HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM Deep End GP Group, Scotland.

“The NHS promise of comprehensive health care based on need and free at the point of use trips off the tongue, but has been hard to deliver especially in primary care… the NHS could and should be a model for wider society, as a gift economy based on giving as well as getting…Inclusive health care, excluding exclusions and building relationships, is a civilising force in an increasingly dangerous, divided, and uncertain world” [1].

The Deep End Group welcomes the opportunity to respond to this consultation from the perspective of frontline General Practitioners in Scotland serving the 100 most deprived populations in Scotland. The Deep End Project originated in Scotland and has now been emulated in Ireland, England and Australia. Deep End work addresses the longstanding but largely neglected NHS issue of the inverse care law [2], with activities and projects involving collaborative working to produce sustainable solutions. The challenge has become how to apply these examples in larger numbers of practices across Scotland.

Of the most deprived 15% of the Scottish population, one third are registered with the 100 most deprived practices as described above, while the other two thirds are registered with about 700 other general practices in Scotland; very few general practices in Scotland do not have Deep End patients [3]. This Deep End response references the projects (Govan SHIP, Pioneer, embedded Welfare workers, and Community Links Workers) we believe are necessary vehicles of primary care transformation across Scotland, but particularly in areas of deprivation where health and social care needs are greatest.

The Deep End Group endorses many of the Panel’s priorities themed around availability and accessibility, communication and trusted relationships. The Panel highlighted several issues that are key to Deep End thinking, e.g. sustained relationships with health staff who know individuals, greater engagement and consultation with patients about services, more effective triage for primary care services, easily accessible information about, and referral/signposting to, services, GPs at the heart of the primary care hub but sharing responsibility with other professionals for care and sign-posting.

The proliferation of specialised services in both secondary and primary care, with referral and exclusion criteria, has resulted in fragmented care for the increasing numbers of patients with complex multi-morbidity, many of whom lack the knowledge and confidence to cope with fragmented care arrangements, involving poor communication, continuity and coordination. Neither patients nor the NHS can afford the results of health care fragmentation and diminished effectiveness of the GP gatekeeper in tackling unmet need and overconsumption of services. This translates into poorly coordinated care, so that complications of physical and mental health conditions are less likely to be prevented, delayed or lessened, resulting in unnecessary pressures on A&E and other emergency services. The strengths of the specialist approach need to be matched by equivalent support to maximise the generalist clinical function, providing unconditional, personalised continuity of care, mostly in the community, for all patients, whatever problems or combinations of problems they may have.

The various Deep End projects are examples of ‘middle ground’ research and practice that demonstrate the difference that GPs and the primary care team could make to health inequalities when resourced adequately. There is a commitment from the Deep End group to expand the experience, evidence and learning across all general practice in Scotland [4].
Long term physical and mental health issues can restrict health and well-being and active participation in community life. In Deep End communities the onset of multi-morbidity occurs 15 years earlier than in more affluent communities [5]. Patients do not present in neatly packaged categories of health needs that fit defined healthcare pathways with an easily identified start and end point. This applies especially to mental health problems - whose ubiquitous nature in primary care, often as co-morbidities, cannot be addressed effectively by supporting mental health services as a separate, referral-based (i.e. arm’s length) activity.

To navigate the best services to address a particular patient’s needs requires a primary care workforce that has expertise in risk management, safety netting, and referral into specialist services at the most appropriate time by anticipating a decline in any combination of physical, psychological or cognitive function.

The core team of Primary Care clinicians includes General Practitioners, Health Visitors, District Nurses, Advances Nurse Practitioners, Midwives and Pharmacists. The Primary Care network is expanding, however, reflecting changing demographics and the demands of managing complex multi-morbidity. It includes colleagues from Social Work, Addiction Services, Physiotherapy, Optometry, Community Mental Health Services, Community Links Workers and others from the Third Sector who are co-located, aligned or embedded within GP practices/Health Centres. The external evaluation of the Govan SHIP project [6] provides a detailed account of the challenges to integrating inter-professional working within an expanding health care system.

1. Considering the Health and Sport Committee’s report on the public panels, what changes are needed to ensure that primary care is delivered in a way that focuses on the health and public health priorities of local communities?

   - Attention to the learning from Deep End projects could drive the transformational change that is required, including a recalibration of the relationship between specialist and generalist clinical practice. The Deep End Group would encourage the Health and Sport Committee to read Deep End report 32 as a useful overview of this learning, including the “key ingredients” of: protected time for extended consultations and service development, attached workers (financial advisors, alcohol nurses, social care workers, mental health workers), enhanced multidisciplinary team (MDT) working, and coordinating projects involving groups of practices [4].

   - Assessment and/or re-assessment of patients’ needs (or, more accurately, their uncoordinated care), was achieved in the Govan SHIP Project, the Care Plus Study and the GP Pioneer Scheme via extended consultations, which helped reset the agenda, establish priorities and shape integrated care. Regular MDT meetings within the practice, and involving key external staff (e.g. district nurses, health visitors, social workers), provide important opportunities to share information (e.g. from different information systems), review cases, plan care and involve new colleagues.

