Scottish School of Primary Care

GP Clusters

Briefing Paper 21

Learning from General Practitioners at the Deep End

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Collaborative Quality Improvement in General Practice Clusters

This paper is number twenty-one in a series that relates to areas of quality and safety on which general practice clusters could usefully focus improvement activity. Each paper summarises research, guidelines and other evidence about areas of care which can be improved, and improvement methods and interventions.

Summary

Since 2009 the Deep End project has comprised the activities of General Practitioners serving the most 100 socio-economically deprived practice populations in Scotland (termed the 'Deep End'). Starting by engaging with Deep End GPs and reporting their experience and views, the project has developed a comprehensive view of how health can be improved and inequalities in health narrowed in deprived communities.

This briefing paper will draw upon research evidence and experience from a range of Deep End initiatives to demonstrate the potential wider benefits (to practices not in the Deep End but how nonetheless serve varying numbers of very deprived patients) of key elements of these initiatives, including: GP protected time; extended consultations for selected patients; multidisciplinary team meetings; the embedding within practices of attached workers; and improved links with other services.

Background

At the first Deep End conference in 2009, general practitioners serving Scotland's most deprived communities were convened and consulted for the very first time (1). More than ten years later, this group has identity, voice, a manifesto, shared activities, camaraderie and impact (2). Deep End Projects have also been started in Ireland, Yorkshire/Humber and Greater Manchester (3).

The 100 Deep End practices have patient lists in which from 45 to 90% of patients live in Scotland's 15% most deprived data zones, where premature mortality and multimorbidity are more than twice as prevalent as in the least deprived areas (4). They deal with 'blanket deprivation'. Most general practices however have some such patients (the majority of the most deprived patients in Scotland are served by non– Deep End practices). They deal with varying levels of 'pocket deprivation'. Solutions in areas of blanket deprivation also need to be applied pro rata in areas of pocket and hidden deprivation if progress is to be made for 'Deep End patients'.

Research shows that consultations in deprived areas are typically shorter, despite a higher and earlier prevalence of complex multimorbidity (5). Patient expectations and patient enablement are lower, with the lowest patient enablement occurring in patients in deprived areas with mental health as a co-morbidity, which is the commonest co-morbidity in deprived areas. GPs report more stress, especially after longer consultations.

Inverse care law

Patients with multimorbidity in affluent areas get 25% more time in consultations, while similar patients in deprived areas get no extra time (6). These findings illustrate the inverse care law, which states that the availability of good medical care tends to vary inversely with the need for it in the population served (7).

The inverse care law, as originally described, is partly about the effect of market forces, but it also operates within the NHS (8), where it is not the difference between good medical care in affluent areas and bad care in poor areas; it is the difference between what practitioners in deprived areas can do and could do if they were better resourced and better organised. The challenge in addressing inequalities in health is to increase the volume, consistency and range of service to patients, whatever problem or combination of problems they present. If this is not done, complications will continue to occur earlier than they should with patients presenting in crisis via out of hours services, at A&E or in a hospital bed.

Consultation rates in general practice are 20-25% higher in the most deprived areas compared with the most affluent areas, but with no extra resource this is only achieved by having shorter consultation times or working a longer day (4). The revised resource allocation formula for the new Scottish GP contract includes a weighting for deprivation, but this is dwarfed by the weighting given to advanced age. The net effect of the new contract has been to increase GP funding by 4% across the board, leaving the inverse care law intact.

In addressing the needs and demands of patients who have acquired longevity, little is left to address differences in life expectancy, and especially healthy life expectancy, between social groups. In contrast to the "worried well", the "unworried unwell" have earlier and more complex multimorbidity, but less knowledge, confidence and agency to cope. Very few official reports and policies on the social determinants of health, inequalities in health, health improvement, quality improvement or realistic medicine acknowledge or address this practical challenge.

Deep End projects

The first step of the Deep End Project was to engage with front line practitioners (made possible at the outset by the availability of Royal College of General Practitioners (RCGP) and Scottish Government Health Department (SGHD) funding to pay locum fees) and to listen to their experience and views. The challenge was to capture what was said concisely and coherently, in language free of jargon which was meaningful to participants and to others who weren't there. There are now over 30 such reports on the Deep End website (9).

This led to a six point Deep End Manifesto for improving health and narrowing the differences in health between deprived and affluent areas (10).

1. extra time for consultations, to address the inverse care law;
2. better use of serial encounters, building knowledge, confidence and agency
3. strengthening the natural hub function of general practice at the heart of local health systems;
4. better connections across the front line, sharing experience, views and plans;
5. better support from the centre;
6. improved leadership at all levels, including GP leadership on the ground.

