

GENERAL PRACTITIONERS AT THE DEEP END INTERNATIONAL BULLETIN NO 6 DECEMBER 2021

The secret of change is to focus all your energy
not in fighting the old but in building the new.

Socrates

Welcome to the sixth Deep End International Bulletin, jam packed with imagination, energy and passion.



The Deep End Projects – islands of progress standing out from the crowd*

Consider the Bulletin as a *caravanserai*, or stopping place along the way, where travellers meet for rest, company, refuelling and the sharing of experience, intelligence and plans. Some Deep End projects have come a long way; others are starting out.

The journey began and begins, as Julian Tudor Hart described the first rule of practical politics, where you are with the people you've got. 12 years after the first Deep End meeting, Horizon A (the status quo) continues for most Deep End practices and patients, as described by Dawn Innes in her reflections on working as an Advanced Nurse Practitioner in Sunderland (Page 3) by Marianne McCallum and Sara Macdonald in their BJGP article (Page 5), and by Claire Norman, Jo Wildman and Sarah Sowden reporting on working conditions during the Covid pandemic (Page 6).

In 2011, Dublin GP Edel McGinnity wrote :-

I am a GP working in a deprived urban area in Ireland. I would like to express my enormous appreciation of the Deep End series that has been running in the Journal since January. I would describe it as having been thrown a lifebelt, if that's not overstretching the analogy. To see one's experience named and, indeed, validated in this way has been very liberating. It must be a bit like a patient with an uncommon illness finding a support group. One of the many insights of the work has been to point out that it is not just governments who do not appreciate the issues, but our own unions, colleges, and indeed GP colleagues.

BJGP 2011;61:439 doi: 10.3399/bjgp11X583083

Edel's last point is less true now than it was then, as perhaps demonstrated by Helen Salisbury's recent column in the BMJ (Page 6) and numerous examples throughout Pages 7-32 of Deep End Projects engaging with power and resource.

Horizon B, or how we are moving forward, is illustrated by reports from 11 Deep End Projects, including the long established and the relatively new. It is especially pleasing to welcome new Deep End Projects in Denmark (Page 11) and the East of England (Page 12), taking the number of Deep End Projects into double figures.

Following the previous Bulletin in July 2021, the third Zoom Meeting for Deep End Coordinators took place in September (Page 34), followed by correspondence (Page 38) in which Dan Hopewell from Bromley-by-Bow makes a strong case for how he sees Horizon C, or where we are heading. I've also included, as a possible Horizon C, my closing remarks from a talk by Zoom to the Norwegian Medical Association meeting in Oslo in April 2021 (Page 42).

Finally, it is a pleasure also to note that James Willis's classic book about clinical generalism, *The Paradox of Progress*, is now freely available on his website (Page 33).

Graham Watt

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December 2021

*Looking north from the top of Fionn Bheinn (933m), near Achnasheen, Ross-shire
at 09.00 on Wednesday 25th August 2021

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**“THIS IS JUST THE WAY LIFE IS”
DECISION DENSITY AND NURSING IN THE DEEP END**



Dawn Innes ANP

Having qualified as a Nurse in 1988, I had a long career in Accident and Emergency nursing before spending the last 14 years in General Practice in the city of Sunderland. I consider myself a highly qualified and experienced nurse whom nothing can intimidate - I can deal with anything thrown at me.

When I was offered a position as head of the nursing service at a large Deep End practice within the same city but different primary care network, I was happy to accept the position. I knew it would be a challenge as it was my understanding that the practice was Deep End (in an area of social deprivation and health inequality) but this was where I wanted to work: in an area I could put my experience and knowledge to use in the later years of my career.

What I wasn't expecting was how different the experience of working in a Deep End practice is. I knew it would be different - but surely not that different, as it is only 5 or 6 miles from the practice I was previously working in.

The first thing that struck me was the sheer number of patients living with multiple chronic diseases. Obviously, we work in a health care setting and we are used to seeing patients with chronic diseases and long-term conditions, but it seemed to me that almost every patient I saw has multiple co-morbidities. No matter what I was seeing them for, they all had multiple chronic conditions and there was always polypharmacy to deal with on top of the presenting complaint.

Some of the most vulnerable, socially deprived and least educated population in the area had the most complex medical management plans to follow. How was I to

address that, and educate my patients to safely manage their condition, health, polypharmacy and symptoms – all in the same length of appointment time as in my previous practice where engagement and understanding was much less of a challenge?

What seemed obvious is that this patient population would need more time in appointments, more regular review - but where would we get the resource? However, it was too much risk to patient, clinician and system to simply discuss and put in a management plan with the expectation that this could and would be followed safely. As head of the nursing service, I was afforded the time to redesign the nursing service to better serve the patient population in this Deep End practice. I did this by writing practice protocols and standard operating procedures for just about all chronic diseases, inclusive of a call, recall and review system tailored to the patient population. I then communicated this throughout the team. This seemed the safest way forward.

This is an organised approach but does not reduce the decision density and complex management decisions around polypharmacy etc, and the issue of safely communicating this information to patients; although as clinicians we are all used to this, what I was not used to was the frequency. This can impact on clinicians as it is exhausting, and can cause an increase in anxiety amongst staff. As such, we set up regular clinical supervision sessions to support the team. This was gratefully received but again takes skill and resource which, as all who work in the Deep End know, is hard to come by. Protected time for chronic disease management review and supervision was even met with some opposition from some admin staff who are continuously under pressure to find appointments; they viewed some of this as reducing usable appointments because although it is aimed at improving patient care and therefore outcomes, it reduces availability of bookable appointments. More communication and work with the admin teams was required.

The next glaringly obvious thing that struck me was that I would need to change my strategy in engaging patients to self-manage their health needs. It would be no good advising on diet and lifestyle as many patients would not be able to achieve this for a variety of reasons: poor socioeconomic backgrounds and simply not being able to afford to achieve some of these lifestyle measures, as well as struggles with mental health, addiction and alcohol abuse. Sometimes there was just pure acceptance among patients that this is just the way life is, having come from whole families struggling with chronic disease and long-term conditions. It felt like a useless exercise in advising, then ticking the box to say you have done so.

I quite simply could not go home at the end of the day feeling satisfied that I had given the information and advice / signposted to digital support, websites etc and

therefore can now leave it up to the patient – and I knew that if I felt like this then my whole team felt like this.

One strategy is referral to a social prescriber to assess and offer tailored support - a service which will become worth its weight in gold but again requires referral and resource. Many patients will require this plus referral to specialist nursing and medical teams.

This is the tip of the iceberg too. Complex conditions that are difficult for our patients to manage generate frequent unscheduled hospital attendances where the presenting complaint will be dealt with then discharged for the GP to follow up. I was overwhelmed with the number of hospital discharge letters requiring drug changes, follow up bloods, alteration to analgesia, onward referral to other teams etc, again in a population who may not understand these changes themselves – creating sometimes what felt like unmanageable workload.

I learned from my colleagues that they had lost clinical staff in the past because they could not cope with the number of patients presenting with such complex conditions on a daily and frequent basis and were much more used to dealing with coughs and colds, rashes and sore throats (which we do also deal with) so they simply left after a very short time.

But at the end of the day, I can deal with this, and if I'm honest I am enjoying making these complex clinical decisions. Even if my decision is that this isn't for me to deal with and I need to refer on, it's still a decision and I feel I am contributing and doing some good for the health of the patient population. Also, I am supported by a likeminded and very good team – crucial in this environment.

This is a personal experience and not based on evidence or figures 😊

RESEARCH CATCH UP 1

Exploring GP work in areas of high socioeconomic deprivation: a secondary analysis

Marianne McCallum^{1*}, Sara MacDonald¹

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Thank you to Helen Salisbury for this comment in her BMJ column.



RESEARCH CATCH UP 2

<https://www.mdpi.com/1660-4601/18/16/8689>

COVID-19 at the Deep End: A Qualitative Interview Study of Primary Care Staff Working in the Most Deprived Areas of England during the COVID-19 Pandemic

by  Claire Norman ^{*} ,  Josephine M. Wildman  and  Sarah Sowden 

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REPORTS FROM DEEP END CANBERRA



Compassion, flexibility, advocacy and respect for evidence – disadvantaged and drug and alcohol affected communities in the pandemic

Michael Levy

COVID hit Canberra late, and contingency plans had been well developed. Other Australian jurisdictions had experienced prolonged and multiple lockdowns, but in the Australian Capital Territory (ACT) we were COVID free for a year, only entering lockdown again in August 2021. By then lessons had been learnt: population-based testing was free, and adaptive to local micro-clusters. Dedicated respiratory assessment units were complementary to the testing services. The ACT Government, not satisfied with the national vaccine ‘stroll-out’, was early to make vaccine distribution and administration a response priority – the effectiveness of this is evidenced by this jurisdiction now recording almost 100% coverage among 12+ year old citizens. To date our population of just under 400,000 has recorded 1872 cases and 14 deaths during the whole pandemic, with 140 active cases currently.

