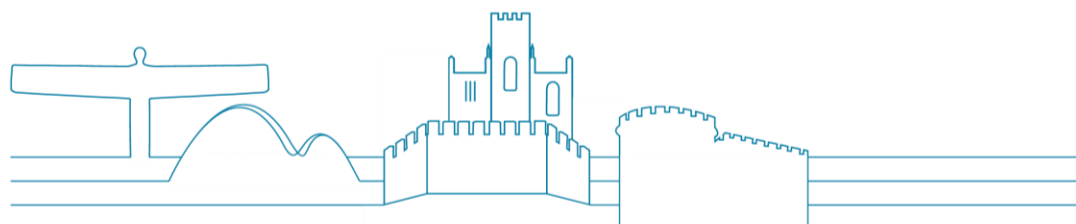
NIHR | Applied Research Collaboration North East and North Cumbria

North East and North Cumbria ICS

Overview of Deep End Webinar 5

Wednesday 28 July 2021



1. Introduction

The Deep End movement started in Glasgow and is spreading across the world. Funding was secured in 2020 to help establish a network of Deep End practices in the North East and North Cumbria region. The Deep End Network is made up of the practices in the North East and North Cumbria serving the most socioeconomically deprived patients and is focussed on working collaboratively to create positive change for practices, patients and communities, working to address the inverse care law and health inequalities.

The NENC Deep End Network aims to support member practices not just through new initiatives and opportunities but also act to influence how resources are allocated. The webinars are an opportunity for member practices to come together and share issues, learning and ideas to inform the future work of the network.

The theme of the fifth webinar was advocacy: how can practices at the Deep End make use of information to help them advocate and raise awareness? The keynote speaker was Professor Edward Kunonga, Director of Population Health Management. Group discussions took place on:

- Deep End advocacy - experiences and challenges
- Deep End pilot projects – reviewing opioid and gabapentinoid prescriptions pilot, GP Clinical Psychologist pilot and the Deep End GP Fellowship Programme pilot.

2. Agenda

The agenda for the event is outlined below:

Item	Topic	Owner	Time
1	Welcome & Introduction	Dr Dave Julien	12:30 – 12:35
2	Using Information to Advocate	Professor Edward Kunonga	12:35 – 12:50
3	Group Discussion and Experiences – Advocating for the Deep End	ALL	12:50 – 13:20
4	Breakout Groups – Deep End Pilot Projects	ALL	13:20 – 13:40
5	Feedback on Key Themes	ALL	13:40 – 13:50
6	Next Steps & Close	Dr Dave Julien	13:50 – 14:00

3. Using Information to Advocate

Professor Kunonga's session focussed on understanding the health inequalities narrative and data and making use of it to influence funding. He outlined the cycle of missed opportunities in insufficient investment in prevention, leading to poor health, resulting in an overdependence on hospital services and acknowledged the influence of the wider determinants of health in this.

Data was presented showing a clear gradient in the rates of hospital episodes by Index of Multiple Deprivations (IMD) quintile, with up to 70% more increase in activity for those in quintile 1. This reflects the challenges that Deep End practices experience. The estimated cost of social inequality for people in this quintile is £2.19 billion, as well as the clear gap in patient outcomes.

Table 1 Number and rate of hospital episodes by admission type

IMD quintile	Elective		Emergency		All	
	Total	Rate*	Total	Rate*	Total	Rate*
Q1 (most deprived)	2 481 014	23 727	2 055 481	19 658	4 536 495	43 385
Q2	2 355 297	22 338	1 706 833	16 188	4 062 130	38 526
Q3	2 310 208	21 811	1 546 013	14 596	3 856 220	36 408
Q4	2 235 779	21 254	1 390 347	13 217	3 626 126	34 472
Q5 (most affluent)	2 095 137	19 804	1 216 063	11 495	3 311 200	31 298
Overall	11 477 435	21 783	7 914 736	15 021	19 392 171	36 804

This table shows the total numbers and rates of hospital episodes split by type of hospital admission and deprivation group. All data are based on hospital episode statistics for year 2011/2012.
*Rate per 100 000 population.
IMD, index of multiple deprivation.

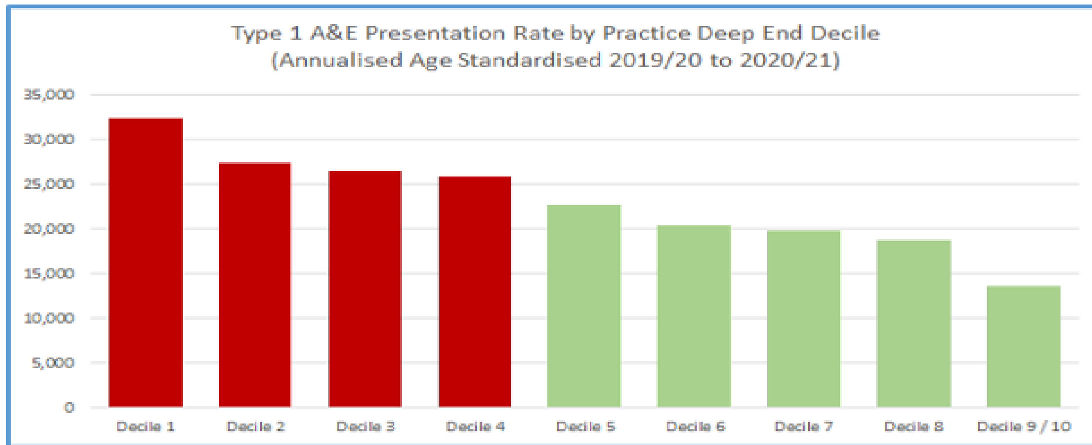
Source: The costs of inequality: whole population modelling study of lifetime inpatient hospital costs in the National Health Service by level of neighbourhood deprivation, Miqdad Asaria, Tim Doran and Richard Cookson

