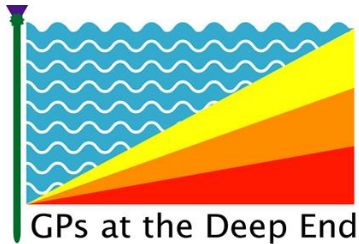

Deep End Report 41

Emergency Medicine at the Deep End

On Tuesday, 12th March 2024, the Deep End GP group co-hosted a hybrid roundtable meeting with the newly created Emergency Medicine at the Deep End Group to explore the challenges faced by Urgent and Emergency care services, understanding that all Emergency Departments are, in essence, at the 'deep end'. Potential ways to mitigate these challenges and better support patients were explored.

July 2024

CONTENTS

Executive Summary

The Challenge

Areas for change

Next steps

Full report

Lessons learned from the deep end

Emergency Medicine at the deep end, where we are and why it matters

The role of RCEM

Areas for change

Where should we focus our attention?

The benefits of a deep end group

Next steps

References

Appendices

Attendees

EXECUTIVE SUMMARY

Hosted by the Scottish Deep End Project, the Emergency Medicine at the Deep End group launched at a hybrid event online and in-person at the Clarice Pears Building in Glasgow on 12th March 2024. Twenty-five health and social care professionals, including emergency physicians and general practitioners from Deep End practices, sat alongside interested individuals from Public Health Scotland, Medics Against Violence and the Navigators programme, Community Links Worker programme, Infectious Diseases, Centre for Sustainable Delivery, University of Edinburgh Centre for Homelessness and Inclusion Health, and Scottish Government. Discussion focussed on the challenges faced in Emergency Departments caring for patients experiencing significant socio-economic deprivation, which drives attendance, colours their experience and affects their outcomes. The discussion focused on how the Emergency Department could mitigate these socio-economic factors and what could be the role of clinicians in advocating for change?

The GPs at the Deep End group have shown that a combination of advocacy and effective intervention, supported by robust research and education, has the potential to improve care for the most vulnerable. With increasing evidence of the impact of social factors in our practice, we believe now is the time for emergency care to develop a similar response.

The Challenge

People experiencing socioeconomic disadvantage have higher rates of emergency attendance across the spectrum of disease severity (1). It is not merely a problem of frequent avoidable attendance (2); the overall disease burden is significantly higher in socioeconomically deprived groups, with resultant high levels of premature, and excess mortality (3). Patients from these groups are more likely to die from critical illness, regardless of severity (4). This issue is pressing and urgent, not a niche special interest, and core to the work of Emergency Medicine. Addressing health inequality and the unmet need that drives people from less affluent backgrounds to access non-emergency care via the Emergency Department (ED) has the potential to both mitigate unjust health inequalities, and reduce the strain on a hospital system in crisis. Whilst many of these solutions will require increased investment and capacity building in primary care, including general practice, social care and the third sector, there are interventions that can be delivered within the ED that can ensure existing inequalities in health and healthcare are not worsened (5).

The Scottish Deep End Project

Since its inception in 2009 the Scottish Deep End Project, a group of GPs from the 100 most socio-economically deprived practices in Scotland, have made significant headway in raising the profile of inclusion health in general practice and have had a number of successes. Their activities have been targeted towards Workforce, Education, Advocacy and Research. Importantly, the model has been adopted internationally, with 16 Deep End groups operating in 7 countries. We propose that there would be benefit in adopting a similar approach in emergency care, and in working collaboratively alongside them (6).

> *"The Inverse Care Law is not an immutable fact of life"*

The Inverse Care Law describes how the availability of good medical care tends to vary inversely with the need for it in the population served (7); and efforts to mitigate these effects have been core to the work of the Deep End projects. The group recognises that the Inverse Care Law extends to the provision of emergency care, and that in Emergency Medicine, regardless of where we work, we are all at the 'Deep End' because of the breadth of the populations that we serve, and the fact that ED use is highly socially patterned.