The epidemic hit public housing, and minority population groups, but the ACT Government never “named and shamed” (an unfortunate Australian trait), and mobilised targeted assessment, treatment, and prevention services – always working with affected communities and credible non-Government organizations.

Patients on opiate-agonist-treatment (OAT), thrust into quarantine, posed very special challenges. A “delivery-to your-front-door” service kicked-in. More than just the technical delivery of OAT, the roster of dedicated staff (alcohol and drug workers, needle and syringe program staff, pharmacist) were engaged advocates for their clients. The recent adoption of depot-buprenorphine offered enhanced choices for patients, but when

negotiating with some services, effective advocacy was a critical element to effect change. A 'champion' has always been important, but never more so, than in the whirlwind of a local COVID outbreak.

In summary, low threshold addiction treatment services have filled a niche in redressing COVID related disruptions faced by drug and alcohol affected patients. While this may read like a gilded view of a situation that we could have gone without, we think that compassion, flexibility and respect for evidence – carried our community well into the next phase of the pandemic response.

Vaccination leaders and creative outreach

Liz Sturgiss

The Australian Capital Territory (ACT) has had one of the most rapid uptakes of COVID vaccination in Australia. As of 19th November, we have 97% of people aged 12 years+ vaccinated in our community. This is not surprising - while we all work in the Deep End, the ACT is relatively advantaged with the highest average salary and highest percentage of people with University degrees in Australia. We are seeing the social determinants of health playing out in a setting of social advantage.

But not all of our community members have benefited from these high vaccine rates - for example, only 79% of the Aboriginal and Torres Strait Islander community are fully vaccinated. This mirrors the difficulties with healthcare access for all other reasons for First Nations people, a result of generational trauma, colonisation and distrust of government.

The relative advantage in the ACT makes our work in the Deep End even more unique as often these populations are hidden and even more difficult to reach. Outreach models have really been essential with a new mobile clinic, home testing and vaccination for the housebound and those with no transport, plus scaling up teamwork within primary care. These models have seen new collaborations between the government health department, non-government organisations and private general practice. It is quite incredible to see the inroads made into working together made necessary by the pandemic. It isn't perfect by any means, but it is miles ahead of where we were prior to Covid-19.

Multicultural shopping and corridor vaccination - a busy and challenging time in refugee health

Sue Baglow and Joo-Inn Chew

This wave of the pandemic hit marginalised and disadvantaged communities hard and early, especially before vaccines were widely available. There were many cases among clients of Companion House, but thankfully no loss of lives. Our communities have large

families and work in essential and high risk settings like aged care, hospitality, cleaning and security. Fear of hospital (isolation from family, language barriers) sometimes delayed people seeking help. The index cases in Canberra received some shameful and distressing hate speech on social media; behind the scenes liaison with police and others enabled this to be taken down and the media tone to improve.

Our medical, counselling and community support staff creatively adapted to accommodate pandemic restrictions. Intensive support was provided to infected and quarantined families, with Telehealth and delivery of food and medications. There were many adventures sourcing unusual foods, leading us to hold a 'multi-cultural shopping prize' award. With dedicated liaison and organisation (thank you nurse Stacey!) we were able to vaccinate a large proportion of our population in-house (more specifically, in a corridor normally shared with the Quilting and Heritage societies in the former primary school building where we work). Challenges included the extra time needed for interpreters, vaccine hesitancy among some communities, and the recent arrival of hundreds of people fleeing Afghanistan. It has been a busy and difficult time that has strained health workers and clients, but we have been heartened by the way we have all come together to meet the challenge.

Winners in our multi-cultural shopping awards – outreach to families in quarantine



Health care for marginalised young people in a pandemic Tanya Robertson

We have maintained face to face consultation throughout at the Junction Youth Health Service (apart from a week of our shutdown due to a COVID positive case attending pre-symptoms). All staff are vaccinated voluntarily. During Canberra's recent lockdown, attendance dropped significantly as many of our young people do not want telehealth and particularly video consults (requiring internet access). As restrictions have eased we are back to seeing most patients in person.

Our COVID 19 Action plan was activated when we were deemed a close contact site and we pivoted to remote work via telehealth for 48 hrs while a deep clean occurred. Staff who were contacts but remained well continued to work from home during their isolation period.

We promoted and facilitated vaccination for many of our clients including providing telehealth vaccination consultations to 16 young people living in Out of Home Care whom the Guardianship tribunal had requested have independent health care advice prior to attendance at the arranged vaccination clinics.

Many of our young people rely on long acting reversible contraception. Although Family Planning Australia provided information about extending the use of Implanon past the 3 years during COVID, we decided to only defer appointments for a few weeks at the beginning of lockdown. After that appointments to insert LARCs were done with clinical staff in full PPE and the young woman in an N95/P2 mask.

Photo of our building – scaffolding to remove the cladding due to fire risk lasted 4 months (instead of scheduled 2 weeks due to COVID lockdowns). We were sad to see this bit of graffiti go –grammar beats spelling!





Empty City of Canberra during our lockdown August 2021

REPORT FROM DEEP END DENMARK



We are in the early stages of establishing a Deep End group in Denmark. So far, we have held several meetings with colleagues, politicians, journalists and other opinion-makers, and we have experienced overwhelming support from our communities and partners. We have scheduled several meetings to explore the funding opportunities for this important initiative, and we believe that the timing is perfect. The Danish government has declared that increased focus should be directed towards three target areas: social inequality, lack of GPs and development of rural areas.

We are currently investigating different ways of identifying Deep End GPs. If we can get permission, we may be able to use existing data from Statistics Denmark to rank each GP clinic according to the socioeconomic characteristics of their listed patients and select the 100 clinics serving the most deprived populations.

We look forward to being part of the unique Deep End organisation and working towards common goals.

Mogens Vestergaard

REPORT FROM DEEP END: EAST OF ENGLAND



Hello from “Deep End: East of England” – we are the newest Deep End Branch having officially launched 21st Sept 2021 with the kind support of Prof Watt and Dr David Blane.

The region serves a population of 5.8 million people from northeast of London stretching from Basildon & Southend at the mouth of the River Thames in the South, over to Great Yarmouth & Lowestoft on the Eastern coast; and King’s Lynn and Peterborough in the North. The East of England (EoE) is currently divided into 19 Clinical Commissioning Groups (CCGs) serving health needs; and about to be ‘merged’ with social care into 6 Integrated Care Systems from April 2022.

The two main ‘co-ordinators’ of Deep End: EoE met in April 2021, on the national Deprivation Trailblazer scheme – a GP Fellowship programme that has developed from the roots of the Deep End Projects! We are both early career GPs with an interest in promoting health equity and our Deprivation Fellowship has allowed us the opportunity to create “Deep End: EoE” – a network of people serious about improving the health and well-being of those communities living in the most deprived areas across the East of England. Following the established Scottish DE formula, we have identified the 100+ most deprived communities & practices across our region, most of them, unsurprisingly, are situated in cities and coastal regions.

With the support of Health Education England (HEE EoE), we launched in mid-September with a lunchtime zoom event. We hoped for a dozen attendees and were overwhelmed that almost 120 people gave up 1.5 hours of their precious time. We were thrilled that Professor Graham Watt and Dr David Blane joined us and Graham did an excellent presentation describing the current ‘climate’ and the need for such Deep End networks & partnerships.

We are still very much in our infancy as a network and have been trying to develop our volunteer Steering Group – it is hard to ask for time of others during this challenging COVID Winter. We have read the work of the various Deep End projects and have agreed our ongoing ‘work streams’ for EoE from your learning & experience – thank you. These are the “A-CREW”!

Advocacy
Climate and environmental sustainability
Research
Education and Training
Wellbeing and workforce

We have already set up three Whatsapp groups for three of the Integrated Care Systems that are very active. These have already proved a useful tool enabling the sharing of ideas, resources, projects and meeting others. We will be writing out to all the Deep End practices in the New Year, with a particular focus to seek further support/networking with the remaining three ICS regions.

We have also started engaging with various stakeholders, interested in supporting the Deep End practices & communities.

Projects in the pipeline:

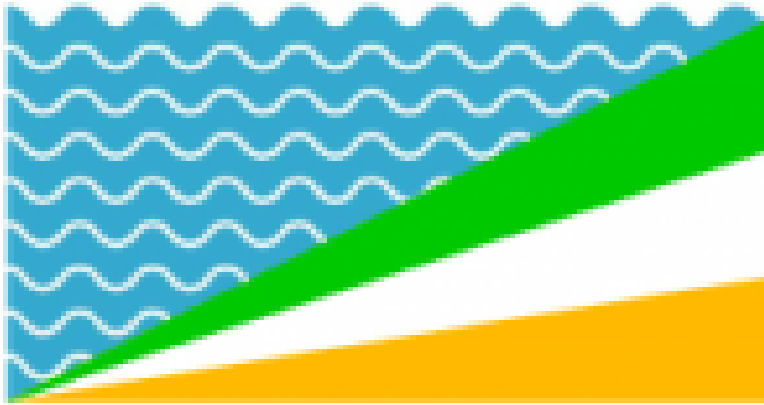
- Working with HEE to increase training capacity within deprived practices
- Piece of work with NHSEI to evaluate the use of social prescriber/link roles in deprived areas
- Working with Global Action Plan to be part of a national pilot project for GP's exposing the danger of air pollution and promoting clean air initiatives
- Starting a monthly 'sounding Board' session for interested people seeking advice and ideas from December
- C&P developed a HCA visiting service for Deep End Practices in Peterborough to visit Housebound patients living with diabetes. This has proved very successful & is starting in Wisbech in January.

