RCGP Health Inequalities Group 29/01/20

Sub- Group ‘Implementing Evidence-based Interventions That Reduce Health Inequalities at Scale’

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‘I fear that over the last ten years or so, despite fantastically good expectations and intentions, we have wasted huge opportunities to learn and we have got to do better in the future’

The sub-group was tasked with exploring the challenges to implementing interventions that reduce health inequalities at scale whilst improving accessibility and availability of good health care in General Practice. This discussion focused on several themes;

What Is The Current Evidence Base?

A House of Commons 2009 report on health inequality\(^1\) concluded that basic research principles must be followed if health inequalities are to be systematically addressed and recommended that future initiatives to tackle health inequalities initiatives must include:

- Piloting;
- randomisation and pairing of controls;
- use of quasi-experimental methods with controls where randomisation would be too costly;
- collection of adequate baseline data; and
- monitoring and measurement of pre-determined health-related outcomes within a set period of time, and in relation to cost

More than a decade on, there is still only limited robust outcome-based evidence demonstrating the effectiveness of interventions in reducing health inequalities. Below we give some examples of research which if implemented at scale would be expected to go at least some way in reducing health inequalities.

Early Years

A focus on early years and prevention is vital because there is evidence that adverse adult health and wellbeing outcomes are firmly rooted in early years experience\(^2\). Experienced GPs who know their patients will recognise this finding from the Dunedin study\(^3\):

“...A segment comprising 22% of the cohort accounted for 36% of the cohort’s injury insurance claims; 40% of excess obese kilograms; 54% of cigarettes smoked; 57% of hospital nights; 66% of welfare benefits; 77% of fatherless child-rearing; 78% of prescription fills; and 81% of criminal convictions. Childhood risks, including poor brain health at three years of age, predicted this segment with large effect sizes”

There are marked social inequalities in the mental wellbeing of pre-school children in Scotland\(^4\) and these inequalities are amplified on starting school\(^5\). There are a number of interventions of proven effectiveness which could potentially reduce these inequalities, including intensive community nursing support\(^6\) and some parenting programmes\(^7\). Nevertheless, early interventions at scale have thus far proved ineffective to date in the UK\(^8\). However, it is very likely that a well-trained and well-resourced health visiting service, working in close collaboration with GPs, would significantly reduce inequalities in early childhood wellbeing, and thus lifetime health inequalities (and use of health care). Multidisciplinary ‘vulnerable child’ meetings, such as those adopted in the SHIP project, could be very valuable and deserve robust evaluation.

Adult interventions

CARE Plus
Multimorbidity is more common and occurs at an earlier age in deprived areas, and both GPs and patients struggle to cope with the complexities of mental, physical and social problems in deprived areas. This is exacerbated by the ongoing existence of the inverse care law, resulting in higher GP stress, low patient enablement and poorer outcomes from clinical encounters. The CARE Plus study demonstrated the feasibility of reversing the inverse care law, by providing longer consultations, relational continuity, and a patient-centred empathic approach in general practice in deprived areas of Glasgow. Outcomes at 12 month demonstrated likely improvements in well-being and cost-effectiveness.10

Deep End Link Workers

Health Scotland commissioned a mixed methods evaluation of the Deep End link Worker Programme, which was carried out by the University of Glasgow. The quasi-experimental design allowed a comparison between practices with and without a link workera. After two years, most practices had only partially implemented the programme and there was no evidence overall of effectiveness in patient outcomes in ‘intention to treat’ analysis. However, per protocol analysis found that patients who saw the link worker at least 3 times engaged more with suggested community resources and had better outcomes at 9 months in terms of quality of life, mental health, and self-reported exercise levels.11

Coincide Study

The Collaborative Interventions for Circulation and Depression (COINCIDE) interventionb was a large RCT that incorporated brief low intensity psychological therapy delivered in partnership with practice nurses in primary care in areas of high deprivation in Manchester. It was found to be cost-effective, and reduced depression and improved self-management in people with mental and physical multimorbidity.

Repeated Non Attendance

People living in deprived areas are more likely than others to miss health care appointments and it is likely that this pattern of low or dysfunctional engagement with care partially mediates the relationship between deprivation and morbidity/mortalityc. Practice as well as patient factors are important in appointment non-attendance and deprived patients registered with practices in affluent areas are most likely to miss appointmentsd. It is therefore likely that practices could learn from each other in terms of improving the engagement of non-attenders, and trials of interventions to reduce non-attendance rates, using ‘hard’ health outcomes may be warranted.

Local Projects

The Deep End approach to address health inequity and reverse the effects of the inverse care law has been outlined in several reports on the DE website and we would recommend that there is a serious attempt to combine core aspects of the DE approach. Govan SHIPb, Pioneer, Community Links Worker, Embedded Financial Worker all had common themes to reduce GP demand, address chaotic use of health services, lift vulnerable families out of poverty, augment the GP advocacy role and a strategic aim to improve standards of collective GP working and embed horizontal accountability between practices within a local primary care system.

One of the key ingredients of Govan SHIP was protected time for GP leadership which is relevant for developing any project and embedding new ways of working in any demographic in Scotland.

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b http://www.sspc.ac.uk/media/Media_587367_smxx.pdf
What Obstacles Do We Need to Overcome?

