

News from the Deep End

Issue 1, October 2021

Meet the Team



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Feedback from Webinar 5

Dr Dave Julien

At the end of July the North East and North Cumbria Deep End Network came together for the fifth in our series of webinars. The opportunity to explore and learn together with colleagues who share a passion for the work at the Deep End is always well received and this session was no exception.

Our work program has four key strands: Workforce, Education, Advocacy and Research. The webinar this time around focused our attention on Advocacy.

“Every system is perfectly designed to get the results it gets” (attributed to W. Edwards Deming)

Our key note speaker Professor Edward Kunonga, Director of Population Health Management addressed the question “How can we use data to advocate for change in the Deep End?”.

Edward shared data that demonstrated the impact of deprivation on health care utilisation: people living in the bottom quintile (20%) for deprivation carry a greater burden of poor health for longer, present more (particularly for unplanned care) and incur more cost when compared to people from other quintiles. Their outcomes are worse, living more years in poor health and living less years overall.

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Feedback from Webinar 5 Continued

The key message that emerged from an excellent presentation and the subsequent conversation was that in order to achieve different results the system needed to fundamentally change how it allocated resources. How do we acknowledge the impact of socio economic deprivation on health care utilisation and outcomes? The current system doesn't. It is both socially unjust and financially unwise. It is perfectly designed to get the results that jumped out from the data that was shared.

Edward went on to describe how we can use the data to advocate for change at national, regional and local levels. Perhaps most relevant to those attending the webinar was the discussion about how the data could be used to support conversations about resource allocation within and between Primary Care Networks. What would it look like if resource allocation was weighted based deprivation not just capitation? What would it take to start those conversations? What support could the Deep End network offer?

A key challenge for us going forward is to ensure we are representing the needs of all people living in deprivation: both the 70% registered with the Deep End Practices serving areas of blanket deprivation and the 30% registered with practices serving more mixed populations that include deep pockets of deprivation. Need is need.

A strong Deep End Network has an important part to play advocating for change at all three of the levels described. What we want: more funding, equitably allocated.

Deep End NECN: A Year On

Dr Sameena Hassan

It has been just over a year now since Deep End NENC was established. We wanted to take this opportunity to reflect on what we have achieved and refresh our intentions and motives for our future direction. As one of the more recent joining members of the network it has been useful to look back at the drive to start the network.

My knowledge of Deep End GP started in 2019 coinciding with the inception of Primary Care Networks, when trying to understand how and what values can motivate practices and teams from separate organisations to work together for a common purpose.



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A Year On - Continued

The core team came together with the desire to tackle the inequality and, more importantly the inequity, in health



resourcing they see and work in every day in Primary Care. The ethos of An-eurin Bevan, where every person is entitled to healthcare that is free to access, is strongly held for our communities. However, we see that there is a disparity in what this means in the modern-day NHS and the gaps are ever widening in key areas of work-force, education, advocacy and re-search in places of high deprivation.

These key themes became the adopted acronym, WEAR, to work against. For the purposes of this narration, I am going to start backwards as the roots of the Deep End Network's actions are based on co-design.

Research

The Deep End Network is primarily focussed on general practice but we are so fortunate to have a strong contingent of researchers and academics which let us truly build the network from grassroot GP teams. Taking the approach of co-design and interviewing practitioners in Deep End GP, we were able to understand and pick out key priorities for practices Our initial report on these co-design findings can be read [here](#). We have also had a paper describing 'COVID-19 at the Deep End' published in the International Journal of Environmental Research and Public Health – this can be read for free [here](#). This provides insights into how the pandemic was experienced in areas of high socioeconomic deprivation and why these areas may have had worse outcomes.

Advocacy

The cross organisational approach of academics, NHSE/I colleagues, Public health representation, voluntary and charitable sector enterprises and local councils involved in the steering group has meant we have been able to advocate in the different stratospheres of NHSE and academia. The embedding of NECS business intelligence representation has meant we have access to data which can provide a springboard for practices to advocate for themselves in their networks to enable better resourcing.

Education

We have now successfully held 5 Deep End webinars, held on Wednesday lunchtime to allow a space and time for practices across NENC ICS footprint to discuss, learn and bring forward ideas. The attendance at these events has grown, with 18/35 practices in the most deprived areas attending, hitting our target of 50% of these practices to be engaged in the network.



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A Year On - Continued

Workforce

We know from research that practices in deprived areas find it harder to recruit and have fewer GPs to patient ratios. This was a key theme in the qualitative research and, in particular, mental health needs of patients needed to be addressed. To that end, 3 pilot projects were developed to tackle some of these issues:

- The Deep End Fellowship to increase GP recruitment to these practices, which are traditionally hard to recruit areas.
- An opportunity to host a GP psychologist
- Dedicated funded time to tackle high opioid and gabapentinoid prescribing.

All 3 pilot projects are due to go live with a spread of practices across the network footprint expressing an interest in one or more of the pilot projects.

Where next?

The strengths of the group are to be celebrated and learning shared as wide as possible. Our key focus is the core practices who work in areas of blanket deprivation, however, we are keen to help share resources and learning to enable areas of pocket deprivation. We aim to hold webinars for external stakeholders and interested organisations. Ultimately to be able to shape policy and reframe resourcing into areas of deprivation to redress the inequity we see and face every day.