Areas for Change

Intervention

Policy in emergency care has focussed on demand management, a strategy that has been established as ineffective (8). Promoting an understanding of "unmet need" rather than "demand" better represents the reality of people who don't choose to be in hospital, but attend because their needs aren't met elsewhere.

Social interventions in the ED do exist, as demonstrated through initiatives such as the Navigator's programme (9). However, more work is required to sustainably integrate these programmes into emergency care, providing support at what might be an important, reachable moment for our patients, and making links to existing social supports in the community.

Research

While higher rates of ED use amongst communities experiencing the greatest deprivation is likely due to a complex combination of barriers to healthcare access elsewhere (e.g. Primary Care) and a higher burden of illness, more work is required to identify patterns of attendance and areas of intervention for marginalised groups. Research into what drives these findings could help to target effective change.

Advocacy

The Scottish Deep End Project has effectively campaigned for recognition of the impact of social deprivation on the delivery of general practice. It is crucial that we are able to follow this example and effectively lobby for meaningful change at a government and policy level, including sharing experience and perspective to influence public opinion. Inclusion in, and collaboration with, groups and forums such as the British Medical Association, Royal Colleges, and all levels of government has allowed the Deep End project to disseminate the message, influence policy and contribute to meaningful change. The group has effectively harnessed media training to present their message more widely, which may be a helpful example for Emergency Medicine at the Deep End.

It was recognised that advocacy is required within Emergency Departments too. With evidence of socio-economic deprivation being an independent risk factor in acute and critical illness, work is required to better mitigate these harms more proactively and robustly consider the social environments to which we may discharge our patients.

Education

Participants were in agreement that inclusion health needs far more visibility within education and training at all levels. This should include greater understanding of health equity, the social determinants of disease and training in trauma informed care.

Next Steps

Challenges in implementing meaningful change at pace were understood across the attendees. However, the success, perseverance and collective voice of the Deep End projects has provided an example of what might also be possible in emergency care.

The immediate next steps identified for the project were:

Defining the Challenge
The next meeting of Emergency Medicine at the Deep End will be in the afternoon of Thursday 20th June on the theme of "Defining the Challenge". The aim will be to widen the network, canvass the opinions of clinicians in emergency care across sites and interests, to define the challenges posed by health inequalities, and to focus the ongoing work of the group.

Develop Research Portfolio
Work is already in progress to evaluate the impact of social intervention in the Emergency Department. Further projects, using the breadth of experience within the group and with collaborators, will be pursued.

Improving Intervention
Connections made during the launch meeting have facilitated discussion and collaboration in social intervention in emergency care and in the community (such as community link workers). Continued work will seek to improve these links, whilst recognising the need to grow capacity.

Integrate with Policy
There was a recognition that policy must acknowledge the needs of the most vulnerable groups presenting to emergency care. Working with Scottish Government to identify areas of policy the group may be able to contribute to, as well as collaboration with the Centre for Sustainable Delivery, where the group may lend its understanding to mitigate the effects of the Inverse Care Law in emergency care.

Providing a Toolkit
The meeting noted the success of groups such as 'Green ED' in raising the profile of environmental issues while also providing a practical toolkit for Emergency Departments to engage in change. This strategy may serve as an example for Emergency Medicine at the Deep End.

Education & Training Opportunities
Improving education and training opportunities in inclusion health at both undergraduate, and postgraduate level. With a focus on developing an 'Introduction to Inclusion Health' training day for speciality Emergency Medicine trainees, as well as local induction resources and ongoing CPD opportunities.

FULL REPORT

The meeting commenced with three short presentations, “Lessons from the Deep End movement”; “Emergency Medicine at the Deep End: Where we are and why it matters” and “What can the Royal College of Emergency Medicine do?”

