



Deep End Report 35

Plans for advocacy and engagement by the Scottish Deep End Project

Deep End Report 32 summarised the shared experience and learning of the Deep End Project in the 8 years since the initial meeting in September 2009. Deep End Report 34 built on that foundation and outlined the planned activities of the Deep End group between 2019 and 2022. This report summarises a roundtable meeting which discussed some of these activities in more detail.

January 2020

Anne Mullin (Chair, Deep End Group)

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Nine general practitioners, all members of the Deep End Steering Group, gathered for a half day meeting on 11th December 2019 at the Department of General Practice, Horselethill Road, Glasgow to discuss the future identity and role of the Scottish Deep End project. The discussion focused on developing the sustained engagement of the Deep End movement – with practices with Deep End patients, relevant primary care and third sector organisations, patient groups and Scotland's institutions that are charged with addressing health inequalities within the broader socio-economic landscape.

SUMMARY

- The proposed program of Deep End Scotland activities for the next three years includes advocacy activity, engagement and collegiate working, developing collective skill sets, GP leadership, and a series of planned meetings.
- This roundtable discussion focussed on advocacy and engagement, and proposed the following objectives:
 - To map Deep End practices (and clusters) that have 40% or more of their patients in the most socio-economically deprived 15% of SIMD postcodes.
 - To have a DE representative connect in person with these DE practices to raise awareness of potential educational and practical resources.
 - To work with Cluster Quality Leads (CQLs) to facilitate education and highlight challenges and solutions to providing health care for DE patients.
 - To expand the collegiate DE movement nationally and internationally.
 - To continue input into, and support, of the RCGP Inequality group and the West of Scotland and Lothian Deprivation Interest Groups.
 - To add a DE blog to the DE website and encourage input from anyone working with DE patients (not just GPs) to describe ways of working, everyday challenges, and DE community solutions.
 - To continue dissemination of our activities across different media.
 - To undertake advocacy training to explore barriers – professional, institutional, political and economic – that are impeding progress.
 - To continue strengthening medical education related to working with marginalised groups across the learning continuum, from widening participation, through undergraduate and postgraduate teaching and training, to lifelong learning.
 - To improve engagement with DE communities affected by poverty by hosting an evening in a community setting to explore DE issues.
- We will continue advocacy on existing projects related to financial inclusion, mental health, addictions, social prescribing, SHIP and Pioneer.

INTRODUCTION

In October 2017, General Practitioners at the Deep End, serving the 100 most deprived populations in Scotland, produced [Deep End report 32](#) “8 years of the Deep End project.” The meeting shared experience, learning and plans of the Deep End Project in the 8 years since the initial meeting in September 2009.

In June 2019, [Deep End report 34](#) outlined the planned activities of the Deep End Project in Scotland for 2019-2022, presented under the headings: 1) Advocacy activity, 2) Engagement and collegiate working, 3) Developing collective skill sets, 4) GP Leadership, and 5) Planned meetings.

This report summarises a half day meeting held in December 2019 between nine members of the Deep End Steering Group to discuss some of these planned activities in more detail. The aim of roundtable meetings is to work towards practical outcomes that will shape certain activities but require more time to flesh out than is possible during the Steering Group meetings. The discussion explored several inter-connected themes that focus on advocacy and connectivity and continue to challenge and direct future interests of the Deep End (DE), summed up as;

- **Engaging with Deep End GPs and others**
- **Status of Deep End Projects**

We identified several issues to address;

- How do we connect with GPs in and beyond the DE?
- How do we expand the number of GPs within the DE learning and support network to host elective students and participate in DE events?
- How do we influence and change perspective by highlighting new ways of working across practices and their communities?
- How do we learn from other DE groups, replicate their findings and scale up new ways of working?

