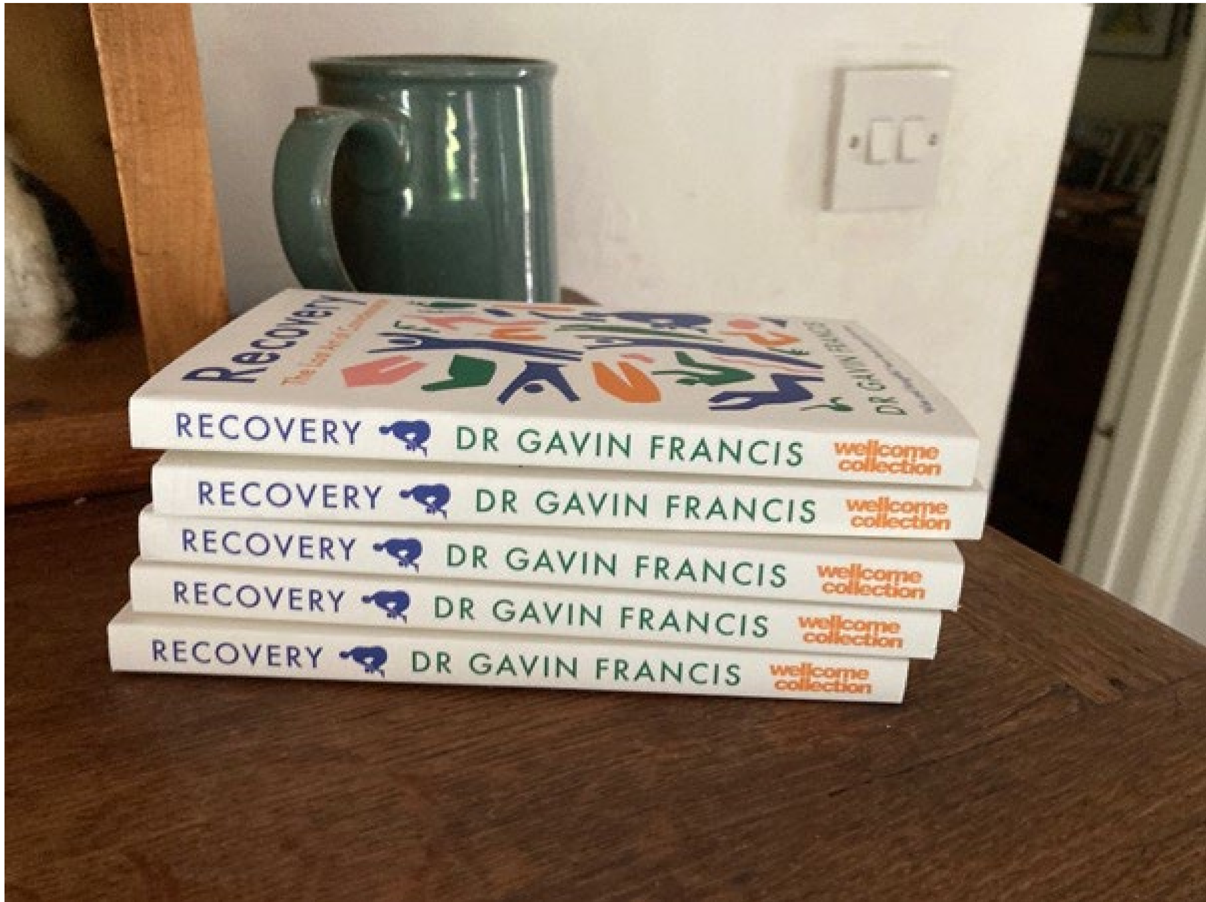
Specifically, I am keen to explore views on primary care advocacy related to social determinants of health and how capacity for advocacy might be developed through research and education. If there are clear evidence uncertainties uncovered, I will build on this with a Priority Setting Partnership, following the process outlined by the James Lind Alliance.