Lessons learned from the Deep End movement

Since its inception in 2009 the Scottish Deep End Project, a group of GPs from the 100 most deprived practices in Scotland, has made significant headway in raising the profile of inclusion health in general practice and have had a number of significant successes. These include establishing an identity and a voice to call for change, creating a body of evidence and developing interventions such as Community Links Workers, Welfare Advisors (both of which started as DE pilots), Care Plus, Govan SHIP, Pioneer Scheme and Alcohol nurses. They have increased understanding within the profession of the challenges faced when working within communities experiencing poverty and have campaigned and lobbied outside the profession for these issues to be addressed. They have shown the realities and impacts of the Inverse Care Law, that access to medical care is most poor for those who need care most, as described by Julian Tudor Hart. The practices in the most deprived quintile of the Scottish Index of Multiple Deprivation have higher mortality within their populations, greater proportions of patients with comorbidities, more consultations per 1000 patients registered and less deprivation-weighted funding per patient.

Examples were shared of the specific issues more commonly affecting DE communities, including:

- Unemployment / Benefits sanctions / Cuts to services
- Drugs and alcohol
- Child protection / Vulnerable adults
- Higher NCD prevalence (cancer, resp/heart/liver disease, obesity)
- Migrant health
- Reduced (healthy) life expectancy
- Bereavement

and the issues more commonly found in DE encounters:

- Premature multimorbidity
- Mental and physical illnesses
- Social complexity
- More problems to discuss
- Higher consultation rates
- Shorter consultations
- Lower patient enablement
- Worse health outcomes
- Higher GP stress
- Weak interfaces

Finally, when considering what is the role of general practice in mitigating health inequalities - five key principles were outlined:

- Involving coordinated services across the system (i.e. connected)
- Accounting for differences within patient groups (i.e. intersectional)
- Making allowances for different patient needs and preferences (i.e. flexible)
- Integrating patient worldviews and cultural references (i.e. inclusive)
- Engaging communities with service design and delivery (i.e. community-centred).

Take-home messages:

- More determinants of health (and health inequalities) lie outside healthcare but the distribution of healthcare resource is an important and under-recognised factor.
- General practice teams can improve their response to social determinants of health, at multiple levels (e.g. trauma-informed care, MDT working community engagement, teaching/training, advocacy, designing systems that are flexible, inclusive and 'sticky').
- Improving volume, quality, and consistency of care where needs are greatest will mitigate health inequalities.

Emergency Medicine at the Deep End: Where We Are and Why It Matters

Emergency attendances are socially patterned; people living in communities experiencing high levels of deprivation are twice as likely to present to the Emergency Department, across the spectrum of illness (1). The experience of emergency care is also influenced by socioeconomic status; with individuals from more deprived areas more likely to experience extremely long waits to admission, and to have poorer outcomes following emergency and critical care (4,10).

We know that Emergency Departments might provide the only route of access to care for some. We observe disproportionate attendance rates from those living in areas of high socioeconomic deprivation, especially when looking at those who self-present to the department. Individuals from the most deprived communities are more likely to present to Emergency Departments, but this effect reduces the greater distance from care people live (i.e. more rural & remote). It is unclear to what extent these rural populations are accessing care elsewhere, or whether they are not accessing care at all, and are 'missing' from services. That access to 'in-hours' primary care e.g. general practice or other health services, can be challenging is further evidenced by findings that individuals from areas of increased deprivation tend to present to the Emergency Department 'out of hours' (11).

We know that individuals experiencing high levels of deprivation carry a higher burden of disease, therefore they are more likely to become acutely unwell. They are more likely to present to an ED for care, and once there, have worse experiences (including long waits to be seen (12) and admitted (4)) and have worse outcomes (higher rates of adverse events and excess mortality). Whilst we have observed and measured these discrepancies, only some of the reasons for these inequalities are understood, with more research required into the healthcare health inequalities we have observed.

The Role of RCEM

The VP of The Royal College of Emergency Medicine (RCEM) in Scotland is supportive of the EM at the DE Group and is engaged with the realities and challenges of health inequalities and their impact on Emergency Medicine. RCEM has a platform that allows it to amplify messaging and to direct people towards the Emergency Medicine at the Deep End Group. They have regular meetings with the Scottish Government, as well as across the UK, and can lobby on specific issues. They also have the opportunity to influence training which could be leveraged to promote better understanding of health inequality and inclusion health issues within the Emergency Medicine curriculum.

