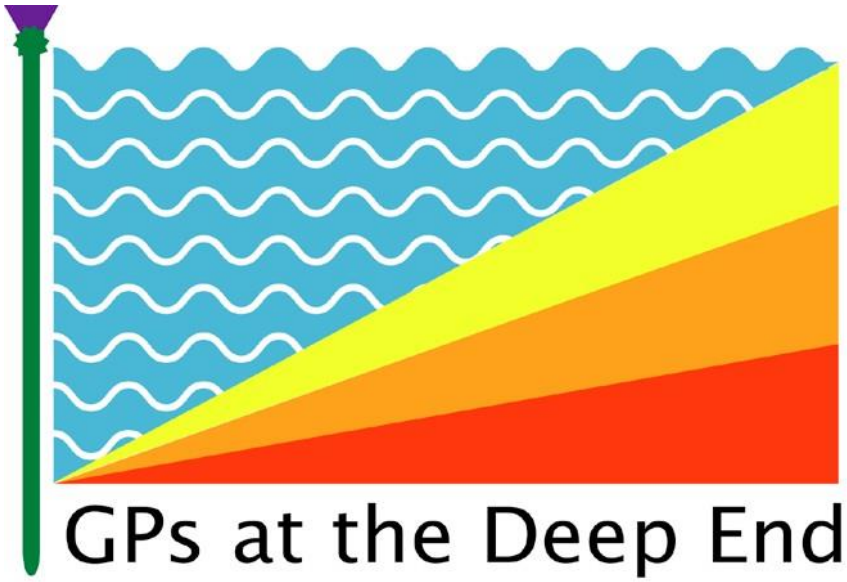

DEEP END MANIFESTO 2017

In March 2013 Deep End Report 20 (Annex A) took the form of a manifesto entitled:-

What can NHS Scotland do to prevent and reduce health inequalities?

The report and recommendations remain relevant but need updating to take account of changed circumstances concerning general practice in NHS Scotland.

Deep End Report 32 (www.gla.ac.uk/deepend), reviewing the past, present and future of the Deep End Project, 8 years after the initial meeting in 2009, provides a detailed background to the new manifesto.

To counter the dominance of specialism and managerialism in NHS Scotland, generalist clinical care based on general practice hubs needs to provide solutions to the health care challenges of multimorbidity, fragmented care, increased pressure on emergency services and static inequalities in health.

If general practitioners are to be recruited and retained in sufficient numbers to serve and lead this function, it is axiomatic that the role of general practitioners must be an attractive career option.

The Deep End Project, comprising the collective activities of General Practitioners at the Deep End, serving Scotland's 100 most deprived communities, has developed a coherent vision, with worked examples, for the future of general practice in Scotland.

The project now seeks common cause with other general practices to protect and promote the future of generalist clinical care in NHS Scotland.

October 2017

CONTENTS

"General Practitioners at the Deep End" *work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Scottish Government Health Department, the Royal College of General Practitioners, and General Practice and Primary Care at the University of Glasgow.*

Full report available at www.gla.ac.uk/deepend

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GPs at the Deep End

HORIZON SCANNING

Horizon A is the status quo, comprising the current power structure and distribution of resources, which is unlikely to reform itself. Horizon C is the future, how things need to be, and Horizon B is how we get from the former to the latter, via sustainable, incremental steps.

Horizon A – the status quo

Horizon A in the Deep End originally comprised the Inverse Care Law and its ramifications, which continue to restrict what general practice can do to meet the needs and aspirations of patients in very deprived areas, not all of whom are registered with Deep End practices. General practitioners at the Deep End struggle with higher volumes and levels of complex need and lower levels of health literacy and personal agency (the "unworried unwell"), with no extra GP funding. This is still the case in most Deep End practices, but our understanding of Horizon A now also includes :-