   - The Community Link Worker (CLW) Project is helping patients to live well and longer in the community by promoting links with community resources for health and healthy living. The original Deep End programme was not restricted to “social prescribing” but involved one-to-one support for patients with complex problems, i.e. a strengthening of the generalist function within practices. The Deep End Group remains concerned that, despite the initial policy intention, the rollout of CLWs in deprived areas has been partial.
Voluntary and third sector organisations are an important component of this landscape but need secure funding. The Parkhead Advice Worker project is a successful example of an embedded model which evolved from initial conversations and thinking at community level, into a service which delivered to those most in need, whilst giving vital support to those professionals working in areas of high deprivation. Embedding the welfare worker in the practice (not simply co-locating) enabled the establishment of trusted relationships to contribute to both the development and delivery of the services. This should be a generic approach to increase the ability of practices to manage local problems. The outcome of the project demonstrated a positive economic return on investment of £25 benefit generated for every £1 of investment. This model provides valuable learning for all GP practices [7].

Direct funding to the SHIP project afforded additional GP capacity and support to more complex patients, increasing access and time for consultations for patients with long term multi-morbidities. There is a detailed description of the practical use of additional GP capacity in Deep End Report 29 [8]. This funding also ensured significant GP contribution to project and work stream development. The work on information management and evaluation demonstrated how an understanding of demand across health and care services at GP practice level could be developed and created the evidence base through qualitative and quantitative evidence on potential areas for focus, input and investment. One example of significant benefit was pharmacy involvement beyond the traditional role of prescribing support. The SHIP pharmacist identified an average of 2.64 interventions per patient reviewed, demonstrating that there are pharmaceutical interventions to be made for almost every patient on medication irrespective of condition ranging from medication optimisation to changes in high risk medications to improve patient care [6].

Joined up planning for in-hours and out-of-hours GP and primary care services should be prioritised. Both systems employ the same workforce and serve the same patients. They should not be regarded as disconnected from each other as the challenges of complex multi-morbidity apply to both services.

2. What are the barriers to delivering a sustainable primary care system in both urban and rural areas?

Barriers (and solutions) to delivering sustainable primary care in the Deep End include, in no particular order:

- **Addressing health behaviours and matching healthcare to needs.** This requires localised knowledge and time to engage with patients who are high users of the service. Research has shown that 10% of patients with 4 or more conditions accounted for 34% of unplanned admissions to hospital and 47% of potentially preventable unplanned admissions [9]. During the Govan SHIP project, 1,866 people were identified as high need, equating to 7% of the rolling population. When compared with the overall practice baseline, the SHIP population proportionately:
  I. Reflected even higher levels of deprivation
  II. Had higher levels of co-morbidity
  III. Was skewed towards the younger and older age groups
  IV. Was skewed towards women aged 17-44

- **Patient Engagement.** This is a particular challenge in DE communities where patients often lack the agency and social capital to engage with planning organisations to influence the provision of their
health care and community needs but with effort it is possible. The Deep End Projects cited in this
response have demonstrated the possibilities and value of community engagement.

- **Lack of time.** Pressure of time in Deep End communities and shorter consultations are barriers to
providing empathetic care [10]. The extra time that was required to address health care needs in the
local population during the SHIP is described in Deep Report 29. All the examples of unmet need
required individualised GP and primary care team input but extra GP capacity was crucial for case
planning and management. This additional GP capacity facilitated:

  I. Extended consultations
  II. Polypharmacy reviews
  III. Case review / planning
  IV. Increased outward facing activity – such as child protection hearings, Adults with Incapacity
     (AWI) and Adult Support & Protection (ASP) procedures.
  V. Leadership activities

- **Interface between primary care and secondary care.** Current arrangements provide little opportunity
for generalist and specialist clinicians within localities to share experience, problems, views, information
and activity particularly around points of risk for patients, e.g. at time of discharge when enhanced
community support is required to ensure maximum patient recovery. Reduction of specialist community
health services, e.g. Sexual Health Services most recently, can impact negatively on GP capacity as
patients are redirected to GP because of increased waiting times. The small but multiple shifts of
workload back to general practice are causing more stress on an already stressed system.

- **GP contract.** The GP contract planned changes will help but need to be fully implemented, e.g.
vaccinations and travel clinics done by others, including the risk management decisions and
judgements associated with this. For example, assessment of capacity, decisions about safety in
relation to reactions to previous vaccines, decisions around safety of live vaccines.

- **Use of data.** Data capture and linkage between big data and small localised datasets which both give
context to the health needs of the practice population. Govan SHIP gathered extensive data that helped
the GPs and the extended team plan preventative health and social care, reduce GP demand and
make better use of community support services. There were varied challenges, limitations and
solutions involved in developing the data framework that are described in the evaluation [6].