This would include patient and carer groups and would result in jointly agreed research priorities, which would then be disseminated widely and used as a focus for future research and advocacy activity.

Q: Based on your experience, what advice do you have for people who are interested in working in the research field?

For those interested in academic primary care – whether clinical or non-clinical – I would highly recommend: 1) contacting your nearest University department of general practice/primary care and finding out about opportunities; and 2) getting involved in the Society for Academic Primary Care (SAPC). It has been a really supportive network for me, and has excellent regional and national research meetings, with a range of special interest groups.

THE LOST ART OF CONVALESCENCE



One aspect of the lean hyper-efficient hospital, so beloved of general managers, has been the abolition of convalescence. Patients are either ill enough to need lots of medical attention or well enough to need none.

So, it was a pleasure to read this new book by Gavin Francis on *Recovery. The Lost Art of Convalescence.*

There are many ways of reviewing a book. Suffice to say that when I had finished it I bought six more copies, confident that I would have opportunities to share with friends and relatives coming to terms with loss and illness. I only have my original copy left.

One copy went to a friend still working her way through a sudden, traumatic bereavement. The photograph above is hers, having bought topies for her medical student son and five student colleagues, hoping to influence the type of doctor they will become. When last I heard she had bought another six.

The power of small books.

Graham Watt

REMEMBERING JULIAN TUDOR HART

The Royal Institution of South Wales ran a series of four lunchtime talks early in 2022, covering different aspects of Julian Tudor Hart's life and work as a general practitioner, scientist, writer and social advocate.

1. Local reflections, local deeds. Dr Brian Gibbons
2. Excerpts from films of Julian Tudor Hart. Introduced by Gareth Jones and Jonathan Richards
3. A general practitioner for the world. Professor Graham Watt
4. The Inverse Care Law. Professor George Davey Smith

The talks can be viewed by searching the "Royal Institution of South Wales" on You Tube.

Graham Watt's talk is also available on the Scottish Deep End Project website as a powerpoint presentation with associated script at :-

https://www.gla.ac.uk/media/Media_838150_smxx.pdf

SLOWLY TURNING WHEELS - 3

The UK Royal College of General Practitioners has called for increased funding for practices serving the most deprived populations as part of its nine point campaign to secure the sustainability of general practice. Source PULSE Magazine, 22 June 2022

RCGP demands in full

- Create and implement improved IT systems which make it easier for medical staff to share patient records and information about what they need to improve relationship-based care.
- Eradicate unnecessary bureaucracy in general practice to enable staff to focus on patient care.
- Introduce changes to the way we deal with the most vulnerable patients moving away from the current Quality Outcomes Framework to a system that encourages GPs to focus on those who need care most and cuts out the red tape and box ticking.
- Improve the experience of accessing care, making it easier for patients to choose to see the same GP or the next available member of the team, achieved through investing in better booking system and organisational development.
- Make it easier for international doctors who complete their training as NHS GPs to apply for long-term visas to stay and work in the UK, bringing the situation into line with trainee doctors in other parts of the NHS.
- Allocate a greater proportion of NHS budgets to general practice to return funding to 11% of total health spend. This should allow investment in:

1. A nationally ringfenced retention fund of at least £150 million annually for GP retention and career development programmes.
2. Additional funding of at least £100m per year to develop primary care networks to take a lead role in transforming patient care and population health. This should include funding to employ community health leads, increased funding for Clinical Directors or management staff and support to help practices work at scale and to implement new ways of working.
3. Extra funding for practices serving the most deprived populations to recruit and retain staff in under-doctored areas, as part of a comprehensive review of the Carr-Hill formula.
4. Investing £1 billion to make general practice premises fit for purpose, including sufficient space to accommodate expanded multidisciplinary teams.