Areas for Change

Intervention

- Routine signposting by clinicians to available social supports
- Bolstering of the Navigator model and workforce
- Closer collaboration with Community Link Workers in general practice
- Proactive identification of unmet social needs
- Use of new technology

Research Priorities and Knowledge Gaps

- Understanding the reasons for ED as first-port-of-call usage for all healthcare needs by more marginalised groups

Advocacy

- Raising awareness around the need for more equitable healthcare provision
- Care with use of language that is recognised to be stigmatising
- Improving ‘permeability’ of, and ‘stickiness’ of services
- Considering ways to effectively lobby organisations, Scottish Government etc.
- Convincing the profession of the importance of an inclusion health approach
- Collaborating, connecting and influencing (e.g. professional organisations, politics and policy)

Education

- Trauma informed and culturally competent

The Benefits of a Deep End Group

- Hope is important
- Collectivism and perseverance
- Motivating and mobilising people
- Collaboration
- Find your allies – and work collaboratively
- Consider who is missing from the conversation?
- Enabling culture change

Where could we focus our attention?

- Consider a ‘suite’ of resources to support EDs to implement practical steps
- National Improvement Work
- Raise awareness/share information across the system of those with more complex needs (e.g. Utilising conferences etc/other routes)
- Create a network to connect colleagues, and showcase examples of best practice at NHS/RCEM conferences etc

Intervention

Signposting patients to social support
Navigators
The work of Navigators was recognised to be crucial, with their experience of being created to look at violence and quickly realising that violence is one symptom of the problem among many, being shared. It is of huge value to have people who are experts by experience in our departments and able to relate to patients at reachable moments.

“We have people working in our ED who suffered (psychological) trauma. He has two children who will never have the life he had. It breaks the intergenerational trauma.”

It was acknowledged that the follow up rate is much better when Navigators meet people in person while they are in the department rather than receiving written referrals to follow up after discharge from the department. What can be done to improve this? How can we ensure that there is a “warm handover” and to mitigate against the distrust of the system that is so common?

Participants also emphasised the importance of there being knowledge and systems in place in departments around access to emergency social support such as how to access transport vouchers, food packages, fuel vouchers and other essentials. This is another area where the work of the Navigators is of great value.

Closer collaboration with practice-based CLWs
There is openness to referrals from ED to practice-based Community Link Workers and it was highlighted that Navigators and CLW’s have had crossover and collaboration in the past but less recently. Participants thought that it would be beneficial to have further discussions around how to optimise which patients are referred where and how.

It was acknowledged that CLWs have capacity issues, with some practices and areas being more stretched than others. Any potential increase in workload would have to be supported and enabled through the growth of the workforces. Participants suggested starting to build a case for how CLWs could support patients following ED attendances and gather data to support funding for this. It may be helpful to have accessible lists of CLW contacts for each practice in Emergency Departments.

Identifying unmet need
Participants considered whether there are ways that we could better identify patients in need of additional social support. It was proposed that an amalgamation of existing data might be used such as GP practice, postcode, reason for attendance, number of previous attendances. Could this then be used as a trigger for referral for social support?

Specific support for asylum seekers and refugees to understand NHS systems was also identified as a way of improving health equity.

New technology
Information was shared about an app that is being developed in Lothian to enable clinicians in the health service who have identified unmet social needs to link with third sector organisations who could help. This work is currently focused on the point of hospital discharge but gives an example of potential uses of technology to optimise existing social supports.

Research Priorities and Knowledge Gaps:

Understanding the reasons for ED as first-port-of-call usage by marginalised groups
It was recognised by participants that we don't fully understand why ED use and particularly OOH ED use is higher amongst individuals coming from less affluent backgrounds. Building a better understanding of this phenomenon could both strengthen the case and create the solutions for people to be seen more appropriately or more timeously in another part of the system (e.g. general practice.)