- **Mental Health Services.** It is the Deep End view that mental health – in the widest sense – needs to
be prioritised. The SHIP project had a strong focus on mental health recognising the frequency and
chronicity of mental illnesses that DE GPs deal with on a daily basis [6]. A transformational change to
the delivery of health services would include:

  I. Consideration of non-clinical responses to distress and suicidal behaviour;
  II. Alignment of service user expectations with available help to facilitate straightforward access to the
right kind of help and to maximise opportunities for self-management;
  III. Supporting services users and carers to navigate service options and improve ‘signposting’;
  IV. Moving away from traditional clinical models of referral and discharge from services, towards self-
directed care, open access and brief and low-intensity interventions - ‘easy in, easy out’;
V. A commitment to simplifying access routes (e.g. self-referral to PCMHTs) with the use of link workers and “choice” appointments to work out how best to respond to more complex difficulties;

VI. A single point of entry for Mental Health services in OOH would help streamline the referral process and reduce the time that a distressed patient waits to access timeous Mental Health support. There should be less reliance on Police services to be used as proxy mental health services.

- **GP Recruitment and retention.** The particular challenges related to undergraduate teaching and postgraduate training in general practice in areas of severe socio-economic deprivation have been described in detail elsewhere [11]. The inverse care law, the unequal distribution of GP teaching and training, and the particular learning needs required to work in Deep End general practice are barriers to sustainable primary care. Potential solutions should be considered across the medical education continuum, from widening access to medical school for pupils from disadvantaged backgrounds, through medical school and postgraduate training, to improving retention of experienced GPs [11].

3. How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?

- The SHIP reports [6, 8] detail the effectiveness of MDT working which should be embedded in the HSCP cluster structures and scaled up. The principal of cluster working is sound but they remain immature structures with no clear guidance or template as to what their exact role is and it will be some time before they can deliver significant changes to the quality agenda. SHIP provides such a template for geographic clusters while the Pioneer scheme demonstrates how practices within a non-geographic cluster can share learning. The SHIP cluster had a clear aim with an excellent health service manager and clinical lead and individual GPs within the cluster happy to take on additional leadership roles within the cluster. This occurred because GPs had the protected time and support of their colleagues to design and introduce the changes required to facilitate this new way of working.

- The SHIP model of MDT working demonstrated extra value from more joined up management, better use of resources and services, shifting demand between health and social care professionals working to the top of their licence to avoid escalation of problems. This was effective in identifying vulnerability and addressing risk which might not have occurred otherwise.

- Key findings from the external evaluation of SHIP indicated this model of working showed promise for addressing the inverse care law with the GPs having additional capacity to plan for and address complex health and social needs, drawing on the expertise of social care and other health colleagues from within the MDT structure. At its simplest level, the discovery process of the MDT would identify contact details of allocated social workers and GPs allowing for appropriate and timeous (email for non-urgent issues) contact, avoiding system blockages or bottlenecks. One GP suggested that this could sometimes save up to 2 hours per week. Future efforts to develop multi-disciplinary team working should never underestimate the impact of bringing different organisational cultures together and the role of organisational development in planning for this. The SHIP project evidenced the overlap between demand for GP services, social work services and socioeconomic deprivation. This should be a driver for greater integration. Directly creating additional GP capacity may still be required in addition to releasing it through alternative resources to adequately meet patient need in deprived practices [6].
Summary

General practice needs not only to be rescued from underinvestment – resulting in unsustainable workloads, and consequent recruitment and retention challenges – but also imagined, developed and supported for what it needs to achieve in the future:

- Building strong patient narratives especially for patients with complex multi-morbidity (the sixth of patients generating half of NHS work).
- Building strong local health systems, based on GP hubs with embedded workers and links to other services and resources.
- Building a strong overall system, based on collegiality, shared learning and horizontal accountability.
- Supporting the career development of the local leaders of these developments, staying long enough to make a difference.

Response submitted, on behalf of the Deep End GP steering group, by:

Dr Anne Mullin (Chair, Deep End GP Group, Scotland) MBChB, DRCOG, FRCGP, PhD
Dr David Blane BSc, MBChB, DRCOG, MRCGP, MPH, PhD
Dr Gillian Dames MBChB, MRCGP, DRCOG, DipFSRH
Dr Maria Duffy MBChB, MRCGP, DRCOG, DCH, Dip Ther.
Dr John Montgomery (Lead Clinician Govan SHIP) MBChB, BSc Hons, DRCOG, FRCGP
Dr Petra Sambale (Lead Clinician Pioneer Scheme) MBChB, FRCGP, DRCOG, DCH
Professor Graham Watt MD, FRCGP, FMedSci, FRSE, CBE

References

7. The Deep End Advice Worker Project: embedding advice in general practice. Accessed at: https://www.gcph.co.uk/publications/728_the_deep_end_advice_worker_project_embedding_advice_in_general_practice