“This is just the way life is”

Decision density and nursing in the Deep End

Dawn Innes, ANP



Having qualified as a Nurse in 1988, I had a long career in Accident and Emergency nursing before spending the last 14 years in General Practice in the city of Sunderland. I consider myself a highly qualified and experienced nurse whom nothing can intimidate - I can deal with anything thrown at me.

When I was offered a position as head of the nursing service at a large Deep End practice within the same city but different primary care network, I was happy to accept the position. I knew it would be a challenge as it was my understanding

that the practice was Deep End (in an area of social deprivation and health inequality) but this was where I wanted to work: in an area I could put my experience and knowledge to use in the later years of my career.

What I wasn't expecting is **how different** the experience of working in a Deep End practice is.

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“This is just the way life is” - continued

I knew it would be different - but surely not *that* different, as it is only 5 or 6 miles from the practice I was previously working in.

The first thing that struck me was the sheer number of patients living with multiple chronic diseases. Obviously, we work in a health care setting and we are used to seeing patients with chronic diseases and long-term conditions, but it seemed to me that almost every patient I saw has multiple co-morbidities. No matter what I was seeing them for, they all had multiple chronic conditions and there was always polypharmacy to deal with on top of the presenting complaint.

Some of the most vulnerable, socially deprived and least educated population in the area had the most complex medical management plans to follow. How was I to address that, and educate my patients to safely manage their condition, health, polypharma and symptoms – all in the same length of appointment time as in my previous practice where engagement and understanding was much less of a challenge?

What seemed obvious is that this patient population would need more time in appointments, more regular review - but where would we get the resource?

However, it was too much risk to patient, clinician and system to simply discuss and put in a management plan with the expectation that this could and would be followed safely. As head of the nursing service, I was afforded the time to redesign the nursing service to better serve the patient population in this Deep End practice. I did this by writing practice protocols and standard operating procedures for just about all chronic diseases, inclusive of a call, recall and review system tailored to the patient population. I then communicated this throughout the team. This seemed the safest way forward.

This is an organised approach but does not reduce the decision density and complex management decisions around polypharmacy etc, and the issue of safely communicating this information to patients; although as clinicians we are all used to this, what I was not used to was the frequency. This can impact on clinicians as it is exhausting, and can cause an increase in anxiety amongst staff. As such, we set up regular clinical supervision sessions to support the team. This was gratefully received but again takes skill and resource which, as all who work in the Deep End know, is hard to come by. Protected time for chronic disease management review and supervision was even met with some opposition from some admin staff who are continuously under pressure to find appointments; they viewed some of this as reducing usable appointments because although all it is aimed at improving patient care and therefore outcomes, it reduces availability of bookable appointments. More communication and work with the admin teams was required.

The next glaringly obvious thing that struck me was that I would need to change my strategy in engaging patients to self-manage their health needs. It would be no good advising on diet and lifestyle as many patients would not be able to achieve this for a variety of reasons: poor socioeconomic backgrounds and simply not being able to afford to achieve some of these lifestyle measures, as well as struggles with mental health,



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“This is just the way life is” - continued

addiction and alcohol abuse. Sometimes there was just pure acceptance among patients that this is just the way life is, having come from whole families struggling with chronic disease and long-term conditions. It felt like a useless exercise in advising then ticking the box to say you have done so.

I quite simply could not go home at the end of the day feeling satisfied that I had given the information and advice / signposted to digital support, websites etc and therefore can now leave it up to the patient – and I knew that if I felt like this then my whole team felt like this. One strategy is referral to a social prescriber to assess and offer tailored support - a service which will become worth its weight in gold but again requires referral and resource. Many patients will require this plus referral to specialist nursing and medical teams.

This is the tip of the iceberg too. Complex conditions that are difficult for our patients to manage generate frequent unscheduled hospital attendances where the presenting complaint will be dealt with then discharged for the GP to follow up. I was overwhelmed with the number of hospital discharge letters requiring drug changes, follow up bloods, alteration to analgesia, onward referral to other teams etc, again in a population who may not understand these changes themselves – creating sometimes what felt like unmanageable workload.

I learned from my colleagues that they had lost clinical staff in the past because they could not cope with number of patients presenting with such complex conditions on a daily and frequent basis and were much more used to dealing with coughs and colds, rashes and sore throats (which we do also deal with) so they simply left after a very short time. But at the end of the day, I can deal with this, and if I'm honest I am enjoying making these complex clinical decisions. Even if my decision is that this isn't for me to deal with and I need to refer on, it's still a decision and I feel I am contributing and doing some good for the health of patient population. Also, I am supported by a likeminded and very good team – crucial in this environment.

This is a personal experience and not based on evidence or figures .

Research Opportunity for Deep End Practices

I am Yu (Maggie), a Senior Research Fellow at Newcastle University. I am writing to invite you to take part in a research project aiming to understand how lipid management can be optimised for deprived populations.

I am keen to hear your views, needs and challenges in the organisation and delivery of routine lipid management in your practice, in a remote informal chat, up to 45 mins confidentially. I hope to speak to people with different job titles, such as GPs, nurses, pharmacists, social prescribers, consulting clinicians, healthcare assistants and so on (Ethics approval reference: Reference no. 2209/14251, Newcastle University's Research Ethics Committee).

If you are interested in taking part or would like more information, please get in touch with me via phone **07809 759652** or yu.fu@newcastle.ac.uk .

The Deep End Project website has been launched : <https://deependnecn.org/>

The website includes the report from the recent Webinar, presented by Professor Edward Kunonga