- Publish a detailed plan to achieve and go beyond the targets of 6000 extra full time equivalent GPs and 26,000 additional staff in non-GP roles. This should include measures to:
- Make the funding rules more flexible so practices are free to use money from the Additional Roles Reimbursement Scheme to hire the staff they need, including nurses, and invest in supporting supervision and training to better integrate teams.
- Expand the number of GP training places by at least 10% year on year. This must sit alongside action to increase the number of trainers and improvements to premises to further expand teaching in general practice.

Source: *RCGP*

MAINSTREAMING A DEEP END PILOT IN GLASGOW

Personal Reflections from Kathy Owens,
outgoing Health Improvement Lead for Community Link Workers.

In 2013/14 Scotland's Deep End group, together with Scottish Government and The Health and Social Care Alliance Scotland were innovators in developing the Link Worker Programme to establish how primary care can better support people to live well in their community.

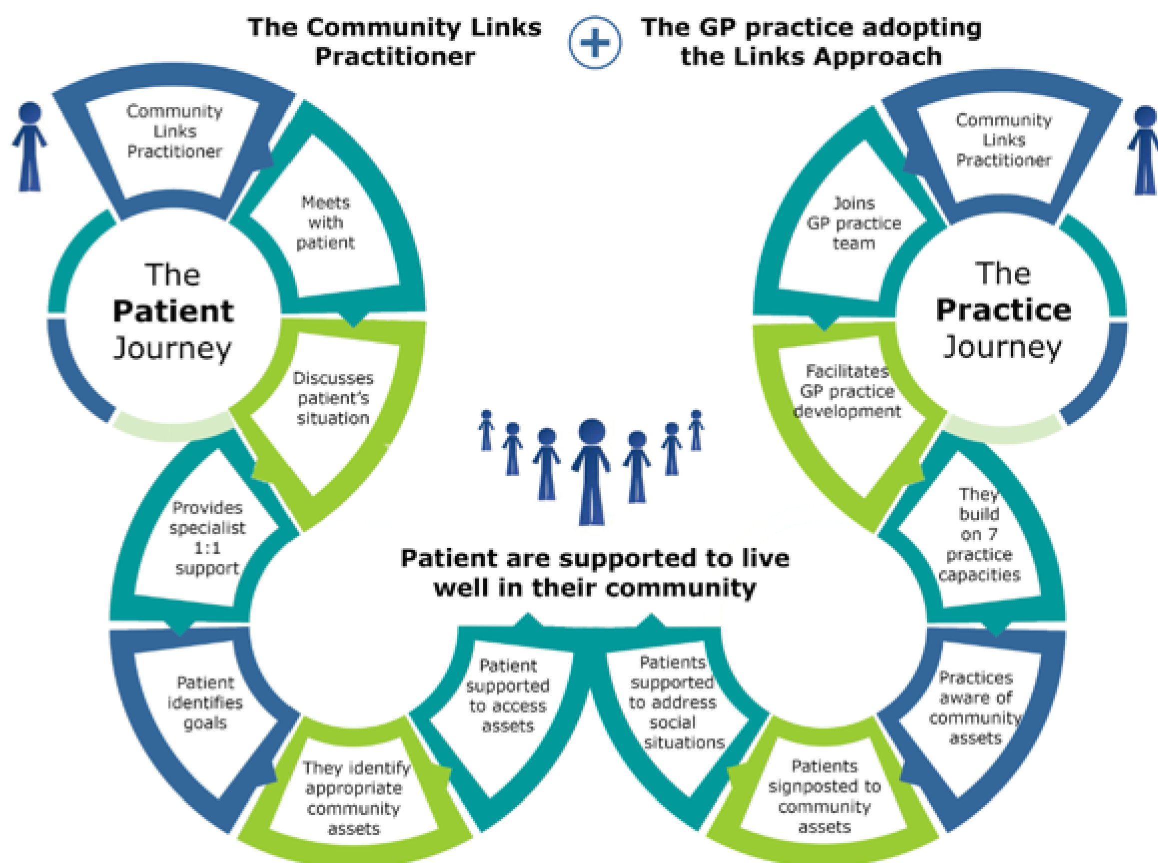
Put very simply the philosophy was to embed non-medical practitioners into General Practices, providing time and support to patients whose social circumstances impact on their ability to live well. While also bridging the gap between community based supports available from Glasgow's buoyant third sector and GP teams who are confronted daily with the consequences of patients' life circumstances.