- A decade of preferential investment in specialist services, in secondary and primary care, with relative underfunding of general practice (as shown by Dr Helene Irvine)
- Weakening of the ability of general practice to prevent, postpone or lessen disease complications and to keep patients in the community, resulting in patient's increased use and reliance on emergency services (i.e. Out Of Hours, A&E, acute hospital admissions)
- The restrictive nature of specialist care (with referral criteria, waiting lists, complex appointment systems, discharge back to general practice) resulting in patients who do not meet referral criteria, are not good at accessing services, have significant co-morbidity or who are not made better by specialist treatment, returning to their GP for continuing care.
- The ubiquitous fragmentation of care, lacking continuity and coordination, especially for patients with complex multimorbidity.
- The increased workload pressures in general practice as a consequence of the ageing population, increasing patient demand and the unfettered transfer of work from secondary care
- The increasing shortage of GPs, due to multiple inter-related factors including training vacancies, emigration, part-time working and early retirement – all secondary to the perceived unsustainability and unattractiveness of general practice as a career
- Variation between general practices in how GP funding is spent, and variation in income streams that are not visible in the public domain, making the GP contract unacceptable to politicians and NHS managers as a mechanism for addressing unmet need in deprived areas.
- Uncertainty concerning whether, how, to what extent and with what effect the imminent new Scottish GP contract addresses the above issues

Horizon B – active ingredients

Horizon B may be considered as a transition and transformation phase in which Scottish Government funding has enabled General Practitioners at the Deep End to develop alternative approaches, involving the following active ingredients.

Activity within practices

- Additional clinical capacity, amounting to about a 10% increase, via the provision of long term GP locums and GP fellows
- Use of additional clinical capacity to provide protected sessions for host GPs
- Uses of protected GP sessions, including extended consultations for selected patients (shown by the Care Plus Study to be cost-effective), involvement in service development and attendance at meetings outside the practice, including case conferences.
- Increased support and use of multidisciplinary meetings (MDTs) to review and coordinate integrated care for selected patients
- Embedded community link practitioners (link workers) enabling patients to access and benefit from community resources for health
- Embedded financial advisors improving patient's access to welfare benefits
- Attached alcohol nurses, improving care for patients with alcohol problems
- GP Fellow posts providing not only additional clinical capacity but also Fellows with experience of general practice in very deprived areas, including involvement in service development projects, early experience of leadership roles and day release for dedicated professional development
- Activities focused on practice team wellbeing ("putting your own oxygen mask on first")

Activity between practices

- Protected time for lead GP roles (Link Worker Programme, Govan SHIP, GP Pioneer Scheme), coordinating activity between practices
- Protected time for meetings of GPs from participating practices
- A dedicated day release education and training programme, with learning summarised and shared via the website (Pioneer Scheme)
- Central administrative and information support (from the ALLIANCE for the Link Worker Programme and NHS Greater Glasgow and Clyde for Govan SHIP and the Pioneer Scheme)

Identity, coordination and momentum

The Deep End Project, comprising the collective activities of General Practitioners at the Deep End, has depended on the following features.

- Regular meetings of a steering group consisting mostly of general practitioners
- Shared understanding and leadership within the group for specific projects and advocacy
- Partnership between service and academic GPs (the latter contribution including report writing, organisation of meetings and realising opportunities for evaluation and research)
- Email communication
- A website containing Deep End news, and reports (supported by Glasgow University)
- Funding support from the Scottish Government
- Occasional administrative support from RCGP Scotland
- Increased links and joint working between 3rd Sector organisations, statutory services and Deep End practice.

The Deep End Steering Group comprises about 15-20 GPs, mostly from Glasgow, but also Edinburgh and Inverclyde, who have met over 50 times during the last 8 years, every 6-8 weeks or so. It's a convivial occasion, in many ways the beating heart of the Deep End Project, sharing news, information and plans, allowing everyone to contribute as often and as much as they wish and can. The various Deep End Projects – Govan SHIP, Link Workers, the Pioneer Scheme and the Parkhead Project, take place between times, with their own arrangements, but it is the steering group which has provided the Deep End's main identity, purpose and coherence.

Horizon C

Horizon C needs to establish a strong competing narrative for the NHS in which specialism and managerialism are complemented by GP leadership and the role of generalism in addressing three issues :-

- Improving health in deprived areas and narrowing health inequalities
- Keeping patients in the community and relieving pressure on emergency services
- Coordinating care for patients with multiple problems, reducing fragmentation of care and driving integrated care, based on patients' needs.