Roundtable participants:

Anne Mullin, David Blane, Catriona Morton, Helen Richardson, Holly Thompson, Marianne McCallum, Claire Crothers, Noy Basu, John Budd

ENGAGING WITH DEEP END GPs AND OTHERS

1) ENGAGEMENT WITH GPs

Following on from our aspiration to engage with practices beyond the Deep End 'top 100' the initial discussion explored barriers to wider engagement and how the Deep End group might break down perceived barriers to communication and intercollegiate working without duplicating the work currently underway in Health & Social Care Partnerships (HSCPs). The process of engagement is relational; we want every practice to have common cause with the Deep End beyond geographic boundaries and deprivation ranking based on % of patients living in the most socio-economically deprived areas.

There are different challenges to the delivery of equitable health care for GP practices and their community health and social care teams that serve 'blanket' deprivation (concentrated deprivation in urban centres) and 'pocket' deprivation (particularly in rural communities). Across settings, however, a well-informed and well-resourced primary care team is more likely to contribute to the solutions for equitable health care.

2) REPRESENTATION ON RCGP INEQUALITY GROUP

The RCGP inequality group has DE representation along with GP representation from other demographics (remote and rural, urban affluent) and is relevant to all GP practices in Scotland. It includes different workstreams to identify challenges and solutions in different areas, e.g. identifying appropriate metrics to inform Health Inequality work, progress on the issue of funding and the governance structure needed. The challenge of generalisability of the existing evidence base and addressing health inequalities through Primary Care Improvement Plans (PCIPs) is also being considered.

3) WEST OF SCOTLAND DEPRIVATION INTEREST GROUP (DIG)

Established in February 2019 and supported by the West Scotland Faculty of the RCGP, the West Scotland DIG group runs a series of evening CPD/networking events related to working with marginalised groups. The DIG already has non-DE GPs and GPs who are not attached to practices who attend meetings because of the educational topics, and we plan to build this network. The invitation to trainees is via the Trainers' Group and we also use our links with academia to promote the DE work. The DE profile has been raised in undergraduate teaching and Pioneer fellows currently provide input to the

Glasgow Access Programme. The University of Glasgow medical school is looking to expand the provision of Student Selected Components (SSCs) in general practice, which involve 5-week funded placements. The Deep End is supportive of these aims to recruit more GP practices for this network of training.

4) THE GP CONTRACT

Whilst the GP contract is not part of the DE remit *per se*, one of our planned activities will be asking GP colleagues about how Phase 1 of the contract is working for them, what are the lessons learned and can we make it better. The HSCP has been charged with delivering the additional services required in deprived populations as expressed in the PCIP through the GP contract and any governance frameworks necessary to ensure resources are spent as intended.

Burnout in our profession is common and hampers experienced GPs' commitment to long careers in general practice. The visibility of burnout is hampering early careers GPs, who are hugely motivated and committed, from taking the plunge and becoming partners. This is particularly relevant to DE practices where the volume of workload can be overwhelming with an impossible time pressure. We plan to work with Cluster Quality Leads (CQLs) and explore the local intelligence gathered within the clusters to shape cluster working, facilitate education, and highlight the challenges and solutions to providing health care for DE patients.

5) THE INTERNATIONAL DEEP END MOVEMENT

The international Deep End movement will continue to develop with each DE group adapting to their respective communities and we now have well established networks of communication and shared learning with the UK and international DE groups. This will continue to expand as the Deep End movement progresses. Future meetings include the Deep End Ireland Conference 'Wellness at the Margins' confirmed for March 19th and 20th 2020 and hosting primary care colleagues from Ghent, Belgium, who will visit a number of DE practices and projects between March 3rd and 5th 2020.