The Scottish School of Primary Care recently evaluated over 200 primary care transformation projects in Scotland and found the following key themes. Though these are not specific to health inequalities, they are likely to be pertinent to all attempts to scale up interventions.

1. Short-term funding is a double-edged sword. The availability of such funding facilitated the tests of change but the short-term nature impacted negatively on the ability to evaluate effectiveness, forward planning and sustainability and in some cases led to a reluctance to embrace change.

2. Building upon or starting anew? Tests of change that built on previous work and where pre-existing relationships were functional, were implemented more effectively than those that were entirely new.

3. Top down versus bottom up. Tests of change that involved front-line staff in the design of new services and had good project leadership were implemented more effectively that those that were ‘imposed’ from above.

4. Forward planning. Tests of change that had a clear rationale and documentation of the steps taken to develop and implement the project were implemented better, and were more likely to become sustainable in the future.

5. Time to train. Staff training and clinical and managerial management from within GP practices facilitated implementation, but this was challenging due to current workload pressures on GPs and practices.

6. Leadership and governance. National leadership was important in establishing criteria for new roles and responsibilities (e.g. ANPs), but local governance issues regarding clinical supervision, remuneration, and accommodation were also key issues that needed resolving.

7. System, workforce, people. Tests of change with perceived early impacts more commonly targeted all three levels: People (e.g., public information and/or engagement campaigns), Workforce (e.g., capitalised on previous relationships and/or developments and invested in staff engagement, training and support), and System (e.g., dedicated funding and protected staff time).

8. Data and evaluation. Those charged with overseeing the implementation and evaluation of the tests of change expressed a need for support in designing evaluations, in identifying outcome measures, and in establishing systems for collecting data.

Current Barriers to Innovation, Collaboration, Scaling Up

Barriers to integrated working, to address health inequalities and to scale up best practice reduce the accessibility and availability of good general practice. This matters because continuity of care is crucial to better patient outcomes and continuity of care is only possible when a locally embedded GP practice can take time to understand the demography of its patients and work with other colleagues to provide community orientated health care. Recent declines in rural life expectancy may be due to decline in medical continuity.

- Interpretations of the Memorandum of Understanding (MOU) of the new GMS contract can limit the ability of GPs to innovate – new barriers exist to the introduction of novel services led by practices.
- Local best practice in one area is not replicated in other HSCP areas

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6 http://www.sspc.ac.uk/media/Media_645963_smxx.pdf
• Institutional intransigence – lack of meaningful integration between Primary Care and GP, GP and Public Health, GP and Social Care
• Little collaboration between Health Boards that should include Public Health
• GP Independent Contractor Status may make ‘top-down’ innovations more difficult to implement
• Dysfunctional engagement at all levels between systems, with systems and frontline working and with patients and GPs
• Appointment systems may act as barriers to patient access with lower health literacy

Deep End (blanket) deprivation challenges us to provide equitable health care to DE communities but it is also important to recognise that rurality in Scotland also presents specific challenges to community orientated health care. Rural deprivation is very poorly captured by area-based metrics so inequality is more difficult to quantify. Specific difficulties in accessing services may apply in rural areas because of geography and greater levels of medical staff vacancies. Many services simply do not exist in rural areas, and this urban/rural service imbalance may have been exacerbated by implementation of the 2018 GP contract in Scotland which preferentially awarded funding and MDT resource to urban areas.

Solutions
We have suggested some solutions that are achievable in the short term but other solutions are longer term and will dictate the direction of travel for institutional and strategic planners. This is not an exhaustive list and we would expect it to expand when other colleagues input into the discussion.

• Emphasis on relational care which is crucial for continuity of care to encourage patients to engage and continue to attend the GP. Care Plus Study\(^{10}\) emphasis on time enabled that function of GP.
• Commit to funding and evaluation in Scotland that has parity with research funding in NHS England. SSPC should have an enhanced and sustainable budget both for rigorous outcome-based research and for middle ground research\(^{16}\) to support the roll out of meaningful new ways of working.
• There should be a commitment to calculation of cost-per-QALY or similar metrics for all innovations designed to reduce health inequalities. This is essential for evidence-based commissioning and long-term commitment of resources for innovative services.
• Central government to acknowledge that most system change in Primary Care requires 5 years to embed, disseminate and normalise.
• Separation of monies from GP remuneration and new ways of working but GPs should have direct control of the budget within a strict financial framework of governance.
• Address recruitment and retention through local measures. Clusters anticipate when GP vacancies arise to facilitate recruitment in cohort of newly qualified GPs. Scaling up of projects requires GP leadership skills, mentoring for early career GPs.
• Acknowledge economic return on investment as evidence of project value
• Scaling up any workstream must acknowledge that GP capacity is qualitatively different in rural practices and urban practices serving deprived and affluent communities
• Resource for remote and rural and urban separately funded aiming for equity from the patient perspective
• Improve accessibility where there are transport issues.
• Acknowledge that the challenges to seamless service provision and communication between day time and OOH primary care services may require specific solutions to avoid duplication and dysfunctional working practices e.g. OOH palliative care teams to coordinate in hours and OOH palliative care
• Rural proofing and inequality proofing in IT systems
- Engagement with patients and their communities in devising new ways of working

References