Several suggestions were put forward as to factors that may drive ED/OOH usage. These included access to transport, insecure employment and fear that taking time off work might lead to financial consequences or redundancy. The participants considered the impact that difficulty getting GP appointments in hours may have, as well as the potential that people may be struggling to register with a GP due to closed lists and other barriers to registration. Understanding these driving factors will be key to reducing the unmet need that leads people to Emergency Departments, when they could have their care needs met more appropriately in another part of the system (eg general practice) where there is also the opportunity for follow -up, relational continuity of care, and coordination of care.

Information about the DE resource 'Supporting registration with a general practice' document was shared. This is available on the DE website and may be helpful in supporting and empowering people who present to the Emergency Department who are not yet registered with a GP.

Participants agreed that it would be helpful to gather qualitative data from patients, for example finding out why they haven't been able to register with a GP.

Advocacy

Raising awareness around more equitable healthcare provision
Inverse Care Law in general practice was described highlighting that practices in more deprived areas are significantly under-resourced when weighted for need and often have smaller workforces. This then impacts on the rest of the system and reduces our ability to take a more proactive approach to health protection and improvement.

Similar is seen with emergency care provision, with critical care units in more deprived areas experiencing greater pressures than those in more affluent areas. With patients from backgrounds of higher socioeconomic deprivation having higher social complexity and a greater burden of disease and higher mortality, these patients contribute to the workload of all Emergency Departments. This is not a niche special interest but at the core of Emergency Medicine. It is relevant to every Emergency Department, to improve access to care for the most vulnerable, to improve health, and to reduce the unmet need that drives people to our waiting rooms and resuscitation rooms.

"The way we have set up hospital services in Scotland just are entirely inequitable"

An example was shared from Edinburgh's Outpatient Antibiotic Treatment (OPAT) service where they had established an award-winning service but when they analysed the data it was shown that their patients were predominantly coming from more affluent areas. This prompted work to refocus the service, resulting in a targeted programme to support people with severe injection-related infection. How can we better use data to redirect services that drift towards serving only the most affluent and make sure that care is available to all those who need it? It was suggested that we should routinely analyse and evaluate services by deprivation so that we can better understand who is using (and who is missing from) services - and mitigate accordingly.

Participants discussed other aspects of the health service where the service-provision could be better matched to the needs of the population. An example of the age threshold for access to specialist geriatric/frailty care being 75 when the life expectancy in populations from areas with the highest levels of deprivation is significantly below this was discussed. People living in the most deprived areas of Scotland develop the diseases of 'old age' around 10-15 years earlier than their affluent counterparts (13). Would the use of biological age rather than chronological age thresholds have the potential to improve equity of access to care? Similarly, it has been well recognised that the average person experiencing homelessness is in their mid-forties with the comorbidities and health of someone in their mid-eighties. What impact could services akin to geriatric care to "wrap around' a person experiencing homelessness when they are admitted to hospital have?

It was also highlighted that although deprivation and social circumstances have an impact on risk, they are rarely captured in decision making tools in Emergency Medicine. Could we better consider where we are discharging people to in our decision making around safe discharge?

Care with use of language
Participants agreed that moving towards using the phrase "unmet need" instead of "demand" and encouraging others to do the same is important in reframing the conversation. It was highlighted that *no-one wants to be in hospital, they are there because their needs are not being met (and not because they are demanding).* This could help mitigate against attitudes that place blame on patients or are stigmatising.

Improving 'permeability' of services
The importance of understanding candidacy theory was also discussed, whereby we make people feel like they 'deserve', and 'are candidates for' care. The challenge is that currently *"Healthcare systems are designed by healthy people for use by healthy people"* and this impacts how easily they can be accessed by those who need them.