Horizon C involves three building programmes :-

- Building strong patient narratives, based on knowledge and confidence in managing their problems and accessing available resources and services
- Building strong local health systems, based on general practice hubs and clusters linked to other local resources and services
- Building a strong generalist function within the NHS, based on networks of local systems serving similar types of populations, with shared learning to ensure that "the best anywhere becomes the standard everywhere".

While patients with multimorbidity may differ hugely in their combinations of problems, their care needs are similar. Specialist care is needed occasionally for investigation, diagnosis and treatment but for most of the time such patients need unconditional continuity of care from a small team of generalists whom they know and trust.

The intrinsic features of general practice in the NHS, including an unconditional approach in clinical encounters, flexibility, population coverage and long term continuity, are hugely important for the provision of equitable and efficient health care, with a proven record of earning patient's trust, but needing closer links with specialist services (including specialist services in the community such as mental health, alcohol and drugs misuses, child health etc) and community resources.

Experience from the Deep End Projects shows that such links are more effective, and better able to capitalise on practice's contact with and knowledge of patients, if attached workers (however employed) are embedded within the practice team, and are not simply "co-located" or working at arm's length to external criteria. They need to embrace the practice ethos "Your problem is our problem".

Horizon B has shown the way forward by identifying the active ingredients of strong generalist care. How these ingredients are combined within general practices either singly or in clusters and within local health systems can only be determined and owned by local leadership.

There is no blueprint or logic plan, only a direction of travel, learning by trial and error with a commitment to shared learning.

The national and local infrastructures needed to support a "coalition of learning", dedicated to the "best anywhere becoming the standard everywhere," are at an early stage of development. Substantial resources exist, but in a fragmented, disorganised way.

THE GP ROLE

The challenge for GP recruitment and retention is not only to fill vacancies but also to develop an attractive and sustainable role for GPs in the future.

We believe that the approach outlined above will help to recruit and retain general practitioners, by offering professional futures with :-

- **Autonomy**, including protected time for service development and the ability to make local decisions
- **Mastery**, with recognition and support for what General Practitioners are good at, especially local leadership and unconditional, personalised continuity of care for patients with complex problems
- **Shared purpose**, based on collegiate learning

The future role of the general practitioner will include not only **generalist expertise** in addressing the needs of patients in very deprived areas, and especially those with complex multimorbidity but also engagement in six other key functions :

- **GP leadership** with protected time for service development
- **building links** between practices and local communities and services
- **collegiality** based on joint working, peer review and shared learning with other practices
- **advocacy** based on collective experience and common cause
- **accountability,** individually and collectively, for the use of public funds
- **involvement of the next generation** of GPs in all the above.

RESEARCH AND DEVELOPMENT

There is a crucial role for the Scottish School of Primary Care :-

- Developing measures of “general practice impact assessment” whereby NHS policy proposals are considered in terms of their impact on patient outcome, continuity of care, coordination of care and population coverage.
- Developing measures of patient experience, especially trajectories of integrated care, including how such information can be collected routinely, including the “measurement of omission”.
- Developing measures of the strength of local health systems, based on the sum of working relationships between individuals and between services.

- Developing better use of routine data, including aggregates of practices serving similar types of population to assess their contributions to health improvement and patients' use of emergency services
- Filling the evidence gaps caused by research which excludes particular types of patient, especially patients with complex multimorbidity and social complexity
- Developing a mixed method research framework that fits better with the complexity and messiness of real life situations

Much of this agenda has been characterised as "middle ground research", which falls between current funding streams for basic research and service evaluation. Part of the way forward must be to establish a secure funding stream for "middle ground research".

In this way, the NHS will be better able to address the following challenges :-

- Changes in skill mix within the practice team (enhancing not fragmenting the generalist function)
- Local leadership, driving integrated care based on patients' needs
- Building capacity within local health systems
- Reducing fragmentation of care (e.g. by aligning specialist services more closely with the intrinsic strengths of general practice, including continuity of care, coordination of care and population coverage).
- Strengthening general practice as a whole system, reducing variation between practices in what they do and what they achieve
- Better accountability for the use of public funds in general practice (the necessary corollary of professional autonomy)
- Joint working with the Integrated Health Boards of Health and Social Care Partnerships, especially as they have devolved responsibility for increased primary care funding
- Aligning health care policy with the needs of patients, practitioners and practices in deprived areas
- Increasing public confidence and support for services keeping patients out of hospital.