6) USING IT AND INFORMATION NETWORKS TO CONNECT

There are many information networks that are available to us – social media, DIG, emails, WhatsApp, etc. As working GPs, we know that the pressure of time prevents

colleagues from reading and engaging with multiple information networks and educational material. The development of the DE network is an organic process, but we do want to speed up the pace of connectivity. Most DE GPs are not connected to academic networks, but the DE website is open access and we hope will be referenced when needed. We now plan to add a DE blog to the DE website and encourage input from anyone working with DE patients (not exclusively GPs!) to describe ways of working, everyday challenges, DE community solutions. It will be an informal story telling aspect of the DE website. This is important. Medicine is a narrative based profession, there is power in the story of patient experience when it is validated along with formal research findings. Building on our links with academics, the Institute of Health & Wellbeing at the University of Glasgow has a monthly e-newsletter (called [Hawkeye](#)) that has also been used to disseminate Deep End activities to a wider audience.

[Healthcare Improvement Scotland](#) (HIS) is developing an information portal that GPs can access, and it is proposed that DE information will be hosted on the site. The '[Right Decision Service](#)' is also a resource that is being explored as a possible learning platform. Apps and accessible learning sites will eventually link to the DE website. We plan to map out geographically using Open Street Map or similar GIS software the Deep End practices that have 40% or more of their patients in the most socio-economically deprived 15% of SIMD postcodes and have a DE ambassador connect in person with the practice to raise the profile of the DE and advise on potential educational and practical resources for DE practices.

7) MEDIA ENGAGEMENT

Media training will continue in the Deep End and media engagement with a proposed link with a journalist who could report on the activities of the Deep End practices and their communities. We will repeat the session on media training for others who missed the first session. It was thought to be useful and will help us develop our own media skills specifically if we develop website videos to tell the patient story.

There are several possibilities of engagement using visual media, the forthcoming Dublin conference, public engagement via the video for DE award, engaging with national broadcasters. At all times we will be mindful of sensitivity of the language and imagery of poverty and multiple disadvantage because our aim is not only to witness and document the struggle of our patients and their communities but do something practical to help them across the boundaries of social and health care needs.

8) INSTITUTIONAL CONNECTIONS

[Public Health Scotland](#) is a new public health body due to be established in April 2020. Its ethos is rooted in a determination *'to build a healthier and fairer Scotland, one where health and wellbeing is improved and protected while health inequality is steadily reduced. A healthy life expectancy with the highest attainable standard of health and wellbeing should be the norm for everyone, regardless of circumstances, location or economic background'*. These aims are aligned with the DE focus on addressing the inverse care law and proportionate universalism. Public Health Scotland should be naturally advocating for our population and should move from HBs more to HSCPs and grass roots working.

[NHS Health Scotland](#) is the national Health Board working to reduce health inequalities and improve population health via research, planning, programme implementation and evaluation and would seem a natural partner to DE innovations.

We are also connecting with Third sector agencies such as the Child Poverty Action Group (CPAG) to further strengthen the impact of specific campaigns and build patient narratives.

9) EDUCATIONAL LINKS

We will continue to work on strengthening medical education related to working with marginalised groups across the learning continuum, from widening participation, through undergraduate and postgraduate teaching and training, to lifelong learning.

Promoting the DE work at RCGP conference using posters and workshops and hosting medical student conferences have been successful at engaging with colleagues at undergraduate and postgraduate levels and this will continue in 2020 and beyond.

The Homeless Health and Inclusion service in Edinburgh is hosting a scheme that will encourage Medical Students and students from other faculties to volunteer in settings for marginalised groups, such as night shelters and mobile clinics. The service aims to secure funding from the University of Edinburgh for all students to undertake volunteering.

10) ENGAGEMENT WITH PATIENTS AND COMMUNITY GROUPS

Certain localities have strong community focus and patient representation group. We want to build a DE network in these communities by hosting an educational evening in a community setting to educate and explore DE issues.

The routes into poverty and disadvantage are well known and described in the '[Hard Edges Scotland](#)' report. The profession must act with other agencies and institutions using multiple strong alliances with Public Health, Sociologists, patients, GPs to navigate routes out of poverty and severe disadvantage. There are examples of the importance of capturing the patient voice when advocating to develop ways of working that suit the local community e.g. the Craigmillar Ability Network documented patient stories of the effectiveness of this support. Springburn in NE Glasgow has a very organised local community hub with representation from faith groups, patient groups, education, health and political representation that is tasked with re-imagining the community and engaging with all aspects of community development.