Gilly Ennals
Jessica Randall-Carrick

Some will consider such words the lip service
to peace as familiar in the mouths of politicians
as quacking in the mouths of ducks

Compton Mackenzie, writing in the 1930s, but still a pertinent
observation on half-hearted virtue-signalling

REPORT FROM THE IRISH DEEP END PROJECT



Fellowship in Urban Deprived General Practice, 2021

Dr Muireann O'Shea took up the one-year ICGP Fellowship in Urban Deprived General Practice commencing in July 2021. She is based half time in the Department of General Practice in RCSI (Royal College of Surgeons in Ireland) and completes clinical placements in 3 Deep End practices over the year. The Fellowship is supervised by Prof Susan Smith and Dr Patrick O'Donnell with support from the Irish College of General Practitioners and her practice supervisors Drs Eimear Mallon, Dr Edel McGinnity and Dr David Gibney.

Muireann is supported through the clinical placement to develop skills in managing complex cases of multimorbidity, and to gain valuable experience working in urban deprived practice. She spends two sessions per week engaged in audit and quality improvement projects within the practice. She has completed an audit of the physical health assessment of opioid substitution therapy patients in the first of her three practices and has presented the findings to practice staff who will now action the audit recommendations and reaudit in one years' time. Currently, she is working on assessing the wait times and referral pathways for children presenting to the three practices with mental health and developmental concerns.

Applications for funding and ethical approval have been submitted for a research study to evaluate the use and implementation of the urban deprived practice grant in Irish General Practice. Muireann has completed the RCSI Course in Research Methods and has been assisting another Deep End Ireland GP, currently completing a PhD, working on a systematic review of the effectiveness of link workers providing social prescribing on health outcomes and costs in primary care and community settings. She has also been facilitated to become involved in the teaching of undergraduate medical students in the RCSI.



Muireann is hoping to link up with other Deep End GP Fellows to share experiences and learning during the Fellowship year. She can be contacted at: muireannoshea@rcsi.ie

REPORTS FROM NORTH EAST AND NORTH CUMBRIA



GPs at the Deep End NENC

It has been just over a year now since Deep End NENC was established. We wanted to take this opportunity to reflect on what we have achieved and refresh our intentions and motives for our future direction. As one of the more recent joining members of the network it has been useful to look back at the drive to start the network. My knowledge of Deep End GP started in 2019 coinciding with the inception of Primary Care Networks, when trying to understand how and what values can motivate practices and teams from separate organisations to work together for a common purpose.

The core team came together with the desire to tackle the inequality and, more importantly the inequity, in health resourcing they see and work in every day in Primary Care. The ethos of Aneurin Bevan, where every person is entitled to healthcare that is free to access, is strongly held for our communities. However, we see that there is a disparity in what this means in the modern-day NHS and the gaps are ever widening in key areas of workforce, education, advocacy and research in places of high deprivation.

These key themes became the adopted acronym, WEAR, to work towards. For the purposes of this narration, I am going to start backwards as the roots of the Deep End Network's actions are based on co-design.

Research

The Deep End Network is primarily focussed on general practice but we are so fortunate to have a strong contingent of researchers and academics which let us truly build the network from grassroot GP teams. Taking the approach of co-design and interviewing practitioners in Deep End GP, we were able to understand and pick out key priorities for practices. Our initial report on these co-design findings can be read [here](#). We have also had a paper describing 'COVID-19 at the Deep End' published in the International Journal of Environmental Research and Public Health – this can be read for free [here](#). This provides insights into how the pandemic was experienced in areas of high socioeconomic deprivation and why these areas may have had worse outcomes.

Advocacy

The cross organisational approach of academics, NHSE/I colleagues, public health representation, voluntary and charitable sector enterprises and local councils involved in the steering group has meant we have been able to advocate in the different stratospheres of NHSE and academia. The embedding of NECS business intelligence representation has meant we have access to data which can provide a springboard for practices to advocate for themselves in their networks to enable better resourcing.

Education

We have now held 5 successful Deep End webinars, held on Wednesday lunchtime to allow a space and time for practices across the NENC ICS footprint to discuss, learn and bring forward ideas. The attendance at these events has grown, with 18/35 practices in the most deprived areas attending, hitting our target of 50% of these practices to be engaged in the network.

Workforce

We know from research that practices in deprived areas find it harder to recruit and have fewer GPs to patient ratios. This was a key theme in the qualitative research and, in particular, mental health needs of patients needed to be addressed. To that end, 3 pilot projects were developed to tackle some of these issues:

- The Deep End Fellowship to increase GP recruitment to these practices, which are traditionally hard to recruit areas.
- An opportunity to host a GP psychologist
- Dedicated funded time to tackle high opioid and gabapentinoid prescribing.

All 3 pilot projects are due to go live with a spread of practices across the network footprint expressing an interest in one or more of the pilot projects.

Where next?

The strengths of the group are to be celebrated and learning shared as wide as possible. Our key focus is the core practices who work in areas of blanket deprivation, however,

we are keen to help share resources and learning to enable areas of pocket deprivation. We aim to hold webinars for external stakeholders and interested organisations. Ultimately our aim is to influence and shape policy and reframe resourcing into areas of deprivation to redress the inequity we see and face every day.



Dr Dave Julien
Chair of NENC Deep End Steering Group

The dream of reason did not take power into account.

Paul Starr, in *The Social Transformation of American Medicine*

NENC Deep End Webinar

At the end of July the North East and North Cumbria Deep End Network came together for the fifth in our series of webinars. The opportunity to explore and learn together with colleagues who share a passion for the work at the Deep End is always well received and this session was no exception.

Our work program has four key strands: Workforce, Education, Advocacy and Research. The webinar this time around focused our attention on Advocacy.

“Every system is perfectly designed to get the results it gets”

attributed to W. Edwards Deming

Our keynote speaker Professor Edward Kunonga, Director of Population Health Management, addressed the question “how can we use data to advocate for change in the Deep End”.

Edward shared data that demonstrated the impact of deprivation on health care utilisation: people living in the bottom quintile (20%) for deprivation carry a greater burden of poor health for longer, present more (particularly for unplanned care) and incur more cost when compared to people from other quintiles. Their outcomes are worse, living more years in poor health and living less years overall.

The key message that emerged from an excellent presentation and the subsequent conversation was that in order to achieve different results the system needed to fundamentally change how it allocated resources. How do we acknowledge the impact of socio-economic deprivation on health care utilisation and outcomes? The current system doesn't. It is both socially unjust and financially unwise. It is perfectly designed to get the results that jumped out from the data that was shared.

Edward went on to describe how we can use the data to advocate for change at national, regional and local levels. Perhaps most relevant to those attending the webinar was the discussion about how the data could be used to support conversations about resource allocation within and between Primary Care Networks. What would it look like if resource allocation was weighted based deprivation not just capitation? What would it take to start those conversations? What support could the Deep End network offer?

A key challenge for us going forward is to ensure we are representing the needs of all people living in deprivation: both the 70% registered with the Deep End Practices serving areas of blanket deprivation and the 30% registered with practices serving more mixed populations that include deep pockets of deprivation. Need is need.

A strong Deep End Network has an important part to play advocating for change at all three of the levels described. What we want: more funding, equitably allocated.



Dr Martin Weatherhead
NENC Deep End Clinical Lead



Dr Sameena Hassan
NENC Deep End Clinical Lead

See also “That’s the way life is” – Dawn Innes of NENC reflecting on her experience as a Deep End Advanced Nurse Practitioner (Page 3)

*God and the doctor we alike adore
But only when in danger, not before.
The danger o’er, both are alike requited,
God is forgotten and the doctor slighted.*

John Owen, 16th century

*The human mind never tires o’ Glenlivet.
If a body could just find oot the exac’ proportions
and quantity that ought to be drunk every day and keep to that,
I verily trow that he might live forever without dying at a’,
and that doctors and kirkyards would go oot a’ fashion.*

James Hogg, who died in 1835, aged 37
having failed to discover “the exact dose”,
but he tried.

REPORT FROM NORTH WEST LONDON



GPs at the Deep End

Prior to the coronavirus pandemic we created a curriculum-based, 'deep end' educational program. It was open to anyone with an interest in building a fairer system, but specifically designed to improve the resilience of people working in 'deep end' areas.