The programme started with 7 GP practices embracing the Link Worker Programme and, following initial evaluation, was extended to 8 additional practices who had acted as comparators for the purpose of evaluation. The initial feedback from GPs, practice teams and patients was overwhelmingly positive. The reach of the programme was further increased to a geographic area with an ethnically diverse population with significant health inequalities. By 2017 18 Community Link Workers were making an impact for patients, practices and communities.

The advocacy, determination and influence of the Deep End Group and the outcomes felt by practice teams and most importantly patients saw a commitment to extend the programme further in Scotland. The mainstreaming of this Deep End Pilot was its inclusion as a component of the 2018 GMS contract Memorandum of Understanding Health and Social Care Partnerships (HSCP).

I started in my role supporting the development and implementation of the Community Links Worker (CLW) Programme in April 2019. The HSCP had awarded the first contracts for delivery of the expanded programme to the ALLIANCE in 10 GP Clusters, including the original 18 practices. This was a period of uncertainty for all involved in developing the programme and there was notable anxiety about whether the programme could sustain its values, goals and ethos while being managed and extended by the HSCP.

With a strong background in public health and health inequalities, I was motivated to apply for the position of Health Improvement Lead - CLW in order to strengthen and grow the programme while maintaining a strong inequalities focus and supporting patients experiencing significant adversities in life. I was fortunate to have had experience of the programme over a number of years and had seen its benefits and impact. I began by reaching out to those I knew, and those I didn't, and listening to their concerns, hopes and vision for the programme. I have fond memories of my first meeting with Professor Graham Watt and Dr Maria Duffy from the Deep End Group, I think we all left a little relived that we understood the challenges faced but shared a strong vision. Over the years that followed both offered great support and discussion which meant no challenge was unsurmountable.



I feel fortunate to have been delivering the programme in the Glasgow City HSCP, with a strong commitment from senior management to retain a deprivation focus. GP colleagues across the city broadly supported the targeting of resource based on deprivation, although I've fielded a call (or 10) from less deprived practices wondering when they would get their CLW as word of the benefit of CLWs to patients spreads fast. Not all HSCPs in Scotland have been able to retain such a strong emphasis on deprivation. Personally I feel this poses a risk of the CLW programme contributing to health inequalities instead of addressing them; or at least not maximising the potential impact.

In Glasgow we have expanded our programme at a rapid speed and now support 81 GP Practices, each of whom have between a 0.5 and 1.0 whole time equivalent CLW embedded in their multi-disciplinary team. The programme is delivered by two commissioned providers the ALLIANCE and We Are With You. We also have thematic CLW posts supporting Asylum Seekers and the Youth Health Service. Recently we have begun testing the concept of the role in two other service areas, the City's Complex Needs Service and Tier 4 Child and Adolescents Mental Health Services (offering support to the young person and their family network). This growth of Glasgow's CLW Programme wouldn’t have been achievable or as enjoyable without the dedication, commitment and support of our two commissioned providers.

Structurally, we allocate our resource based on measures of deprivation, taking a proportionate universalism approach by accounting for the numbers of patients living in the most socio-economically deprived datazones. But also attempting to address the inverse care law by considering the proportion of the practice population list these individuals account for. Operationally, there are many more considerations which need to be taken by everyone involved in the programme to ensure the continued focus to address inequality. Some of these can seem counterintuitive when managing delivery of contracted services.