The groundwork of engaging with practitioners, developing a shared view and keeping in touch made it possible to respond quickly to funding opportunities, mostly from Scottish Government, for projects putting parts of the Deep End manifesto into effect.

- **Link Workers**, comprising a series of projects involving social prescribing, community engagement and the development of a community links practitioner role (11).
- **Govan SHIP** (Social and Health Integration Partnership), focusing on the strengthening of integrated care (12).
- **The Pioneer Scheme**, as part of the Scottish Government's GP recruitment and retention scheme (13).
- **Financial Advisor project**, to increase the uptake of welfare benefits (14).

Implementation in real life NHS practice in Scotland

These projects are discussed below in terms of their contribution to addressing the Deep End Manifesto.

Extra time for consultations

The Govan SHIP Project and GP Pioneer Scheme both provided participating practices with additional clinical capacity via the attachment of long-term locums and GP fellows, respectively. The increases were modest, amounting to about a 10% increase, which was much less than needed to address the inverse care law but nevertheless sufficient to have a powerful effect in releasing the energy and increasing the morale of GPs.

In both cases the additional clinical capacity was used to support experienced GPs in the practices by giving them one protected session per week. It was left to individual practitioners how to use this time. Almost all GPs used their protected time initially for extended consultations with selected patients, re-assessing their situations and needs and re-coordinating their care, mostly via existing local arrangements. Although some patients were selected as easily identified "high users", most selected patients were chosen based on practitioner knowledge and perceptions of poorly coordinated care.

A parallel research study, CARE Plus, evaluating the use of extended consultations for selected patients in 8 Deep End practices, has provided evidence of the cost-effectiveness of this approach, within NICE guidelines levels for cost-effective interventions (15).

Better use of serial encounters

The silver bullet in general practice is unconditional, personalised continuity of care.

Current emphases on self-help, self-management and realistic medicine have tended to ignore the additional challenges when patients lack knowledge and expectations are low. Such patients often need a "worried doctor" or other health professional to take the initiative at first, transferring knowledge and building confidence, trust and agency over time (16).

All of the Deep End Projects have been short term, lasting 2-3 years. Evaluations, where funded, have covered shorter periods. The Deep End Projects have been limited, therefore, in evaluating their impacts not only on individual patients but also on health system development. Both types of development are based on building relationships.

About 8% of Govan Health Centre's 14,000 patients received a SHIP intervention. Over time, this made a difference to GP workload. An independent analysis has shown how GP contacts overall have started to dip in Govan SHIP practices while in comparator practices serving similar populations in Glasgow, the number of GP contacts is rising (12).

Strengthening the natural hub function of general practice

The traditional strengths of general practice are contact, continuity, coverage, coordination, flexibility, long term relationships and trust. These features are not exclusive to general practice and are not consistent within general practice, but no other part of public service has these features in such large measure.

While essential, these features are insufficient for providing the wide range of types of integrated care which are increasingly required to meet the needs of people with complex multimorbidity. The natural hub function of general practice needs to be complemented, therefore, by a large number of relationships with other services and resources.

In a King's Fund report, the active ingredients of coordinated care were described, including schemes for palliative care at home, mental health services, home care for people with dementia, care for older and frail people, and complex case management to reduce unnecessary hospital admissions (17). The report questioned the need for defined care packages, arguing that protocol driven approaches lack the flexibility that patients with complex needs require. Such schemes are weaker without GP engagement, knowledge and leadership. Bottom-up approaches are needed to develop "the building blocks of effective partnership working", rather than top-down approaches, no matter how well they may have worked elsewhere. Most of the projects took six to seven years to achieve the desired changes.

For example, monthly multidisciplinary team (MDT) meetings were used in the Govan SHIP Project to review complicated and urgent cases of vulnerable children and adults. The range of disciplines attending MDTs increased over time. Although their information systems may not be connected with each other, colleagues could access and share information at the meeting.

The health centre was initially given two attached social workers – an old idea that needed re-invention. The arrangement didn't work well at first. Old attitudes and stereotypes got in the way. All change involving relationships takes time. The initial attached social workers were hidebound by strict protocols and high thresholds. They were replaced, by "social care workers", who were less senior but had more flexibility and the ability to address problems before they become a crisis (18).