The program included QSIR training and involved attending 16 'workshops' that explored how systems cause and perpetuate inequity, the impact this has on residents and workforce across sectors, and practical, evidence-based things we can do to make a difference.

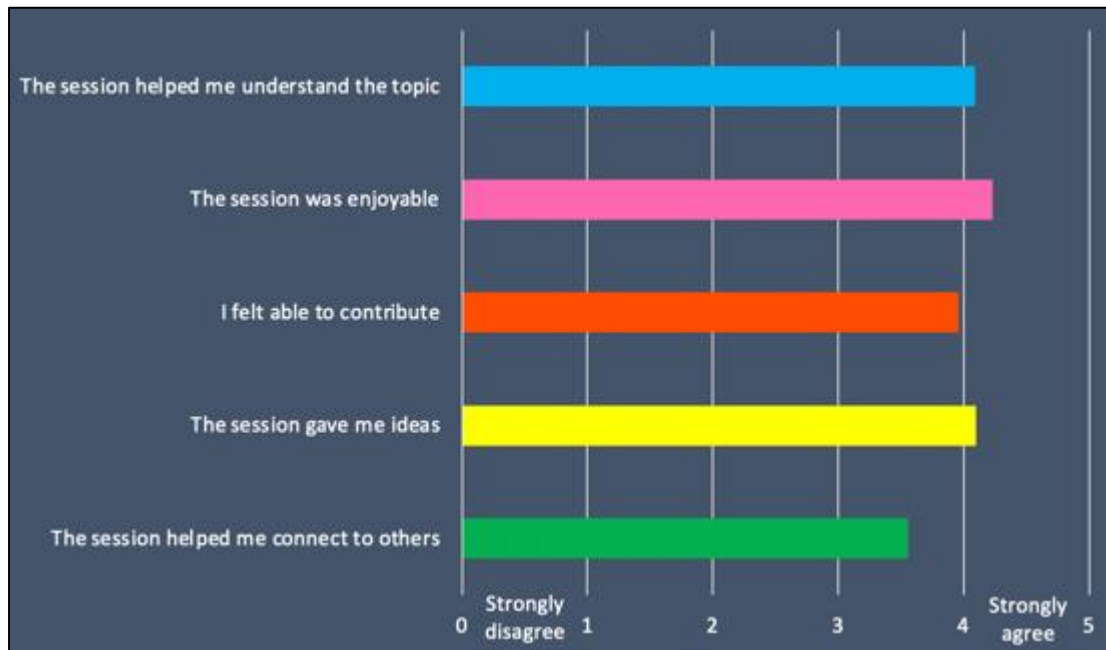
The pandemic made it impossible to continue this program in the same face-to-face format. We therefore reinvented it to be delivered virtually, using the same principles as had been successful in the original design, with the same focus on resilience.

Being online meant we weren't constrained by room capacity so we explored whether we could target a larger audience, and worked with East London colleagues in an attempt to create a model that could deliver the program across multiple London ICS footprints.

Within a fortnight demand outstripped our administrative capacity and we had to stop advertising. The program ran from Nov '20 to Jun '21, and overall 1,697 people visited the booking page, and 619 people from London and beyond booked onto workshops.

Attendance was variable and people had issues with connectivity and dropped in and out of sessions to balance commitments. Nevertheless, we collected feedback at the end of each session using the same set of questions (Figure 1).

Figure 1: Amalgamated workshop feedback from 129 respondents



We also found similarities regarding the core issues being faced by staff, and that this transcended background, level of experience and geography: the program enabled us to capture this frontline feedback and narrative from across London ICSs (Figure 2).

Figure 2: 'Three words to describe how you feel...' [relating to working in the 'deep end']



This was our first foray into delivering a virtual program to build resilience, and we have lots of learning from having completed the first cohort. However, we were funded for 8 nurses for a day a week for 6 months but ended up reaching hundreds of people across London.

PCNs are now being asked to each have a nominated 'health equity' lead, yet there has been little focus on how to develop them for this role. We are therefore working to try and systematize our program to fill this gap.

Chad Hockey

REPORT FROM NORTH EAST LONDON

**Transformative leadership for fairer systems and healthier places:
Engaging with the ethical dimension of individuals for system change**

In September 2020 an inclusive virtual network was facilitated in NE and central London, around values of fairness in health drawing from the Deep End movement which is

based on support, learning, improvement, and advocacy in areas of deprivation. The aim was to restore trust in a vulnerable, morally distressed GP and primary care workforce disproportionately affected by Covid-19 from a legacy of racism and deprivation, and to build a vision of Marmot informed PCNs.

Facilitative leadership came from the RCGP NEL Faculty where there was recognition of the need to develop an integrated narrative of health equity and urgently address: the unequal impact of the pandemic; a legacy of historical racism and exclusion in the RCGP and to promote a culture of support, inclusion, belonging and recognition for GPs and teams working in areas of deprivation.



Timing coincided with harnessing an open access virtual Deep End platform in NWL from Nov 20- Jul 21, which addressed learning needs and provided evidence of how Improvement Science (QI) can transform systems. An unsuccessful attempt was made to align with some of the stalled local system roll out of Improvement Science (QI), as it has been promoted without accessing the ethical dimension of staff.

Membership was built from pre-existing relationships; aimed to include at least one GP in each of the thirteen Boroughs of the Faculty irrespective of their RCGP membership and to include senior NHS GP leaders, as many were either members or fellows of the RCGP NEL Faculty.

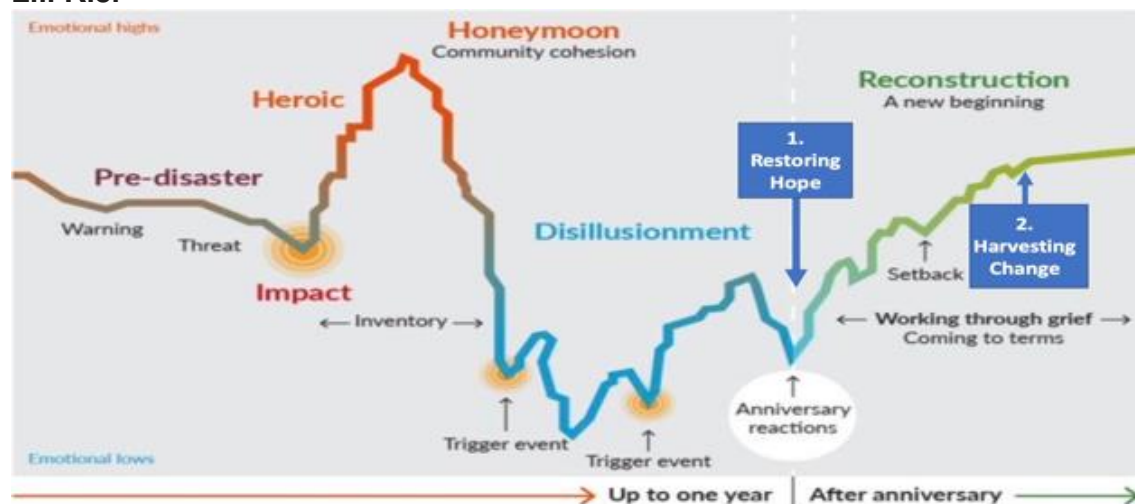
The overarching aim was to move to an integrated narrative and vision of health equity encompassing resourceful people; strong communities; resilient systems; and fairer environments. Three thematic phases emerged over a 12-month period: beacon in the storm; restoring hope; and creating a vision for system change.

We have tested at a:

- micro- level the sharing of skills such as a trauma informed care approach which has been taken up and disseminated by one HEE training hub;
- meso-level facilitation of data and evidence on inequalities to inform equitable care design in practices and networks;
- macro level in the integration of narratives through open access free festivals initially in our local geography (Restoring Hope) on the anniversary of the pandemic and then London wide ([Harvesting sustainable seeds of change](#)), to envision and advocate for health creation.

Concomitantly the local medical school QMUL embedded the Community Based Medical Education module in the curriculum for third year medical students. By November 2021 over 80 people, mostly GPs in all roles and stages, from trainees to retired GPs, as well as other members of the primary care team including commissioners, were linked into this network. We believe that we have identified the necessary components for supportive engagement with professionals and communities which can deliver health equity at scale for emerging health equity leads in the NHSE PCN DES.

Lili Risi



[Pandemic pathway to recovery](#) with Health Equity Festival focal points

REPORT FROM NOTTINGHAMSHIRE



Despite the pandemic creating an increase in the workload for general practice Deep End Nottinghamshire have been meeting regularly. The group has expanded and we are pleased to have more practice managers and GP's engaged. The focus has remained on advocacy, workforce and building connections.

Advocacy:

Our name is getting out there and Deep End Notts has joined meetings with the ICS board. There is a Health Inequalities group feeding to the ICS. Deep End Notts was also contacted by the CQC's BME GP Inequalities project to offer our insight on how deprivation impacts our patients' outcomes and whether the CQC inspection has been less favourable to BME GP's working as single handed GPs in areas of deprivation.