Considering ways to effectively lobby
Some change is achievable within Emergency Departments, some will require collaboration with other bodies and other elements of the health and social care system, however it is crucial that we are able to effectively lobby for wider change at a government level. This will include sharing our experiences and perspectives to influence and harness public opinion. The Deep End GP group engage in a wide range of influencing and lobbying activity: they organise MSP visits to general practices and have met with successive Cabinet Secretaries for Health and Social Care. They selectively engage in media work (social media, radio, television and print) to raise concerns and explain the context of inclusion health issues, with several members having had formal media training. They have raised a petition in Parliament about the threats to the Community Link Worker workforce; they use anonymised case studies and patient journeys to "speak what we see". Several Deep End GPs are now involved in related policy work within Scottish Government. The EM at the Deep End group may wish to consider some of these options and there has already been contact with journalists around EM at the Deep End project.

Convincing the profession of the importance of an inclusion health approach
Concerns were shared that colleagues are often from affluent backgrounds and don't see reducing health inequalities as part of their job. Although being from an affluent (or privileged) background does not always correspond with a lack of interest in the social determinants of health, it often correlates with a poorer understanding of the pressures, stressors and complexity that are routinely experienced by patients from other communities. There was a lot of discussion about the challenges we experienced about how to win hearts and minds about this issue. On the other side of the coin however, it was also suggested that perhaps Emergency Medicine doctors are a more socio-economically diverse group than doctors as a whole. Does that make them more invested/interested in this? Many view it as important and want to 'shape the world'. It was recognised that interest appears to be growing and there may be many who are not outspoken about their interest because of lack of opportunity. The importance of influencing and encouraging doctors early in their careers when people tend to be more interested and motivated around issues of justice was also discussed.

Getting this right could mean reducing workload in the ED, which would likely be a key motivating factor for many staff (14).

The example of the Deep End Govan SHIP project, which brought £1 million of investment into deprived-areas general practice, was discussed in terms of what can happen when additional resources create headspace and interprofessional relationship building. This offered a new way of working which is motivating for teams. Participants also reflected on the motivation brought about by the successful Community Links Worker lobbying strategy recently undertaken by the DE which saw the funding being committed for a further two years.

Although the Deep End group has made significant strides in increasing awareness of inclusion health, 'winning hearts and minds' across the wider general practice profession is still very much a work in progress. They advised that it is important to find areas of common ground with professional organisations such as the BMA and Royal Colleges as they have different circles of influence and change can take a lot of time. Participants agreed that we need to emphasise that *"addressing health inequalities is everyone's role. It is core NHS work, not a special interest topic."*

Infiltrating and influencing

Being creative and innovative in expanding our circles of influence was discussed. Examples of the BMA, Scottish Government, and Colleges were highlighted as forums that the Deep End GP group have collaborated with in order to get the message heard and maximise the levers in the systems. The success of the 'Green ED' from the RCEM Environmental Sustainability group in raising its profile and having a coherent toolkit to help departments implement change was highlighted.

The upcoming RCEM conference was suggested as a forum that could be used to raise awareness of upcoming work.

Education

Participants were in agreement that inclusion health needs far more visibility within education and training at all levels.

The Deep End GP group is already working to improve undergraduate medical experience, postgraduate GP training and CPD opportunities. There is still an over-reliance on having had the opportunity to train in a Deep End Practice in order to gain experience and confidence, but things are improving with undergraduate and postgraduate conferences, and some areas adopting curriculum changes. Ideally, we would be able to maintain and sustain the empathy and desire for social justice that medical students often have when they first enter medical school.

Within Emergency Medicine, knowledge and understanding of inclusion health and health inequalities is low despite the impact that it has on the patients presenting to our departments. For example, one participant had observed that some of their colleagues did not know what "SIMD" was. Participants emphasised the importance of role modelling and encouraging other clinicians to consider social determinants of health. Examples of situations where individuals use the Scottish Index of Multiple Deprivation (SIMD) to highlight this were shared, for example routine inclusion of this information when students are asked to present cases and when

clinicians are presenting morbidity and mortality (M&M) cases. Routine inclusion of this information in assessing risk and making clinical decisions was also discussed.

