

The Review

The Keppoch Medical Practice:

reporting from the Deep End

According to those who have worked elsewhere, the only difference in our Deep End practice compared with other practices is that there are 'very few easy cases'. For a GP in problem-solving mode it can be galling to find so few solutions — the chest problem cannot be cured immediately because giving up smoking, in a life fraught with anxiety and debt, can only be achieved in the long term. To allow this to happen, the practice has needed more resources than are required in a 'normal' practice. Otherwise we would have been repeating the mistakes of the past in depriving the deprived of any hope of change. A major resource need concerns communication.

The only real way to ensure that doctor and patient are on the same wavelength is for face-to-face meetings to pick up the non-verbal signals. Unread leaflets are regularly found discarded on the ramp from the surgery. Of course there is no point in using doctor time when all that is needed is to communicate that there are others with the necessary skills in the community. The main difficulty, however, lies in gaining the patients' confidence that such a transfer of care to a stranger is not a threat. That needs longer consultations to talk through the issues. GPs also need to know of nearby community resources. Our strategy for making the best use of these often transitory resources is to make time for doctors and nurses to meet the project workers.

Only by having weekly practice meetings with all the GPs, health visitors, district and practice nurses, with the monthly addition of a social worker, an addiction worker, and a school nurse, can everyone appreciate the people and families at risk of failing to receive medical and social care, the signs to look for, and the resources available to help. We are all too aware of the need to prevent the tragedies of Peter Connelly, Brandon Muir, and Victoria Climbié happening in our practice.

Sometimes the only way to monitor a child is when a granny attends for her own illness. If you do not notice the child in the surgery or waiting room you may miss a rare opportunity to observe and share with others in the practice team. Likewise, if the woman with the chest problem also suffers from obesity, diabetes, and ischaemic heart disease at the age of 39, a 10-minute GP consultation often becomes 20 minutes to

start to address some of her problems. Such opportunistic activity plays havoc with the appointment system which has needed to have an expensive degree of flexibility built-in.

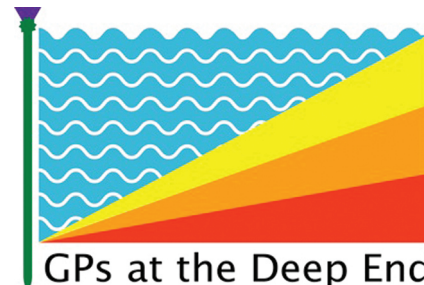
The next step in dealing with the woman with her list of problems is to constantly remind her to engage with practice nurses and hospitals. For example, receptionists, staff on the prescription desk and managers, as well as GPs and practice nurses, need to have a coordinated recall system for titration and monitoring of medication.

GP support is important for practice nurses and GP trainees. The ischaemic heart disease review becomes complex if uncontrolled epilepsy and lack of contraception are picked up. Our GP trainees are often overwhelmed by the agenda of our patients, including social, addiction and bereavement issues in addition to their medical problems, and by their lack of background knowledge concerning individual patients.

In a pilot study, which provided increased time for consulting with complex patients in our practice, extra time was associated not only with increased reported enablement by patients with complex problems, but also reduced practitioner stress and increased reported enablement by other patients receiving usual consultations.¹ This promising initiative deserves wider and longer-term application.

At present, we are a PMS/Section 17c practice, (one that has a locally negotiated agreement, enabling, for example, flexible provision of services in accordance with specific local circumstances), which enables us to deliver the standard of service we regard as necessary, but in times of austerity we increasingly experience funding cuts, impeding the quality of service we are able to provide.

General practice in an area of high deprivation requires continuity of care, supported teamwork, networking with community resources, and an intimate knowledge of family backgrounds. The Deep End project has helped us to reflect on our work, to learn from models of good care provided by other teams and to strengthen our identity as GPs working in a deprived area. Peer support and developing solutions from grassroots experience are motivating factors.



We welcome the Scottish government's aim of reducing inequalities in health via concerted action across government.² We believe a comprehensive approach, including education, housing, employment opportunities, health, and a concentration on early years and parenting, is paramount in achieving better outcomes for our patients. In our opinion, GPs have a unique role in the communities where they work.

We think GPs have the skills to answer the challenge of providing holistic patient care for a deprived population and of tying together a fragmented care system. Eighty-eight per cent of our patients belong to the most deprived 15% of Scotland's population. For a practice with 'so few easy cases', adequate resources are needed not only to deliver high quality coordinated care, but also to prevent demoralisation and burnout.

Petra Sambale and Bob Mandeville,

On behalf of the Keppoch Medical Practice, Possilpark Health Centre, Glasgow, whose practice population is consistently the most deprived in Scotland. Petra Sambale is a member of the Deep End Steering Group. This is the 7th in a series of articles from General Practitioners at the Deep End.

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ADDRESS FOR CORRESPONDENCE

Petra Sambale/Bob Mandeville, Keppoch Medical Practice, Possilpark Health Centre, 85 Denmark Street, Glasgow, G22 5EG.

E-mail: psambale@btinternet.com

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