STATUS OF DEEP END PROJECTS

What is Advocacy?

[Advocacy for health](#) is defined by the WHO as “*A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme.*”

All documented DE projects have advocacy as a core component. We propose an advocacy training meeting next year as the first step in exploring the barriers – professional, institutional, political and economic – that are impeding progress. We are in a phase of moving beyond inventing new ways of working to agitating for these new ways to become the standard everywhere; a substantial focus of the DE group currently.

Whilst DE projects demonstrate the potential of general practice in addressing the inverse care law and making real differences to their communities the projects are not always supported externally. This agenda – “*the best anywhere should be the standard everywhere*” – leads us to ask questions of why established ways of working in one health board, a practice, an HSCP cannot be replicated throughout the system if they have proven and sustainable benefit to their communities.

1) EMBEDDED FINANCIAL WORKER PROJECT

All of Glasgow's regional and list MSPs have been sent a summary of the embedded financial worker and the evidence of why it should be scaled up throughout Scotland's GP practices. It has unequivocally demonstrated viable progress in ensuring that the devolved welfare powers that have been returned to Scotland are of benefit to the communities who are entitled to them. The rollout of this successful scheme is of national relevance and importance and demonstrates that welfare reform can have a very significant impact on the quality of life and health and wellbeing for vulnerable children and families.

Embedding money advice in general practice reaches people who are expected to access advice services but don't and generates large financial gains, especially for patients with disabilities and long-term conditions.

Over 4 years, beginning with 2 general practices and now with 17, the scheme has engaged with 1,384 patients and generated financial gains totalling £5,042,608. A simple return on investment analysis indicates that the project generates over £27 in financial gains for every £1 invested.

After a series of short-term arrangements, funding for the scheme ends in March 2020. There is a need to secure future funding for embedded money advisors not only in the 17 initial practices but also in all general practices serving very deprived communities.

2) LINKS WITH MENTAL HEALTH SERVICES

We know that complex MH issues are the most common long-term condition that we deal with in General Practice and often squeezed into a consultation slot alongside physical health complaints. It would make sense as a first-tier service to have MH services embedded in the system where the demand is highest and where most cases are managed.

One DE practice in Lothian HB has 2 attached CPNs that are primary care trained and employed by the practice using its GMS funding. Lothian GPs were surveyed about what extended workforce they wanted under the PCIP. Most wanted mental health nurses and despite the considerable HR challenges to establish the posts they are now in place and other Health Boards can learn from this process. It would seem a reasonable ask that Glasgow DE practices have a similar set up with attached mental health staff that are embedded in the practices and not at arm's length.

The Govan SHIP also employed a dedicated CPN who worked across the practices and who was tasked with mapping out the MH referrals, appropriate MH support (whether in community teams or specialist MH services) and one conclusion in the forthcoming evaluation of the SHIP project reinforces the need for localised and accessible community health care teams:

“...the majority of mental health presentations exhibited symptoms relating to depression, anxiety, low mood or stress. A large number of individuals were on medication. Most were not linked with support but had been referred to or engaged with treatment previously. The audit of referral outcomes showed less than 20% of referrals to primary care or community mental health teams went on to engage with treatment.”
(p.17, forthcoming evaluation)

3) COMMUNITY LINKS WORKER PROGRAMME

This project is now in its second phase and mainstreamed in deprived practices although not all DE practices have an attaches CLW. There are emergent issues as the new service have developed. For example, overwhelming demand and blurring of boundaries when working as generalists, but this is part of the learning process and it may be that a CLW conference could be hosted in 2020 by the DE with other 3rd sector agencies, e.g. CPAG, SHAAP who we work closely with and regard as integral to the health and social care networks.