Two of the Govan practices were also part of the Link Worker Programme, in which 7 Deep End practices had an embedded "community links practitioner". The Deep End link workers were much more than social prescribers. They can hold one-to-one conversations with complex patients, often serially, not only referring patients to community resources and helping some patients to take the first step, but also helping patients who were floundering in the complicated maze of fragmented services that is our health and social care system.

In these ways, the link workers bolstered the generalist function of general practice: "If it's the patient's problem, it's our problem." The system remains fragmented, but patients are helped through it.

A large independent evaluation (288 and 214 (74.3%) patients in the intervention practices at baseline and follow-up, respectively, and on 612 and 561 (92%) patients in the comparison practices) found no improvements overall in outcomes on an 'intention to treat' analysis (all patients referred to a link worker) but patients who saw the CLP on 3 or more occasions (45% of those referred) had significant improvements in quality of life, depression, anxiety and self-reported exercise levels. There was a high positive correlation between CLP consultation rates and patient uptake of suggested community resources (19).

The same embedded approach transformed the effectiveness of financial advisors in general practice, first in two practices at Parkhead Heath Centre and then in 9 practices in the local cluster. 80% were new referrals. The average increase in annual income for each patient taking up the referral was £7000 (20).

A key condition was that the project should generate no extra work for the practices. A key component was the financial advisor preparing reports, letters and appeals that the GPs could then check and sign. GPs report that this has given them more time to address clinical problems.

A repeated call from general practitioners working in very deprived areas is that patient referrals are more likely to be taken up if the referred service is available quickly and locally in a familiar setting. A key feature of the success of the Link Worker and Financial Advice Projects has been the embedding of link workers and advice workers within host general practices. For example, in its first year, the Parkhead project generated more referrals for financial advice from the two participating practices than the other 42 practices in Glasgow's East End combined.

Better connections across the front line

A feature of all the Deep End projects has been collegiate working between practices. As with building new relationships and behaviours with patients, the development of collegiate working takes time. Each of the projects has had a GP lead with protected time to support shared learning. The lead role requires patience and perseverance.

A collegiate culture based on "levelling up" depends on regular meetings, the sharing of information (face to face and electronically), productive relationships and internal accountability (whereby individuals are accountable to the group and the group supports individuals).

The first 50 meetings of the Deep End steering group took place during evenings after a day's work. Always well attended, these meetings of 15 or so Deep End GPs every 6-8 weeks maintained the crucial elements of GP ownership and direction.

Better support from the centre

A consistent comment from general practitioners at the Deep End has been the low profile in deprived areas, in terms of acknowledging and supporting efforts to address the inverse care law, of national and local NHS organisations concerned with information, health improvement, quality improvement, education and training and research.

The Link Workers Programme, Govan SHIP and the GP Pioneer Scheme have all been funded by SGHD in response to Deep End initiatives. Local NHS has helped to deliver these programmes but has not been the source of either initiatives or funding.

Although NHS Education for Scotland (NES) has a Health Inequalities GP Fellowship Scheme, no such fellow in the last ten years has been based in a Deep End general practice in Glasgow, where 75% of Scottish Deep End general practices are based.

The Deep End GP Pioneer Scheme existed as an unfunded proposal for several years before the SGHD GP recruitment and retention programme provided funding.

Despite a substantial information services establishment, there have been very few analyses based on grouping general practices according to the type of population served. Many of the issues concerning general practice in deprived areas have been hidden from view by the convention of geographical reporting.

Improved leadership at all levels

Transforming a "culture of coping" to a "culture of changing" in general practice, whether consulting with patients, developing services or working with others, is largely dependent on GP initiative and leadership.

Developments in general practice and primary care can be supported by central organisations and managers but mainly depend on local knowledge, initiative, patience, perseverance and flexibility, both within and between general practices.

The Link Worker Programme, Govan SHIP and GP Pioneer Scheme all have GP lead roles with protected time. Within Govan SHIP and the Pioneer Scheme, many of the host GPs used their protected time to take on leadership roles on specific issues on behalf of groups of practices, sharing their experience and learning via regular meetings and website reports.

There has been recognition of the work done by some of these pioneering practices.

The Garscadden Burn practice in Drumchapel, a leading practice in the Link Worker Programme, was awarded RCGP Scotland's prize for Practice Team of the Year in 2016. The David Elder practice at Govan Health Centre, representing all practices taking part in Govan SHIP, was awarded the same prize the following year.

Implications for collaborative quality improvement in GP clusters

In extending Deep End projects to other practices, within and between clusters, the GP lead role will be essential to achieve "levelling up" rather than "levelling down".