Participants agreed that information from the Scottish Ambulance Service is crucial as they have often been in the patient's home so can give a great deal of insight into home circumstances. Giving space for this and proactively seeking this information from them is recognised to be helpful.

Fellowship opportunities were discussed, as there was recognition that the GP “Pioneer Scheme” health inequalities fellowships were of value. Could we have a fellowship within ED? It would be important that this did not propagate the misperception that health inequalities is a ‘niche topic’ and so routine inclusion of inclusion health in undergraduate and postgraduate training needs to also happen in parallel.

Regarding departmental induction, it was expressed that often more junior trainees don’t have a clear understanding of the geography and demographics of the area that they are working in; could an explanation of the local area at induction help staff understand where patients are coming from and what that might mean? Could we go one step further and consider a formal ‘walk-about’ of the local area to aid understanding, as well as meeting with local third sector groups.
The value of trainee case study write ups and reflections on inclusion health issues was also discussed. Participants agreed that inclusion health, health inequalities and the social determinants of disease should be better represented in the RCEM curriculum.

Trauma-informed and culturally competent services
Increasing understanding of trauma-informed care amongst the ED workforce was thought to be important and there may be benefit to embedding this into policy. It was considered that in practice this may help with moving from exclusion from ED to “exclusion prevention”

As migrant health needs increasingly form part of our workload it is recognised that staff in Emergency Departments and all aspects of health care have to develop greater cultural competence in order to avoid creating barriers to people seeking healthcare.

The Benefits of a Deep End Group

“it is better to start where you are and do what you can, when you can” - Andrea Williamson

Hope is important
The participants proposed that engaging with issues of health inequality and making efforts to influence “upstream” issues could offer hope and relief from moral injury for those working in Emergency Medicine. It was thought to be motivating to be able to make more of a difference and not just offer a sticking plaster, particularly when working alongside like-minded colleagues. It was felt that this might reduce burnout (14).

Motivating and mobilising people
Having a 'collective voice' and perseverance was recognised as an important element of the success of the Deep End. Participants reflected that this had raised its profile and exposure. The group can be a vital support for difficult work and at times of particular professional challenges. The ability to opt in and out of the DE commitments as personal capacity allows while the rest of the group maintains momentum was highlighted as a crucial piece. The DE GP participants reported that they know that they can rely on each other.

Collaboration with others was noted to be helpful in finding ways of articulating what we see on the frontline of health services and maintaining the sense of advocacy and social justice that we often feel more strongly early in our careers.

Collaboration: Find your allies – and work collaboratively
The importance of collaboration was agreed by all participants. This was demonstrated both by the previously mentioned success and collective momentum that the Deep End GP group has experienced and by contrast the difficulty that has been experienced in Emergency Medicine circles in trying to raise awareness of these issues without finding other interested and like-minded people. The benefit of collaboration across specialties and between professions was also emphasised.

It was considered that it might be helpful to explore what issues are internal to Emergency Medicine and what are across the front door of hospital and acute services that would benefit from a wider approach. It was also recognised to be necessary to consider where changes in the systems that interface most commonly with our departments affects other parts, for example NHS24, SAS, GP OOH, GP in hours and the police.

Within Emergency Medicine it is likely that those doing frequent attender work in each department and consultants linked in with drug-related deaths work would be potential allies in this work.

Consider who is missing from the conversation?
Importantly, participants recognised a lack of representation from the Ambulance services at the roundtable discussion. As previously mentioned, they go into people's homes, so they have a unique understanding of the patient's background, and the people around them. Future conversations would aim to include them.

Where could we focus our attention?

Consider a 'suite' of resources to support EDs to implement practical steps
Participants were very aware that health inequalities can feel like an insurmountable, overwhelming topic. The encouragement was shared to consider what can be done in practical terms?

- Team training, team roles
- Consider how services are designed and delivered
- Consider how data is collected and used

- Consider practical advocacy and influence

This could potentially be developed into a toolkit, akin to the “green ED toolkit” to support departments in making practical changes to move towards greater health equity.