Local analysis has also been undertaken which shows higher A&E attendances, emergency admissions and emergency readmissions for patients in decile 1. The data also shows that there was no definitive pattern observed when looking at this by a practice's deep end status suggesting that socioeconomic factors are the key drivers for this difference, rather than clinical practice or pathways.

The data also shows that the average age of A&E presentations, emergency admissions and readmissions is younger for those patients in decile 1. This reinforces what Deep End Practices have observed; Deep End Practice have a higher proportion of patients who develop health problems earlier and have higher service utilisation, but this burden is not reflected in the way primary care is funded or the way other resources are allocated.

A&E Presentations– All Patients

Decreasing demand for emergency care as the proportion of Deep End Patients declines.



Significantly higher than the regional rate
In line with the regional rate
Significantly lower than the regional rate

The full presentation is available on the NENC website at: Webinar 5 - GPs at the Deep End NENC GPs at the Deep End NENC

4. Discussion on Using Data to Advocate

Key points:

- People who live in the most deprived areas cost health services more and use services more – so the deep end practices who have a higher proportion of these patients have a need of more resources to support them.
- It is not the nature of the practice, but the nature of the patient that determines this pattern of utilisation.
- Can this data help in PCNs when considering resource allocations – allocations should be based on where the need is.
- How can we share this data at a higher level to influence discussions on primary care allocations?
- The data does not show what is appropriate utilisation – however the fact that readmissions are higher does suggest that patients could be more ill.
- More work to be done in the future to incorporate primary care data when possible, and further down the line social care data.
- The data shows why we need a Deep End Network – we are stronger together and can advocate better as a group.

5. Discussion on Deep End Pilot Projects

Group 1 – Key Points

- Issues in identifying buddy practices for the Career Start Fellowship pilot were noted. Discussion around the Fellowships suggested that support with recruitment would be of central importance.
- Collaboration and peer-support was acknowledged as a vital component.
- It was widely agreed having a lead employer for the fellowships would be helpful in creating a simple and consistent employment model. However, being the only Deep End practice in a CCG could create problems with a lead employer.
- Dave Julien suggested bringing practices together to design the Career Start Fellowships so they worked for Deep End practices.
- Two delegates were from practices hosting a Clinical Psychology pilot. They both noted the central importance of mental health in their practice. One had been inspired to take part in the pilot by Nick Hartley and Jonny Coates' presentation at Webinar 4. They both praised the ease of expressing an interest in the pilots.
- Both delegates were keen to hear about the next steps for the pilots. Donna Bradbury provided details and explained that project groups for each pilot would be set up to support practices with implementation and evaluation.
- It was noted that the pilots could be used to advocate for longer-term funding for Deep End practices.

Group 2 – Key Points

- Skill mix and realising access to mental health services was considered limited. The need for the practice psychology input pilot was discussed – there is very wide remit for referral to in house GP which provides a more flexible offer than IAPT.
- Could some of the psychologist role be picked up by lower-level MH support workers? A higher-level practitioner potentially avoids patients being referred later to the wider GP team.
- Barriers to the Fellowship scheme were discussed – limited applicants and recruitment is difficult. Is there an organisation who could hold the sponsorship when recruiting to allow us retain people within the area as it's not feasible for individual practices to do this? How do we make the role more attractive? There is a shortage of skills in this area. People have left/reduced hours because of the pandemic which is putting additional pressure on and it's difficult to recruit to deep end practices.
- Need to consider how we make these posts attractive given the complexity and challenges faced in a deep end practice.
- Value in the practices working together to develop the fellowship scheme for the future.

6. Next Steps

Comments in all the sessions showed practices appreciated the value of the support from coming together as a network to share experiences with similar practices. Further webinars will be organised for the network to come together.

In the discovery interviews with Deep End Practices, it was noted that the biggest challenge for practices working at the deep end as time, and this in kept in mind by the network. The Expression of Interest process for the pilot projects was kept as easy as possible for practices as a result. The network is keen to hear from practices who didn't put forward an expression of interest whether we can do anything differently in the future to encourage more applications.

The break out discussions gave useful feedback on the pilot projects, which will be taken forward when implementation groups are formed. The discussions generated some useful ideas for us to work on for any future rounds of expressions of interest.
The data shared reinforces the instinct of the practices working at the Deep End – that current allocations of resources do not adequately take account of needs of patients from most socioeconomically deprived groups. We will use this data as a starting point to advocate and influence, as well as considering other data that might help demonstrate the Deep End perspective.

Working together and having a cohesive voice to advocate for the Deep End is already making a difference in new initiatives being implemented and data to help us highlight the issues with current resource allocations. We will build on this, with future webinars being an important mechanism to make sure we are addressing the key issues faced by practices in the network.

For further information, queries or comments please contact
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