GENERAL PRACTITIONERS AT THE DEEP END INTERNATIONAL BULLETIN NO 8 DECEMBER 2022

Tie yourself as deeply as possible to the things you love.
It's the deep love you have for something that feeds you
with energy, hope, imagination and creativity.
Nicola Benedetti, Director of the Edinburgh International Festival

Welcome to the 8th Deep End International Bulletin – another bumper issue with 64 pages of experience and views from 14 Deep End Projects in eight countries at various stages of development. A big thankyou to the 30 colleagues who have contributed.

You will find lots of energy, hope, imagination and creativity in these pages – exhausting to read in one go, so the Bulletin can be considered in three parts.

Part One (Pages 4-22) comprises 5 general articles, beginning with a Cost-of-Living review by Tom Ratcliffe (Page 4), which in the UK could not be more topical or important, followed by articles from New Zealand, Scotland and Belgium.

Part Two (Pages 23-40) includes contributions from 7 Deep End Projects which are new or recently starting up – be impressed by their range and energy. Part Three (Pages 41-64) includes reports from 7 established Deep End Projects which continue to expand and impress. Collectively we have an international Deep End Movement.

It has become something of a routine to record two new Deep End Projects in successive editions of the Bulletin and this edition is no exception. Welcome to Deep End Cheshire and Mersey and Deep End Wales. We await their logos with interest.

There is a new Deep End logo from Cornwall, highlighting a tin mine and the black and white of the flag of Saint Piran, the Standard of Cornwall.

Deep End Cornwall involves a small network of local general practitioners, while Deep End Denmark is the first project to start on a national basis with the support of national institutions. November saw the inaugural meetings of Deep End Cheshire and Mersey (Page 30) and Deep End Wales (Page 36), so that there is now hardly any corner of the UK without a Deep End Project. We look forward to developments in all these starting projects.

The meeting of Deep End Wales included Julian Tudor Hart's former practice at Glyncorrwg. Felicity Goodyear-Smith, Professor of General Practice at the University of Auckland in New Zealand, visited the Glyncorrwg practice early in her career, with long lasting effect, as she describes (Page7) a primary care research network in Pacific Island Communities. In her part of the world, the equivalent of the Deep End swimming pool metaphor is "*Swimming Beyond the Reef.*"

A historical feature of such communities was their deep knowledge of tides and currents which enabled them to travel long distances on open sea. On Page 11 Lesley Morrison describes her recent book *"The Wellbeing Toolkit for Doctors"* with many examples of the deep knowledge and experience of general practitioners.

Finally, please note that he Deep End London logo has been revised to include the course of the river Thames.

Graham Watt graham.watt@glasgow.ac.uk **December 2022**

And a Merry Christmas and Prosperous New Year to all
Christmas cards by Orson Welles

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THE 2022 COST OF LIVING CRISIS: A MATTER OF LIFE AND DEATH

This will be a bleak winter.

Even after the Government's huge intervention to help pay for increased energy bills, one in four of the population will face fuel poverty. That is a total of 6.7 million households. (1)

And we are starting from a bad place. At the beginning of 2022, 22% of people in the UK were living in poverty. Millions of people, including 500,000 children, had experienced destitution in the preceding 12 months prior to the pandemic. This is the severest form of poverty where people do not have the money to pay for shelter, food, heat and clothing – and it is thought to be getting worse. Rates of poverty affecting children and older people have risen over the last decade.

The Joseph Rowntree Foundation have highlighted changes to the benefits system that have made things worse. Most recently, removal of the £20 Universal Credit uplift. Over the last decade: the two child limit in income related benefits, the benefit cap, frozen local housing benefit rates and a five week wait for universal credit provision. (2) Looking at the poorest households, 47% of their net income is spent on housing, food, fuel, heating and clothing. And this was before the high levels of inflation we are currently experiencing (2).

One in three of the poorest one fifth households have less than £250 of cash available to them, meaning they have no capacity to absorb additional costs, emergency / unexpected expenses or, indeed, rising prices. The same households currently have negative disposable income to the tune of £60 per month (3).

It is terrifying to contemplate the possibility of working age benefit cuts, which, at the time of writing, are not being ruled out by policy-makers. Those in power need to ask a simple question: if they do this, how will people who already have less than no money survive?

I work as a GP in an area of West Yorkshire that experiences high levels of poverty and socioeconomic deprivation. Patients coming to the practice for help are more stressed than I have ever seen before. And looking at the above statistics it is not hard to understand why.

The same stories are commonplace:

- People missing meals on a daily basis to make ends meet or prioritise feeding their children

- People sitting huddled on the sofa in blankets because they can't afford to turn on the heating (and it is only September)
- People missing their medications because they can't afford prescription fees (I saw a patient last week who narrowly avoided hospital admission for Asthma because he'd run out of inhalers and was waiting until payday before he could cover the cost of his next prescription)
- Burnt out parents who drop their children off with their grandparents, work a 10-12 hour nightshift, come home, drop the kids at school, and try and grab a few hours of sleep before repeating the same routine day in day out and still barely make ends meet
- Public sector workers who, on the face of it, you would expect to have decent incomes but who have to rely on foodbanks to get through the week
- People struggling in dangerous, stressful and/or harmful work environments, with cash strapped business squeezing more and more out of precariously employed workers who have little bargaining power

So, why is this a matter of life and death?