4) GOVAN SOCIAL AND HEALTH INTEGRATION PARTNERSHIP (SHIP)

[Govan SHIP](#) was ‘mothballed’ at the beginning of 2019 at the end of its funding provision. The evaluation demonstrated the positive progress that the project made in a relatively short period of time in addressing unmet need, GP demand and the consequences of fragmented health and social care services in DE communities. The main component was protected GP time that is necessary if GPs are to manage long-term conditions in the community and maximise the benefits of a strengthened GP gatekeeper role to the NHS in Scotland as a whole. The Deep End Group will continue to advocate that aspects of Govan SHIP should be mainstreamed throughout HSCP cluster working.

5) DEEP END GP PIONEER SCHEME

The Deep End GP Pioneer scheme was set up in 2016 with funding from the Scottish Government's GP Recruitment and Retention Fund, in recognition of GP workforce issues in deprived areas.

The aim was to develop a [change model](#) for general practices serving areas of socio-economic deprivation, involving the recruitment of younger GPs, the retention of experienced GPs, and their joint engagement in strengthening the role of general practice as the natural hub of local health systems. Funding ends in April 2020 and discussions are ongoing between the project leads, Glasgow City HSCP and the Scottish Government about how to apply the considerable learning from the scheme and ensure its continuation in some form, to support general practice sustainability, development and innovation in the Deep End and beyond.

6) ALCOHOL ATTACHED NURSE ROLL OUT GLASGOW (PCANOS)

Following the success of the Attached Alcohol Nurse pilot in NE Glasgow, Glasgow Alcohol and Drug Recovery Services (GADRS) have secured joint primary care and addictions funding to extend provision across Glasgow's three HSCPs and are now driving this development with some Deep End input. Six Alcohol Nurses are attached to GP practices at GP cluster level who remain line managed by GADRS.

The HSCP Clinical Directors identified 3 lead GPs in Possilpark, Bridgeton and Castlemilk Health Centres who will advise the project's Steering Group as the project is scaled up. The project has started in the 3 practices with a gradual roll out across the clusters. The Steering group will meet quarterly. Evaluation of the roll- out is embedded in the clinical recording IT systems; these have improved since the pilot. There is GADRS researcher resource dedicated to the output from this.

In Lothian the Edinburgh Access Practice (EAP) is a homeless practice with mental health and addiction workers (all CPNs) employed and managed by the practice itself. This is important when looking at developing a culture and consistency of practice in a primary care setting.

UNINTENDED CONSEQUENCES AND LEARNING POINTS

Experienced clinicians know what works and should be able to practically influence systems change provided there is a governance structure, horizontal and vertical accountability and sound evidence of quality improvement. When central government funds a project that achieves all its stated goals, the challenge to normalise and embed change falters if there is no linkage to the local health structure and no local champions to promote it.

The system reverts to the status quo (which was the impetus to implement change) and there is a negative impact on staff morale and the expectation of the community health care provision when funding is withdrawn. There is a withering of strategic planning and oversight if the project is handed over to local organisations who do not support its progress. Learning evidence and team building melt away and become lost to organisational memory when it should be the basis of building and expanding organisational memory.

This is not a new dilemma for General Practice, but we now have a reasonable body of evidence on how best to support community orientated health care that has a specific focus on the DE patient and this cannot be ignored or consigned to a dusty corner of history under the health strategy of 'too difficult and too expensive'. The cost to society of doing nothing is not a philosophy that the DE will enforce.

We remember and celebrate the words of Julian Tudor Hart and will continue to enact this guiding vision;

“Everything depends on leadership at practice level, demanding media attention, gaining broad public support, and insisting on material resourcing from their governments, in return for which they can guarantee immensely greater efficiency of care given to and received by people who know each other.”

Julian Tudor Hart, Commentary on [RCGP Occasional paper 89](#) (2012)