Workforce:

The first year of trailblazers is coming to an end with 4 out of the 5 GP fellows staying in Deep End practices. We have 6 more starting this year. A mid career fellow post was created and this is underway currently with the focus on childhood immunisation take up.

We have also been granted some funding for an NHS England Public Engagement pilot for our PCN. This funding is giving our GP partners some headspace to concentrate on the unmet needs of our community. The main focus has been on diabetes and the huge increase in uncontrolled diabetes during the pandemic. This also ties in with building connections.

Building Connections:

Connecting with our community has been at the very heart of Deep End Notts but we found this to be much harder during lockdown in the pandemic. Nothing compares to face to face connections. Now with things opening up more we are engaging with local school teachers, school nurses and community leaders. Plans are in place to support children and their parents to join a junior park run with the aim of a few team leaders being present each week to build some relationships.

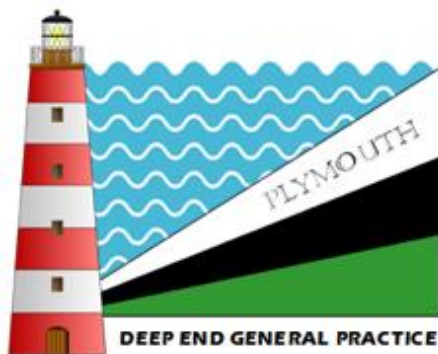
We have found it easier to engage with more colleagues who work in the Deep End in Nottinghamshire now that our name is getting out there and visible things are happening. We are pleased to have so many practice managers involved. We'd like to spread this further and engage with other team members supporting our communities.

As stated earlier we have been invited to give our input in meetings with the ICS board. Nottingham City Council received a grant for providing a Greenspace project in 2020. "Growing healthy people connected to nature". It is focused on improving mental health in the areas of the city with the highest deprivation by connecting people to green spaces and nature. We attend the core meetings for this.

The ball is very much rolling with momentum now and as we said last time it has been a joy to be part of a positive, like-minded community.

Julia White

REPORT FROM PLYMOUTH DEEP END



Plymouth Deep End has just passed its 2nd birthday!

Devon and the South West are often seen as "green and leafy" and as being a pretty healthy place to live. Whilst that is broadly true, as in many places this perception hides huge inequality.

Plymouth in particular lines up better with cities further north such as Middlesbrough and Blackpool in terms of its health statistics than with the rest of the county. One of our neighbourhoods is in the 1% most deprived in England according to IMD2017 and several are in the lowest 5%.

The 8 practices making up Plymouth Deep End serve the areas of highest deprivation, broadly around the waterfront on the west and south of the city.

When we formed we used the acronym “WEAR” to describe what we wanted to do. This stood for workforce, education, advocacy and research. Here is the past year under those headings:

Workforce

This has been a landmark year in which we have managed to get funding for 8 GP Deep End Fellowships worth £10,000 each with funding from the Clinical Commissioning Group and Health Education England

The Fellowships run for 1 year at least initially and 6 of the 8 practices have appointed a Fellow. Unusually we obtained agreement that funding could go to existing doctors as well as being used to help recruitment of new ones. Since retention is as much of a problem as recruitment for General Practice in Deep End areas, this was very welcome.

We have a mentor scheme and action learning sets that meet regularly for our fellows, sometimes combining with a “Health Inequality Fellowship” scheme that was already running in the S West. Fellows are also making use of the wonderful Fairhealth training resources.

Fellows will be undertaking Deep End related projects during their years, and we already have wonderful ideas circulating.

We are now exploring a Deep End nurse fellowship scheme for practice nurses.

Education

As Deep End lead I have been teaching regularly to post-grad doctors on health inequalities including to Foundation doctors and on our vocational training scheme. Our clinicians are often asked to contribute to the clinical commissioning group and even to Plymouth City Council on Deep End issues.

We host medical students from Peninsula medical school and provide a mainstream “Pathway week” in Complex needs/substance misuse that every student passes through.

Advocacy

Many of our Deep End practices are housed in old and inadequate premises – a wonderful example of the inverse care law!

We were approached by Plymouth City Council to be involved in a bid to central government for funding for one of the proposed “Cavell Centres” that would provide a “one stop shop” health hub rather like the Bromley by Bow model in Tower Hamlets. This bid has gone through and the West End of Plymouth, right in the middle of our Deep End patch is the proposed site.

The West End Health and Wellbeing hub will house 3 of our Deep End practices, plus a wide variety of other services including mental health, citizens advice, outreach from the hospital, dentistry and pharmacy – along with a suite of social prescribing. It will be an absolute game changer for health in the neediest part of our city if we can get it through – and I am sure that it was because we had come together as “Deep End Plymouth” and had been advocating for our populations that we were immediately involved and are now on the steering group.

Covid-19 has of course greatly impacted on all areas of our work this year and added to the huge stress of providing care to people suffering from multiple deprivation. Despite this, we were able collaboratively to run 2 highly successful Covid Vaccine days for homeless and complex needs patients in a city centre sports venue, reaching over 300 patients who as well as vaccination were screened for BBV, offered general health interventions - and we even had “street vets” providing care to accompanying dogs!

Research

Several of our Deep End GPs also work for the University and drive a number of research projects that involve Deep End practice, including the “digital by default” project looking at digital inequity, “Destress” examining the social determinants of mental distress and “Engager” supporting prisoners with common mental health problems to achieve their goals.

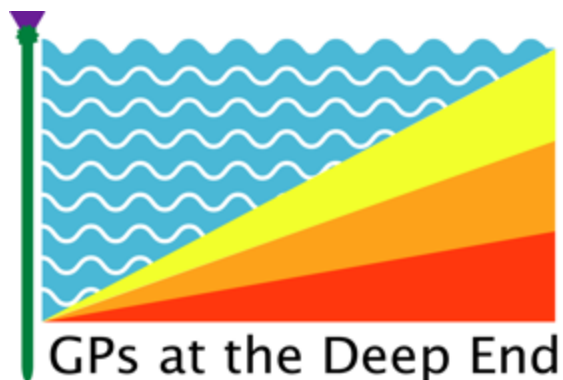
It has been an amazing first 2 years for Plymouth Deep End with huge challenges, but many highlights. We are very glad to be part of International Deep End and able to share with colleagues trying to make a difference around the world.

Richard Ayres

*Coming together is a beginning
Keeping together is progress
Working together is a success*

Henry Ford

REPORT FROM THE SCOTTISH DEEP END PROJECT



Reflecting on this last year, it has been a busy and intense time for the Scottish Deep End project – but a productive one. We have met on three occasions as a Steering Group, which always gives us the grounding and context for our wider work, advocating on behalf of the communities we serve, and influencing policy based on our frontline experience and the continually emerging evidence base from the Deep End projects and the research that many of our members are involved in.

There have been two virtual roundtable events and subsequent Deep End reports this year: the first on [inclusive Covid 19 vaccination](#) and the second on [climate change and health inequalities](#). We hosted a successful [online conference](#) marking 50 years of the Inverse Care Law, with the creation of a report that captures the key themes and recommendations for next steps. Many of our members have been involved in media work, especially around drug-related deaths, workload and workforce capacity, the value of face to face consulting, inclusive vaccination, and digital poverty.

There have been many opportunities for education and engagement which we have been keen to grasp whenever possible, through involvement in webinars, podcasts, panel discussions, conferences. We had a constructive introductory meeting with our new Scottish Cabinet Secretary for Health and Sport in October, when we shared the learning from the Deep End and made some specific requests to address the funding gap to address unmet need, support fellowship opportunities, and deliver public messaging in support of general practice.

We recognise the importance of collaborative working with our key stakeholders in finding the ‘common ground’ for making change to address persisting health inequalities. This has included working alongside the BMA in the development of their new toolkit for clinicians in addressing health inequalities, launched at their conference in October, when Carey was also a keynote speaker. In recognition of the frontline expertise that we can bring, we have been represented on a number of the national policy groups in Scotland: the Drug Deaths Taskforce, the Inclusive Vaccination Steering Group, and the Deputy First Minister Covid Recovery group. The intention is always to offer a voice on

behalf of our patients, and to articulate how services could be delivered more equitably, safely and collaboratively.

There have been varying levels of success in the wider rollout of Deep End projects. We welcomed the commitment to [150 welfare advisors across GP practices](#) in Scotland and 250 Community Link Workers, targeted first to the most deprived areas. Many barriers have had to be overcome along the way, and this is a testimony to sustained lobbying over many years. There is a commitment to further develop and pilot the key elements of the [Govan SHIP](#) and [Pioneer scheme](#) into a new 'Fairhealth Fellowship', with an emphasis on multidisciplinary working. This is one of the proposed recommendations to come out of the Scottish Government Short Life Working Group on Health Inequalities in Primary care, of which we have been active participants, and which crucially also includes a commitment to a new enhanced service for Inclusion Health. This would secure additional funding to enable general practice teams to address the unmet needs of their patients, whose health is adversely impacted by their socio-economic circumstances. These are challenging but exciting times to be involved in this work, and we look forward to building on it further as we move into a New Year.