Good housing that is free from cold and damp, secure meaningful employment with adequate household income and access to healthy food are all key social determinants of health. Rising poverty, stress and destitution will all feed through to poorer health and widening health inequalities.

The health gap had already been growing before both the Covid-19 pandemic and the current cost living crisis. Men in the poorest areas of the UK live almost 8 years less than men in the most affluent areas. Women in the poorest areas of the UK live 6 years less than women in the most affluent areas and, for the women in the 10% most deprived neighbourhoods, their life expectancy is actually falling. Comparing rich and poor areas, the difference in healthy life expectancy is as great as 18 years, averaging out at around 12 years across the country. (4)

At times like these we need to be able to fall back on public services but look at the state of these after 10 years of budget cuts and/or inadequate funding. Where I work, our health centre roof regularly leaks and our local hospitals' roof is held up by metal supports. Across the NHS, waits for outpatient care are enormous and ambulance delays are commonplace. In the last 12 months, I have had to personally drive three critically ill patients to hospital because we could not get an ambulance to them in time. Social care is on its knees, schools are struggling to catch up on children's education post-Covid, the criminal justice system is in disarray and public transport systems are paralysed by strikes and a lack of longterm investment. Again, the possibility of further budget cuts at his moment, and a second round of austerity, is unimaginable.

In the short term, over the winter of 2022/23, poverty will have an immediate health impact. More children will end up in hospital with respiratory illness (children living in the poorest areas already have rates of emergency hospital attendances and chronic illness that are 60% higher than children in wealthier areas). Rates of acute cardiovascular and respiratory disease in adults, especially older people, will rise. Mental health problems will get worse, both due to the chronic stress of dealing with poverty, but also as a result of colder homes and hunger.

In the medium to long term, these short term challenges will cast a long shadow. Cold damp homes and poor nutrition mean that children use more of their energy to keep warm and less of their energy to develop health organ systems. For example, lungs develop most in the first 3 years of life and exposure to cold and poor diet during this period increases the long term risk of COPD several fold. There will be more older adults suffering with the long term impacts of strokes and heart attacks that simply would not have happened.

So what can we do?

- As healthcare professionals, we must speak out about the impacts of social and economic policy and the cost-of-living crisis on health – if not now, then when?
- As GPs, we must try and double down on our efforts to address health inequalities – the 20% of the health gap highlighted above that is amenable to healthcare intervention. The Core20 plus five framework is a great place to start (5).
- As members of the community we must do our bit to link with grassroots organisations and the voluntary and charitable sector to provide additional and targeted support and help people access funding to support our patients and our communities
- As anchor institutions and, sometimes, major employers, we must ensure that we look after our staff and place our assets, such as buildings, data and universal reach, at the disposal of people who need them or who are trying to make a difference
- As primary care leaders and organisers, we must consider health inequalities the impact of poverty and destitution at the heart of our decision making, including using Primary Care Network funding to employ people who can help (social prescribers, health coaches and others) and taking services out into the parts of the community that need them most

The coming months and years will not be easy. However, people are waking up to what is happening to the poorest in society, perhaps because we are now all affected in a more direct and obvious way. In healthcare we can be a part in changing things for the better. If enough of us now find the humanity, passion and determination to act, we

might do more than survive. We might help sow the seeds of stronger communities and a better society.

Tom Ratcliffe
Yorkshire/Humber Deep End and Fairhealth

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SWIMMING BEYOND THE REEF

Felicity Goodyear-Smith

I am a professor of general practice from the University of Auckland, Aotearoa New Zealand (NZ). As an aside, I was fortunate to know Julian Tudor Hart in the 1970s when I worked in Blaengwynfi, a neighbouring village to Glyncorrwg. Julian inspired me and talking with him helped shape my future career.[1]

In 2016 I was invited to bring a general practitioner (GP) with a patient to a Patient and Clinical Engagement (PaCE) workshop at the North American Primary Care Research Group conference in Colorado, USA. The purpose of PaCE is for patients and GPs to be involved from the onset in research aimed at improving the health and well-being of their communities.[2] My GP colleague Tana Fishman invited Rose Lamont, a Samoan teacher from South Auckland.[3] Together the three of us attended the workshop and learnt how other patient and clinician groups were developing research agendas, in partnership with university-based researchers.

Inspired, in 2017 Rose recruited a group of South Auckland Pacific Island community members, and formed the Pacific People's Health Advisory Group (PPHAG).[4] Members belong to a number of Pacific ethnicities including Samoan, Tongan and Nuiean, come from a variety of backgrounds, and range in age from young to the retired. Pasifika (people who have migrated from Pacific nations) live in relative deprivation (many in south Auckland) and have poorer health outcomes than the general NZ population.