An important component of leadership development is addressing the specific educational and training needs of Deep End practice (21), comprising not only clinical issues (multimorbidity, mental health, social complexity, drug and alcohol misuse, violence, vulnerable families) but also underlying issues such as engaging with patients who are hard to engage, dealing with complexity in high volume and applying evidence when so little research evidence is based on Deep End patients and practices.

- **GP clusters could consider providing shared educational sessions for practices within their cluster**

GP recruitment and retention

It is axiomatic that measures to improve GP retention and recruitment will only be successful if GP careers are attractive to current and future general practitioners. Mastery, autonomy and purpose are essential components of professional job satisfaction (22). GPs need not only to be valued for what they are good at (clinical generalists dealing with variety, complexity and uncertainty) but also to be supported in a collegiate culture sharing learning and avoiding isolation and burnout.

The Deep End GP Pioneer Project was part of the SGHD GP Recruitment and Retention Programme but can also be seen as a development in collegiate culture. Building on previous projects in South Wales and North Dublin, five Deep End practices (in Phase 1) had an attached GP Fellow, employed for 8 sessions a week. Three of the sessions added clinical capacity, addressing the inverse care law; three provided backfill to give the host GPs protected sessions, including one session for a GP practice lead. GP fellows and host GPs were all involved in service developments, sharing their experiences every six weeks in a joint meeting.

Meanwhile the GP fellows met fortnightly for an academic programme addressing their learning needs. For all these activities, the key learning is summarised and shared on a website.

- **GP clusters could consider the use of a web-based platform (e.g. https://trello.com/) to share learning and resources, such as practice protocols**

It is the scheme rather than any individual that is pioneering, developing a collaboration between host GPs, GP fellows and academic colleagues who work together to imagine and develop their future practice. A key feature of both Govan SHIP and the Pioneer Scheme has been the energising of host GPs via protected sessions provided via the placement of GP locums and/or fellows. The Pioneer Scheme has the additional features of investing in the career development and training of the GP fellows while involving them not only in clinical work but also service developments in their host practice.

- **GP practices within clusters could consider how to involve early career GP colleagues in service development projects alongside more experienced GPs, providing them protected time to do so**

Five GP locums at Govan SHIP have become GP partners in practices in the health centre, which is now the only health centre in Glasgow without GP vacancies. Ten of the twelve GP Pioneer Fellows (from Phases 1 and 2 combined) are continuing to work in Deep End practices, either as partners, or salaried GPs.

Conclusion

Only about 25 of the 100 Deep End practices have benefitted from the projects described. The inverse care law still exists for most Deep End practices. Compared with ten years ago, however, General Practitioners at the Deep End have identity, voice and worked out examples of what is needed to address the inverse care law.

Health care should be best where it is needed most. Otherwise inequalities in health will widen. By highlighting the strengths and developing the potential of generalist clinical practice, the Deep End Project provides rich learning for all practices who serve deprived patients across Scotland.

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1. First meeting at Erskine
2. Needs, demands and resources
3. Vulnerable families
4. Keep Well and ASSIGN
5. Single-handed practice
6. Patient encounters
7. GP training
8. Social prescribing
9. Learning Journey
10. Care of the elderly
11. Alcohol problems in young adults
12. Caring for vulnerable children and families
13. The Access Toolkit : views of Deep End GPs
14. Reviewing progress in 2010 and plans for 2011
15. Palliative care in the Deep End
16. Austerity Report
17. Detecting cancer early
18. Integrated care
19. Access to specialists
20. What can NHS Scotland do to prevent and reduce heath inequalities
21. GP experience of welfare reform in very deprived areas
22. Mental health issues in the Deep End
23. The contribution of general practice to improving the health of vulnerable children and families
24. What are the CPD needs of GPs working in Deep End practices?
25. Strengthening primary care partnership responses to the welfare reforms
26. Generalist and specialist views of mental health issues in very deprived areas
27. Improving partnership working between general practices and financial advice services in Glasgow : one year on
28. GP recruitment and retention in deprived areas
29. GP use of additional time as part of the SHIP project
30. A role for members of the Scottish parliament in addressing inequalities in health care in Scotland
31. Attached Alcohol Nurse Deep End Pilot
32. 8 years of the Deep End Project

Websites

- Scottish Deep End Project www.gla.ac.uk/deepend
- Deep End Ireland (www.deepend.ie)
- Deep End Yorkshire/Humber (https://yorkshiredeependgp.org/)
- Greater Manchester(https://www.sharedhealthfoundation.org.uk/deepend-gm)