NEXT STEPS

The next phase of the Deep End Project should include, in no particular order :-

- Developing common cause with general practices outside the Deep End (dropping the Deep End label for shared activities, applying lessons from Deep End projects in other settings).

- Advocacy and development of a competing narrative for the NHS, based on a stronger generalist function
- The roll out of Link Workers to all Deep End practices, and other practices as part of the national roll out, maintaining the best practice-based features of the original programme
- Maintaining Govan SHIP as a lead project for integrated care, building on generic learning from the initial project, as documented in detail via reports and strategy documents. There is potential to scale up the generic elements to all general practices nationally.
- Realising the potential of the GP Pioneer Scheme (not only a package of pioneers but also, importantly, a pioneering package), collating service developments across practices and shared learning via practice projects and the day release programme.
- Roundtable meetings to capture and report the experience and views of practitioners on key topics
- Complementing meetings based on geographical clusters with meetings based on non-geographical clusters based on common cause (e.g. very elderly patient populations)
- Building a programme of activities for shared learning (the "Coalition of Learning"), building on the GP Pioneer day release programme and involving meetings, use of social media and the Deep End website
- Advocacy and development of the role of embedded workers
- Advocacy for general practice-based financial advisors as part of the new Scottish Social Security System
- Promotion of the clinical generalist and GP leadership roles, as exemplified in Deep End projects, to medical students, young doctors and GP registrars
- Inclusion of newly qualified doctors in all the above
- Renewal and expansion of the Deep End steering group
- An international meeting in 2018 involving colleagues from Deep End Projects in Scotland, Ireland, England, The United States and Australia
- Production of a book for general practitioners

Additional information on the Deep End Project can be found at

www.gla.ac.uk/deepend

October 2017

ANNEX A : SUMMARY OF DEEP END REPORT 20

What can NHS Scotland do to prevent and reduce health inequalities?

- General Practitioners at the Deep End are NHS Scotland's front line in areas of severe socio-economic deprivation.
- They have patient contact, population coverage, continuity, flexibility, long term relationships, substantial knowledge and experience and the trust of patients.
- These characteristics make general practices the natural hubs around which local health systems should develop.
- But Deep End practices lack the time, links to other services, NHS support and leadership roles needed to maximise what NHS Scotland can do to prevent and reduce inequalities in health.
- The Deep End Project has been unusually successful, with Scottish Government support, in engaging with general practices, in capturing and communicating their experience and views, and in harnessing their commitment to the Links, CarePlus and Bridge Projects.
- It is time to move beyond advocacy, and small projects, however, and to make a real difference to inequalities in health.
- By recognising the causes and consequences of the inverse care law, NHS Scotland can help to prevent poor health and life chances in young families, improve the health and life expectancy of patients with established conditions and prevent the further widening of health inequalities in adults.
- Additional clinical capacity is required, on a pro rata basis, providing one extra GP session per week per 1000 patients living in very deprived areas.
- The principles of co-production, including mutuality and respect, should be applied to serial encounters in general practice and primary care, enabling patients to become more knowledgeable and confident in living with their conditions and in making good use of available resources.
- The principles of co-production should also be applied to the joint work of general practices and area-based services, including attached workers (from social work, mental health, addictions and child health services), on a named basis.
- The lay link worker role should be developed to link practices and patients with community-based services and resources.
- Building on the Deep End Project, practices serving very deprived populations need regular opportunities to share experience, views and activities.
- NHS Scotland should re-deploy its substantial support systems (including information, research and development, training, continuing professional and leadership development) to provide more effective, integrated support for practices in the front line.
- These proposals should be applied together, as a demonstration of integrated care for patients with multimorbidity, an antidote to health service fragmentation and a model for NHS Scotland in the future.
- NHS Scotland should be seen at its best in areas of greatest need, or inequalities in health will widen. A new partnership with General Practitioners at the Deep End can show the way.