Successful implementatio requires busy and overwhelmed GPs to have a strong understanding of the programme, the potential the support of a CLW could have for an individual and their ability to live well, and the time to have a meaningful conversation with patients about the link worker support. There is variation across practitioners in their referral levels and the ‘issues’ they feel confident referring for. We have a number of GPs yet to make their first referrals, so I always encourage GPs to talk to their peers and share their experience of making appropriate referrals and the benefit patients have experienced from CLW support.

We also remain mindful that for the individuals we aspire to support though the programme, the journey from one consultation room to the next can require significant courage - from both the medical professional and the patient. The engagement process and pace of a journey can vary immensely. On paper the issues facing two patients can

be identical; but the matrix of their experience, circumstances, self-efficacy and ultimately trust in services can change engagement duration from one or two person-centred caring conversations/appointments and a social prescription to a community support to a period of engagement lasting months; for example, listening, understanding circumstances, advocating, motivating, listening some more, physically supporting engagement to attend services and groups, or just getting out for a walk.

Embedding CLWs in the GP Practice Multi-disciplinary Team is core to the success of the programme in individual practices. This was identified in the University of Glasgow evaluation and is certainly my experience. Key features are:

- a person-centred approach and holistic approach to be adopted across disciplines in the practice team
- a strong and consistent focus on the social determinants of health,
- allowing relationships and trust to develop
- improvement of patient care and outcomes.

It saddens me when I hear about the culture and the dynamics in a small number of GP Practices which mean CLW and other multi-disciplinary team members, are not engaged and involved in the practice and where even getting a cup of coffee can be a daily battle. The evidence is clear that these impact on team cohesion, and wellness, and negatively affect patient outcomes. I have witnessed this effect though the programme and we continue to work to support these practices to reflect and adapt their approach.

Accommodation is also precious in Glasgow. Some practices struggle to deliver their clinical services within space limitations. This pressure can result in CLWs and their social role being placed as a secondary function, and sometimes bottom of the priority list for space. Practice managers play an essential role in managing and maximising the utilisation of space. It will always be essential that CLWs have some time in practice for both face-to-face appointments and administration. This is core for patients and for building relationships in the practice. Moving forward we need to be creative in this regard and consider other options to ensure CLWs have access to other spaces to meet with patients to ensure the support can be offered locally for patients and that CLWs feel valued by having space to undertake their roles.

I would be dishonest if I said that everything always goes smoothly. There have been challenges over the years. In my experience, if something doesn't sit right with you, or if you are unsure about appropriateness of delivery, ways of working or just have any uncertainty thoughts or feelings, pick up the phone for an informal chat to the service manager, or HSCP programme leads. This can help gain clarity, find quick and easy solutions and in my experience can prevent months of discontentment from both practices and CLWs. Where there are more serious issues, be reassured we have

robust processes for responding to these both within the services and within the partnership.

Reporting and performance monitoring of the CLW programme is an area of frustration for some CLWs and Practices. This needs to be a core component of the programme for a number of reasons, primarily accountability. The value of the contract is significant and we must be able to demonstrate the impact and outcomes of the programme for patients, practices and communities. We also need to collect data to be able to understand delivery, need and effective practice. This has enabled significant service development and improvement over the past 3 years. It has also allowed us to share learning at practitioner, practice and national levels. We have worked closely with our commissioned services to understand what case load and referral numbers should look like for CLWs. Support and guidance on managing the workload and maintaining a quality service is core to delivery and as commissioners we take a pragmatic approach to changes in these based on real-time experience and the evidence available to us. When I present findings from the programme delivery it often validates the experience of GPs over many years, evidencing the magnitude of social determinates of health that present in general practice.

As I move forward in my career in health improvement and tackling inequality I will always reflect on the following statement 'If what we are doing is easy, we most likely aren't reaching those who need support the most'. Delivering services at the Deep End is hard, but the impact of patient centred community link working is undeniable, and for some people, life changing. Hopefully my path will cross with Deep End colleagues in Ireland and Northern Ireland over the coming years!