Carey Lunan

REPORT FROM YORKSHIRE AND HUMBER DEEP END



The Yorkshire and Humber Deep End movement has increasingly become more of a network of related activities across the region. With at least three centres – Hull, Leeds and Sheffield – and a large geography this was expected, even before Covid-19. Deep End activities thereby develop organically amongst a growing number of likeminded individuals.

The following report is therefore only the activities I am aware of currently – there are efforts to bring all these activities together in some way through a revamped website (see below). We need some help from our Deep End colleagues in other areas in relation to one major project. Caroline and Kate’s report is a highlight.

1. **Patient involvement in research from Deep End communities.** Caroline Mitchell and Kate Fryer have produced this amazing piece of work describing the importance of inclusive research that hears the voice of patients from a wide variety of backgrounds
2. **Undergraduate Student involvement in the Deep End.** Sheffield Medical School is restarting its Deep End Student Placement. We plan for about 30 students to spend an additional 6 weeks with third sector organisations linked with Deep End General Practices across South Yorkshire each year. The students will work on projects that support the organisations work and the organisations will get funding for hosting the students just as practices do.

Here is a short video with some great stories from previous students. https://digitalmedia.sheffield.ac.uk/media/Phase+3a+Deep+End+SSC+2022/1_zb9oiuei

Sheffield medical students ‘Inequality Matters’ movement has aligned with Student Fairhealth bringing students from Leeds, Hull and Sheffield together. Gemma Ashwell has led this with help from some GP leadership fellows under the Fairhealth banner.

3. An ambitious project. The Academic Unit of Primary Medical Care and School of Health Related Research are collaborating on this project with three programmes. Thanks to Dom Patterson and the Yorkshire and Humber School of Primary Care for funding this.
 - a. An integrative review of relevant international literature on interventions that have been delivered through primary care services for populations less than about 50,000 – either through single or collections of practices working together and including education and training. Data extraction from about 160 papers that describe some evaluation of these interventions is about 60% through. This review looks at theories underpinning how interventions were designed and evaluations of how they worked in practice. Grey literature is included. This is registered on PROSPERO here :

https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=262149 (See Also Catch-up articles 3 (Page 32) and 4 (Page 39) – Ed)

- b. This review is informing a Delphi Project to understand what interventions front line Deep End practitioners considered useful, feasible and valuable. The idea is to connect the evidence with the service in a way that we haven't seen done before in this way. There are additional 'barriers and facilitator' type papers from the review that will inform analysis of the responses.
- c. An inclusive practitioner and patient involvement programme utilising the Deep End research network and Patient Participation groups we have nurtured in Sheffield – thanks to Liz Walton and Caroline Mitchell along with Tom Lawy and Kate Fryer for this.

We will be looking for up to 50 participants in the next few weeks along with 6 experts in Deep End practice to help with the analysis.

- 4. Linked to the above is the **re-development of our Deep End Y&H website**, which will serve to host the Delphi but also capture activity across the region. The aim is for this to function as a portal to activities across the region rather than house information itself. Calls will go out every three months for links to new projects to go on the website
- 5. **Workforce** leads in health inequalities and race equity. The South Yorkshire and Bassetlaw Primary Care Workforce hub programme now includes secondments to work with practitioners from all professions across the region to develop educate and discussions around health inequities and how to address them. Interviews for this role are taking place in the next weeks. A Race Equity Lead has just been appointed to work across the primary care landscape in the Integrated Care System to highlight racial injustices and support practitioners.

Ben Jackson

EVIDENCE CATCH UP 3

<https://www.bma.org.uk/what-we-do/population-health/addressing-social-determinants-that-influence-health/reducing-health-inequalities-in-your-local-area-a-toolkit-for-clinicians>

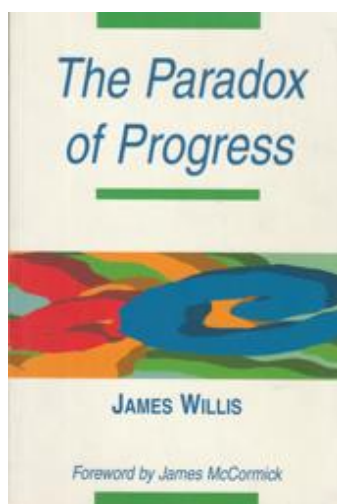
Reducing health inequalities in your local area: a toolkit for clinicians

This toolkit is intended to support clinicians working across the UK.



This recent report from the BMA, under Sir Harry Burns' Presidency, reviews practical steps that can be taken to address health inequalities, including some Deep End Projects

THE PARADOX OF PROGRESS



James Willis's *The Paradox of Progress*, first published in 1995, is a classic reflection on generalist clinical practice and the ways that practitioners and patients think and behave, based on the author's experience of a lifetime in practice.

Its 132 pages divided into 13 chapters are easily read, as described in James McCormick's Foreword, shown below.

Just occasionally in medicine, as in life, you encounter original ideas whose truth you recognize instinctively despite the fact that they run counter to accepted wisdom. And when these ideas are expressed with such lucidity and illustrated with examples drawn from experience that you share, their force becomes overwhelming. General practice is the most vibrant and exciting branch of British medicine but radical and relentless change has resulted in a profound crisis of professional morale. This book rekindles the spirit that some have lost and explores the problem of retaining respect for human values in an increasingly systematized world.

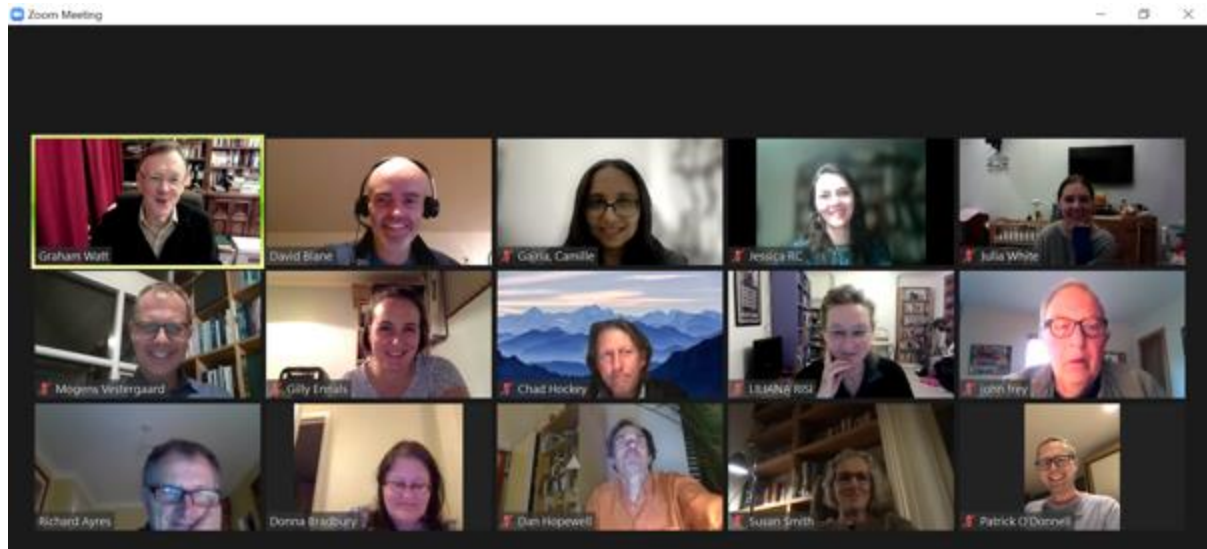
'James Willis has written a book that is both delightful and important. It is delightful because it is full of the very stuff of general practice, not the technical problems of diagnosis and therapy, but the human problems of people in distress. It also provides a moving portrait of a man who loves his work. This is because he satisfies one of the few important criteria of being a general practitioner, "he likes the human race and likes its silly face" . . . This is, in many respects, a serious book, but the touch is so light and so often illuminated by wit, that reading it is a joy and the journey is fun. I would wish it the wide readership it deserves.'

*From the Foreword by Professor James McCormick,
Department of Community Health and General Practice, University of Dublin*

The Paradox of Progress is available on-line at www.friendsinlowplaces.co.uk

NOTE FROM 3rd DEEP END INTERNATIONAL ZOOM MEETING

The meeting on Thursday 30th September 2021 involved 15 Deep End colleagues from Scotland (Graham Watt, David Blane), London (Chad Hockey, Lili Risi, Camille Garjia, Dan Hopewell), Plymouth (Richard Ayres), East of England (Jessica Randall-Carrick, Gilly Ennals), North East and North Cumbria (Donna Bradbury), Nottinghamshire (Julia White), Denmark (Mogens Vestergaard), Ireland (Susan Smith, Patrick O'Donnell) and the United States (John Frey).