National Improvement Work
Currently there are a number of local projects happening in different parts of the country. Some of these would be beneficial to scale up nationally. It would be possible to look at national data with a health equity focus and the Centre for Sustainable Delivery would be keen to contribute to this.

Raise awareness/share information across the system of those with more complex needs
Participants discussed optimising the use of existing IT systems to raise awareness about patients who have complex social situations and circumstances that it would be helpful to bring into decision making. Examples of the use of the Key Information Summary (KIS) were shared as a means of electronically and securely sharing specific patient information from general practice IT systems across the interfaces of care for example to Emergency Medicine departments, or to the GP Out of Hours service. It was also recognised that the functionality of KIS is very limited as the information in a KIS can only be created and edited within general practices. The KIS also disappears from the general practice clinical record if a patient moves practice. This is particularly problematic for patients who may be moving around a lot.

Information from Lothian around frequent attender work and care planning was discussed. Information on patients who were attending frequently was used to identify unmet needs and to target social intervention.

Centre for Sustainable Delivery is currently undertaking significant Anticipatory Care Planning work and participants discussed the possibility of an inclusion health focus or aspect to this work.

Next Steps

Challenges in implementing meaningful change at pace were understood across the attendees. However, the success, perseverance and collective voice of the Deep End projects has provided an example of what might be possible in emergency care.

The immediate next steps identified for the project were:

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APPENDIX ONE

Co-chairs

David Blane (Academic Lead - Deep End)
Joanna Quinn (Scottish Clinical Leadership Fellow, ED ST6).

Present

Ryan McHenry – *Emergency Medicine Registrar and Clinical Research Fellow*
Lynda Fenton – *Consultant in Public Health, Public Health Scotland*
Elspeth Strang – *GP and Scottish Clinical Leadership Fellow*
Dave Chung – *Emergency Medicine Consultant, NHS Ayrshire and Arran*
Scott Diamond – *Medics Against Violence (Navigators) and Paramedic with Scottish Ambulance Service*
Michele Open – *Emergency Medicine Consultant, NHS Lothian*
Colette Mason – *Community Links Worker Glasgow Program Manager*
Claire McIntosh – *Infectious Disease Consultant, Associate Medical Director for Medicine WGH, NHS Lothian*
Christine Goodhall – *Prof of Oral Surgery and Violence Reduction, Founder of Medics Against Violence (Navigators)*
Cath Aspden – *Emergency Medicine Consultant, NHS Greater Glasgow and Clyde*
Sian Tucker – *Senior Advisor to Scottish Government Primary Care Out of Hours and Urgent Care, Deputy Medical Director of National Services Scotland*
Andrea Williamson – *Prof General Practice and Inclusion Health, Founding member of GPs at the Deep End*
Richard Lowrie – *University of Edinburgh Centre for Homelessness and Inclusion Health, formally involved with PHOENIx*
Annette Cosgrove – *Emergency Department Senior Charge Nurse, NHS Lothian*
Marion Campbell – *Emergency Medicine Consultant, NHS Lanarkshire*
John-Paul Loughrey – *Vice President (Scotland) Royal College of Emergency Medicine*
Richard Stevenson – *Emergency Medicine Consultant, NHS Greater Glasgow and Clyde*
Sile MacGlone - *Emergency Medicine Consultant, NHS Greater Glasgow and Clyde*
John Montgomery – *GP, Founding member of GPs at the Deep End, Clinical Lead for Govan SHIP project*
Andrea Jamieson – *National Associate Director, Urgent and Unscheduled Care, Centre for Sustainable Delivery*
Andy Hall – *Urgent and Unscheduled Care, Centre for Sustainable Delivery*
Jessica Milne – *Scottish Government Unscheduled Care Policy Lead*
Neil Dignon - *Emergency Medicine Consultant, NHS Greater Glasgow and Clyde and EMRS*

Apologies

Cian Lombard