Kathy Owens

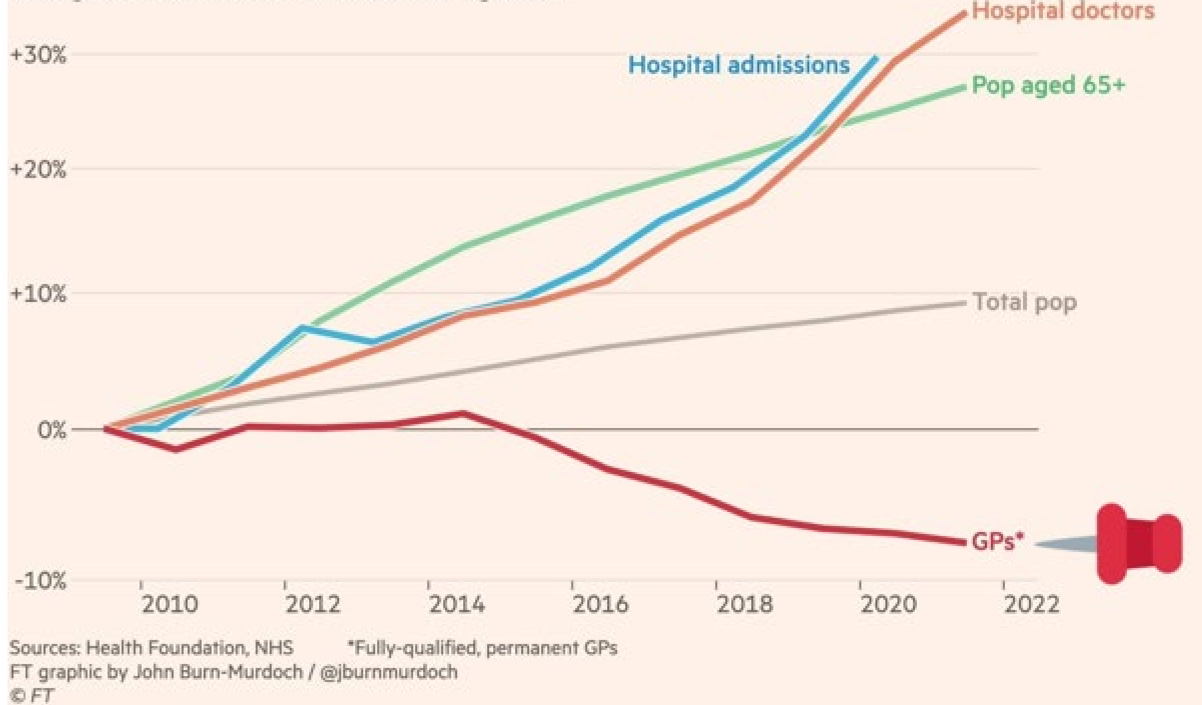
EVIDENCE CATCH UP

Jumping in at the Deep End: supporting young GPs working in deprivation

Rachel Steen, Elizabeth Walton and Dominic Patterson

British Journal of General Practice 2020; 70 (692): 132-133. **DOI:** https://doi.org/10.3399/bjgp20X708641

> ...at the chance to **dive** into the **deep** end of any river or lake. In view of this, I wondered why I, and other GP trainee colleagues coming to the end of our training, might not be as keen to jump into the waters of **Deep** End general practice. Perhaps it is because we see our GP role models working in deprived areas ...



Many readers will be familiar with the above graphic, which provided the backdrop to the article below, which first appeared as part of a series on NHS Futures in the Herald Newspaper in March 2022.

IF WE DO NOT CHANGE DIRECTION ....

There is a Chinese saying, "If we do not change direction, we shall arrive where we are heading". As the NHS emerges from the multiple consequences and challenges of the pandemic, will we find ourselves on the right road?