Jessica, Gilly, Donna and Mogens were welcomed to their first Deep End international meeting. Apologies had been received from Carey Lunan, Catriona Morton, Andrea Williamson, Stewart Mercer, Liz Walton, Joo-Inn Chew and Liz Sturgiss (both understandably asleep in Australia).

News

Richard Ayres reported the allocation by the local CCG of GP Fellows to six Deep End practices in Plymouth.

Susan Smith is in the process of moving from RCSI to the Chair at Trinity College Dublin, previously occupied by James McCormick (Page 33) and Tom O'Dowd.

Jessica Randall-Carrick and Gilly Ennals managed to attract over 100 viewers for the inaugural meeting of the East of England Deep End Project. (Page 12)

Mogens Vestergaard is seeking resources and colleagues with which to launch a Deep End group in Denmark. (Page 11)

Lili Risi reported Deep End developments involving social movement principles in East London, involving 13 local boroughs: <https://www.rcgp.org.uk/rcgp-near-you/faculties/london-and-south-england-region/north-east-london-faculty.aspx>

Horizons A, B and C

These provide an organising principle for much of the discussion. Horizon A is where we are, with existing arrangements, constraints and opportunities. Horizon C is where we want to go, requiring imagination and vision. Horizon B is the process of getting from A to C. [Three Horizons | International Futures Forum](#)

Horizon A has been well documented and researched and is the common experience of Deep End colleagues. Recognising this common experience has been a powerful engagement and bonding factor in establishing Deep End Projects (See also Edel McGinnity on Page 1 and Dawn Innes on Page 3).

Horizon B

Deep End Projects are at various stages of development including some just starting. There is no best way, with each project responding to its own circumstances and opportunities.

A key issue is engagement with frontline practitioners. Money to pay locum fees had helped for the first Scottish meeting but the East of England start attracted a similar number via zoom for a lunchtime meeting.

If practitioners think a meeting is important and relevant to them, they will come.

Julian Tudor Hart had expressed the importance of being respectful to colleagues, especially concerning the circumstances in which they worked. Engaging with “hard to reach” colleagues can involve the same opportunism and patience used to reach “hard to reach” patients. Relationships can be slow to build.

Some resource is needed for the hub functions of coordination, continuity and advocacy. Academics are often involved but in addition to their usual University tasks, looking outwards to engage, support and learn from practitioners. A valuable contribution in writing up group meetings is to provide a coherent account of what has often been a disparate discussion, adding value but not invention.

Having started with engagement, some form of vehicle is needed to keep interest and activity alive. Chad described serial educational activities which had been very successful in NW London, but it was tiresome continually having to generate new funding.

The Scottish project had used its network of willing practices to respond to funding opportunities for projects leading to worked and evaluated examples of longer consultations, link workers, integrated care, pioneer fellows and embedded financial advisors.

GP Fellowship schemes have cascaded with shared experience driving expansion in many areas, including the most recent example of Plymouth.

As part of the advocacy function, several colleagues described their engagement with current and changing organisational structures in NHS England with their new responsibilities for addressing health inequalities.

It is welcome and helpful that the “Deep End” has entered the vocabulary and now has a place in strategic thinking, although what is meant by the “Deep End” can be a place, a group of practitioners or a direction of travel.

Focusing on practices based on available deprivation data is helpful for group identity but misses the many Deep End patients in socially-mixed practice populations.

Julia reported how engagement with practice managers had proved more productive than engagement with local GPs in Nottinghamshire.

Lili highlighted the particular challenge of working with very big practices in England.

John Frey asked if all Deep End practices and/or networks have learners, such as students and trainees, as part of their structure. Are they participating in the group discussions with GPs teaching the next generation how important it is for GPs and practices to spend time helping each other? As Govan SHIP had shown this can be a great investment in future partners.

David Blane described how teaching undergraduate medical students in Glasgow had led to students choosing Deep End general practice as their career destination. Gilly Ennals described how her experience as a GP trainee of the Yorkshire/Humber Deep End had spurred her to work with Jessica on establishing a Deep End project in the East of England.

Horizon C

Dan Hopewell, Chad Hockey and Lili Risi all expressed clear visions of a future based on health creation rather than disease management.

A first step for practitioners can be to walk around their surrounding area and community, for example with students identifying factors for and against health creation. Meetings with colleagues from other sectors such as schools and food banks can kickstart productive relationships. Every community is different and unknowable from elsewhere.

Dan Hopewell from Bromley-by-Bow commented that under a bio-medical model of health there will never be enough resources, while under a social model of health the resources are in abundance.

Chad Hockey observed that activating people to become change agents is key. Local populations include huge resources of imagination and energy.

Health creation involves far more than general practice but general practice has a part to play.

Conclusion

There is never a conclusion to Deep End activity, which is an ongoing process and journey. Deep End International Bulletin No 6 is planned for distribution in December.

NOTE

The five previous Bulletins are accessible on the Scottish Deep End website.

DEEP END INTERNATIONAL BULLETIN NOS 1-5

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

www.gla.ac.uk/deepend

POST-ZOOM CORRESPONDENCE

From Dan Hopewell to Graham Watt

Some reflections on the current situation of our Deep End communities leads me to feel that renewed urgency, energy and broader thinking is required to our Deep End endeavour in order to meet the needs of our communities.

Considering the figures released by PHE a couple of weeks ago, the life expectancy of Deep End citizens fell by two whole years last year, compared to only a one year fall in the life expectancy of the most affluent folk at the other end of town. The life expectancy gap between rich and poor therefore opened up a whole year to 10.3 years, and as we know the poor live their last 20 years in significant ill health, whilst their wealthy neighbours not only live ten years longer, but also only live their last ten years in significant ill health. It is predicted that next year will see a further widening of health inequalities because of the ongoing disproportionate effects of Covid on the poor, and the disproportionate effect of the treatment backlog on the poor.

In England Primary Care Networks have been established with certain remits, such as
a) reducing the health inequalities of their registered patient population, and
b) managing the health (as opposed to the illness) of that population.

However, it seems to me that current plans for primary care and primary care networks are highly unlikely to achieve these aims as they continue to focus on the treatment of illness, rather than the creation of health and wellbeing.

I think it would be interesting for the Deep End practices to consider what practical steps they might take themselves and with local stakeholders, to achieve these. Attached is a piece from the Health Creation Alliance that speaks to the health creation agenda. (Page 40)

From Graham Watt to Dan Hopewell

I'm reminded of two points involving Julian Tudor Hart.

First, his own ideas and practice were so far ahead of everyone else that they were daunting and perhaps discouraged as much as encouraged.

Second, in arguing for "accountability downwards" to patients and communities, he was challenging practitioners to change their allegiance from the established order to patients and communities, based on that's where their most important interests lay. But that's a huge change and one reason why the Deep End projects have tended to be cautious politically, focusing on how outcomes can be improved for patients and, through that,

working our way towards the bigger issues. No point in rushing ahead if you lose people on the way.

From Dan Hopewell to Graham Watt

Both very good points, well made, and of course the current system, from the training of clinicians (who are not taught about the social determinants of health), to the clinical targets and funding arrangements, and, arguably the whole model of General Practice as private profit-making businesses with an inherent conflict of interest, all reinforce the status quo, acting as barriers to change.

From Susan Smith to Dan Hopewell

I really appreciate your perspective and thoughts. You are reminding me of the balance between how we support individuals, often the main focus of general practice, but also our responsibility at a population level for our communities. Deep End in Ireland has probably tried to emphasise more the role of general practice for individuals and communities as we feel people listen to us more on that though we do of course try and avoid any sense of individual blame and keep a focus on social determinants of health and well-being. There is a whole broader multidisciplinary health inequalities community that overlaps a lot with our work and may be more important. I am a strong believer in incrementalism but realise that can slip into stagnation if morale and hope drop. I like your focus on well-being as well. Graham reminded me earlier this year in one of his articles of one of JTH's great quotes:

"the most satisfying and exciting things had been the events that had not happened: no strokes, no heart attacks, no complications of diabetes."

A lot of our work in general practice is in the secondary prevention space but we mustn't lose focus on evidence-based primary prevention.

RESEARCH CATCH UP 4 – sent in by Deep End GP Gary Bloch in Toronto



<https://www.cmaj.ca/content/cmaj/193/44/E1696.full.pdf>

Implementing social interventions in primary care

Gary Bloch and Linda Rozmovits

CMAJ November 08, 2021 193 (44) E1696-E1701; DOI: <https://doi.org/10.1503/cmaj.210229>

Building Back Together

Valuing community and embedding Health Creation across the health and care system to address health inequalities

These key messages are relevant to everyone who has a role in health, care and wellbeing

1 HELP PEOPLE GAIN CONTROL

Efforts to address health inequalities must focus on enabling local people to gain a sense of purpose, hope, mastery and control over their own lives and immediate environment.

2 PRIORITISE HEALTH CREATION

ICs must prioritise Health Creation alongside treating illness and preventing ill-health in partnership with local authorities, communities and other local partners. It is core to an effective, sustainable health and care service that makes real progress in addressing health inequalities.

3 BUILD TRUST WITH COMMUNITY NETWORKS

All parts of the NHS and local authorities must seize the opportunity during and following COVID-19 to develop relationships of trust with enhanced community networks that understand their communities and are reaching more vulnerable people than before the pandemic.

4 SUPPORT COMMUNITY-LED ACTIVITY

All parts of the NHS and local authorities need to get behind and support communities to lead activity in their localities and to work with communities to integrate formal and informal forms of care.

5 FUND COMMUNITIES TO CREATE HEALTH

ICs should make resources available to fund health creating community-led work alongside local authorities, housing providers, VCSE and other local partners without trying to control how the outcomes are achieved.

6 VALUE AND BUILD RELATIONSHIPS

Relationship-building with communities and local partners needs to be valued as an essential role by the NHS. Paid 'connector' roles operating at a strategic level are required to drive genuine connections between the NHS, community groups and organisations

7 INCLUDE COMMUNITIES WITHIN GOVERNANCE

ICs, NHS Trusts and PCNs must include communities and local partners within their governance arrangements.

8 SUPPORT COMMUNITY DEVELOPMENT

ICs, including local authorities and other local partners, must assess the existing provision of community development and support further capacity where necessary.

9 DEVELOP NEW RECOVERY PATHWAYS

ICs must support the development of 'place-based multi-disciplinary teams' that can address the wider determinants of people's health needs as well as their clinical needs and that embed the five features of health creating practices within their working practices.

10 SHARE ANONYMISED DATA

All relevant parts of the NHS must embrace Health Creation alongside the current trend to Population Health Management. This means sharing anonymised data with communities, local authorities and other local partners, inviting them to help interpret it and participate in design and delivery of new services that respond to it.

ICs that consistently drive forward action on these 10 key messages will make real and sustained progress in addressing health inequalities across their footprints. Read the full reports at: thehealthcreationalliance.org



POSTSCRIPT AND FORWARD LOOK

Readers who have made their way through this Bulletin cannot fail to be impressed by the volume, range and spread of activity. For most the starting point has been the daily experience of working in the Deep End and the possibility of sharing that experience with others.

Five of the nine Deep End Reports in this Bulletin provide updates on GP Fellowship Schemes under the heading of “Workforce”, one of four such headings describing activity within Deep End Projects.

WORKFORCE EDUCATION ADVOCACY RESEARCH

In this way the Deep End Projects have moved on from not only being a support network (Page 1) but also a vehicle for change. Looking ahead, a question is whether and to what extent can this range of Deep End activity be captured in an over-riding vision of where colleagues want to go and how they plan to get there, linking these mainly central activities with the experience of practitioners on the ground.

In one sense it is clear. Practitioners want to improve the health of the patients they see in front of them and are frustrated by the gap between what they are able to do and what they could do with more time and more support, including better links with other services and local communities. By closing the gap not only for some patients but for all patients, especially those with the greatest needs, population health can be improved and inequalities in health narrowed. What could be simpler?

A possible breakdown of activities indicates the different levels at which action is possible, either individually or collectively :-

- with patients within consultations
- within the core practice team
- within the wider primary care team
- making contacts with other services in community and hospital services
- within the local community
- within established institutions
- within professional organisations
- within the local Deep End network, as a participant or coordinator
- advocacy in the public domain

The list is daunting, especially in these hard-pressed times, but should not discourage. Everything does not need to be done at once and everyone doesn't have to do everything.

*It is the greatest of all mistakes to do nothing because you can only do a little.
Do what you can*

Sydney Smith

A PERSONAL VIEW

The following text come from a talk on *Learning from the Scottish Deep End Project* given by Professor Graham Watt at a session on "Social Inequality and Health" at the annual meeting of the College of the Norwegian Medical Association, coordinated virtually from Oslo on 20 April 2021. Full text and slides available at:- https://www.gla.ac.uk/media/Media_789570_smxx.pdf

The primary motivation of most Deep End general practitioners is not to address the abstraction of inequalities in health, but rather, to improve patient care, closing the gap between what they are able to do and what they could do with more time and resource. This is partly about evidence, but it is also about values.

I shadowed a GP in Scotland's most deprived general practice, observing her day from 7 in the morning to 7 in the evening, and wrote it up in the BJGP. I saw multimorbidity in large measure (not the simple counting of conditions but rather, the number, severity, complexity and continuing nature of health and social problems in families and households) - a succession of complicated stories. I saw the importance of prior knowledge, allowing consultations to start at a higher level and without which much less could be achieved in a short consultation. I saw the importance of empathy and the trust patients placed in a doctor who knew them well and cared what happened to them. I saw no worried well patients but I saw a "worried doctor", using her better knowledge to anticipate and try to prevent complications. She was ambitious for what might be achieved, not immediately but over time. Every patient mattered.

In *Tales of the 1001 Nights*, Sheherazade had to invent a new story every day. Her life depended on it. That's also the task of primary care, helping to create strong patient stories. Every practice is a compendium of such stories, but are they long stories, or short stories, fairy stories, horror stories? Who knows?

An important part of story building is boosting patients' knowledge, confidence and agency. Without which, self-help and self-management are destinations not starting points. It's a shared journey, at an appropriate pace, in Julian Tudor Hart's words, "*initially face to face, shifting slowly to side by side*".

Not every patient needs this but in Scotland, and I expect here too, the 10% of patients with 4 or more conditions, who account for a third of unplanned admissions to hospital and a half of potentially preventable unplanned admissions, certainly do.

Patients with multimorbidity are all different (there is no simple case definition), but their needs are the same – unconditional, personalised continuity of care from a small team of providers whom they know and trust. Relationships are the silver bullets of general practice and primary care. But not just relationships with patients.

The intrinsic strengths of general practice are first contact, continuity, population coverage, coordination, flexibility, long term relationships and trust. These features are not exclusive to general practice but very few public services have them in such large degree. They make general practice the natural hub of local health systems. But hubs go nowhere unless connected via spokes to other services and community resources, each spoke a relationship that needs to be built up and looked after.

It follows that realising the exceptional potential of general practice requires competence not only in clinical consultations but also in two practice-based building programmes, based neither on bricks and mortar nor fancy architecture, but on relationships: the first, building a compendium of patient narratives; the second building strong local health systems based on general practice hubs.

The independence of individual general practices is an asset, providing huge scope for local initiative and enterprise, but conversely it is also a prescription for variation, inefficiency, inequity and a weak collective voice. The equitable potential of general practice depends, therefore, on three types of accountability: upwards to funders, providing quality and value for money; downwards to patients and local communities, addressing their needs; and third, sideways to other practices, ironing out inefficiencies and inequity.

So, a third building programme is needed, based on the collegiality and solidarity of practices, and requiring a variety of connecting infrastructure.

- resources commensurate with need;
- information systems to measure omission and monitor progress (e.g. the balance between routine and emergency care, the quality of patient experience, the amount of social capital in local systems);
- educational opportunities to share experience and learning;
- research and evaluation to establish what works;
- career opportunities to attract and retain committed practitioners.

The building programmes I have described are needed everywhere, pro rata based on need, but if the NHS is not at its best where it is needed most, inequalities in health will widen. There are four cogent reasons for beginning at the bottom of the slope.

First, by improving outcomes for individual patients and delivering such care for all patients, population health can be improved and inequalities in health narrowed. Addressing health inequalities is a consequence of such care rather than its starting point.

Second, for health service managers, stronger care in the community can prevent, postpone or lessen crises requiring emergency A&E attendance or hospital admission. Patients can pass through the gateway to emergency services at any time, but when they have access to a primary care team they know and trust, when they are confident in their care arrangements, when the complications of their conditions have been prevented, they choose not to. The beauty of this type of gatekeeping is that there is no gate.

Third, for an increasing group of Deep End practitioners, from newcomers to old hands, this is what they aspire to do, it is the direction they want their careers to take and it is the collegiate culture they want to be part of. Here is the Scottish Deep End steering group, meeting recently, lots of young GPs, mostly women. They are the future.



But finally, and perhaps most important, it is what publicly-funded doctors can contribute to the healing of society.

The late John Berger wrote a seminal book about general practice called *The Fortunate Man* but, reviewing the work of the artist Frida Kahlo, he also wrote,

In the dark age in which we are living and the new world order the sharing of pain is one of the essential preconditions for a re-finding of dignity and hope. Much pain is unshareable. But the will to share pain is shareable. And from that inevitably inadequate sharing comes a resistance.

Health care can be part of that resistance. The common purpose of the Deep End Projects is that

*“By excluding exclusions,
keeping everyone on board,
and building three types of relationship,
inclusive health care can be a civilizing force
in this increasingly dangerous, fragmented and uncertain world”*

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**Don't judge each day by the harvest you reap
but by the seeds that you plant.**

**It is better to travel hopefully than to arrive
and the true success is to labour.**

Robert Louis Stevenson