The NHS will continue to deal with emergencies, large and small, to provide access to specialist investigations and treatments, to give children a good start in life and to help people die in comfort and with dignity, but an increasing challenge will be supporting and enabling people to live well with multimorbidity.

Multimorbidity is not a single entity and varies from the accumulation of physical problems with old age to the combinations of physical, psychological and social problems in deprived areas which make longevity a distant prospect. But while people with multimorbidity are all different, their needs are the same, namely unconditional,

personalised continuity of care, building the knowledge, confidence and ability to live well, to make good use of services and to avoid or delay complications.

It is often said that about 15% of consultant vacancies in NHS Scotland are unfilled, suggesting a crisis, but this needs to be viewed in context. In the last two decades the numbers of hospital consultants and specialists working in community health services have increased by about 50%, while the number of general practitioners has stayed more or less the same. The resulting imbalance of specialist and generalist services has had big consequences.

Specialist services are important, and often brilliant, but leave a lot for general practice to do in terms of patients who do not meet referral criteria, have difficulty in accessing services, are not made better by treatment, have conditions outside specialist interest and are discharged from specialist care. With post-Covid syndrome, catching up with chronic disease management and the increasing health impacts of poverty and financial distress, workload in general practice has increased. Exhausted GPs are retiring early. The capacity of general practice (the "community sink" into which all sorts of problems have traditionally been poured) can no longer be taken for granted.

With nearly 90% of NHS patient contacts taking place in primary care, a reduction to 88% is imperceptible in the community but the impact in hospital, from 10% to 12% is huge. Understandably there are calls for increased A&E resources, but when a ship is listing to one side it is not the side nearest the water that needs extra weight.

The gatekeeping role of general practice is not confined to writing referral letters. Patients can attend A&E at any time but when the complications of their conditions have been prevented, when they are confident in their care and have ready and reliable access to a small team of health professionals whom they know and trust, they choose not to. The elegance of this aspect of gatekeeping is that there is no gate.

It is possible, of course, to live long and well without the help of doctors but in Scotland the 10% of patients with 4+ conditions account for nearly 50% of potentially preventable hospital admissions. Such patients are generally excluded from research and the evidence base but keep the NHS busy and are most in need of unconditional, personalised, continuity of care, building knowledge, confidence and agency.

A study of 700 consultations in general practice showed that affluent patients with multimorbidity had 25% more time with their doctor than deprived patients with similar levels of multimorbidity – a feature of NHS Scotland whereby everyone has equal access through the front door but not equal access to needs-based care. Despite premature mortality and multimorbidity increasing 2-3 fold across the social spectrum, the distribution of GP manpower is virtually flat, especially in the more deprived half of the population.

The road we are on is paved with good intentions but has led us into three undesirable situations. First, an archipelago of efficient, centrally-managed, specialist services in hospital and the community has fragmented care and increased the “treatment burden” of patients with multimorbidity i.e. the work that patients do in accessing different services for different conditions. Second, the weakened capacity of general practice exposes emergency services to patients whose preventable complications and crises have not been prevented. Third, the gap between what GPs can do and could for their patients with more time, better connections and better support is greatest in deprived areas.

Key features of the NHS at its onset were access, taking money out of the doctor-patient consultation and reducing the appeal, for those who could afford it, of private medicine. For individual families the best protection lay in all families being protected. These features are still important but health care has new challenges, especially in its contribution to improving population health. If health care is not at its best where it is needed most, inequalities in health will widen, as some groups benefit while others do not.

To paraphrase George Orwell, the argument that politics should be kept out of health care is itself a political statement, favouring those who benefit most from current arrangements. Of its own accord the NHS does not travel in a straight direction but veers to the pull of special interests, including managerial, professional and public. If politicians take their hands off the wheel, we shall arrive where we are heading.

Graham Watt
Emeritus Professor
General Practice and Primary Care
University of Glasgow
graham.watt@glasgow.ac.uk