In 2018 we also formed a Pacific Practice-Based Research Network (PPBRN) of south Auckland practices, with each practice providing a 'research officer' (GP, nurse or receptionist) to serve as a research champion for the practice. A Tongan researcher Malakai 'Ofanoa and I ran workshops for the combined groups on how to ask research questions, basic methodology and Pacific research frameworks. One of the latter is the *fa'afaletui* model which emphasises a collective approach, requiring different perspectives to solve a problem. This fits well with co-design and mixed methodology.[5] A second framework is *fonofale*, which uses the meeting *(fono)* house (*fale*) metaphor for holistic health and well-being, with family as the foundation, four house-posts (spiritual, physical, mental and social) supporting a roof of cultural values, and set in a wider context of time and place.

In further workshops the group members generated research questions and explored how these might be framed in a way that is feasible to answer, can lead to new knowledge, and have results that might make a difference.

The research questions generated by the collective group were prioritised. The two on top of the list are :-

How can we improve uptake of urate-lowering therapy by Pasifika with gout in South Auckland?
How can we prevent or reduce rheumatic fever for Pasifika in South Auckland?.

These are both serious health issues for this population. Pasifika have a genetic predisposition for gout, with 22% of men aged over 20 years suffering from the condition, increasing to over 50% by age 65. However, they are less likely to receive preventive medication than the general population, with only 35% of Pasifika with gout receiving continuous urate-lowering therapy. PPHAG members either suffer from gout themselves, or have family members who do.

Similarly, Pasifika have the highest prevalence of rheumatic fever in NZ (one of the highest in the world), with over 60% going on to develop rheumatic heart disease. Pasifika in Auckland are 240 times more likely to be hospitalised from rheumatic fever compared with the general population, and Pasifika boys in South Auckland aged between five and 14 have a staggering rate of rheumatic fever of 112.8 per 100,000. Tragically in 2019 one of our PPHAG members, Joseph, died in his 40s from rheumatic heart disease, making this issue particularly poignant.

We set about answering the two questions. Initially we used summer, honours and Masters students, and eventually secured research grants to develop and evaluate interventions to address the issues. We now have two Pacific postdocs, Samuela ‘Ofanoa and Siobhan Tu’akoi, leading the gout and rheumatic fever projects respectively, but working in tandem on each other’s projects. Our core team consists of Malakai, Samuela and Siobhan, Rose (our PPHAG leader), and two Samoan GP members of the PPBRN, Maryann Heather and Hinamaha Lutui, although all group members are actively involved. I am the only Palagi (non-Pacific) investigator, and hence we are also building Pacific research capacity. We are also fortunate to have very strong advisory board, with eminent NZ leaders in Pacific and Māori health, and expertise in gout and rheumatic fever.

We are using the same methodology for both projects.[6 7] We have conducted systematic reviews of the international literature,[8] and stock-takes of what has already been tried in NZ, including the results of any evaluations.[9 10] We are analysing national and regional clinical datasets to assess the Pacific health burden and treatment need from the two

conditions and to explore trends over the past five years, to estimate whether any previous interventions appear to have had an impact.

Building on existing knowledge of what has worked and what has not, we are using co-design to develop, implement and evaluate novel innovations. Using a collective approach involving university researchers, PPHAG and PPBRN members, we are using Talanga, interactive conversations in series of workshops, working in parallel for the two conditions. Following the presentation of summaries of what has already been tried, the group brainstorms interventions. The ideas are collated, synthesised and fed back to the group. The advisory group are consulted on their opinions regarding what might be feasible and effective, and the interventions are then further refined. Although initially our workshops were face-to-face, the advent of COVID-19 required meeting remotely. However, the group adapted rapidly to meeting by zoom with consistently high attendance and engagement. We are close to finalising our interventions, which will then be implemented and process and outcome evaluations conducted, involving our collective groups at every step.

Our projects do share many features of the Deep End. In the Pacific context this is swimming outside the reef, beyond the safety of the lagoon. There is certainly engagement with and of frontline practitioners working in deprived communities, but central to our project is the active participation of community members. Our university research team provide central coordination for communication, continuity and momentum with both PPHAG and our PPBRN. Our community and practice members remain enthusiastic and engaged. However ,a move for the initiative to be independent from the established organisation of the university is unrealistic. Our GPs have neither the time nor expertise to drive the projects themselves, and nor do our community group,

and are happy with the status quo. Our Beyond the Reef project is a collective approach and requires ongoing participation of university researchers to be successful.

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BEYOND RIGHT AND WRONG THERE IS A FIELD. I WILL MEET YOU THERE

At the recent evening of celebration for the life of Dr Runa Mackay, a very fine doctor, human being and advocate for the rights of Palestinians, a quote from Rumi expressed Runa's philosophy of life, *"Beyond right and wrong there is a field. I will meet you there".*

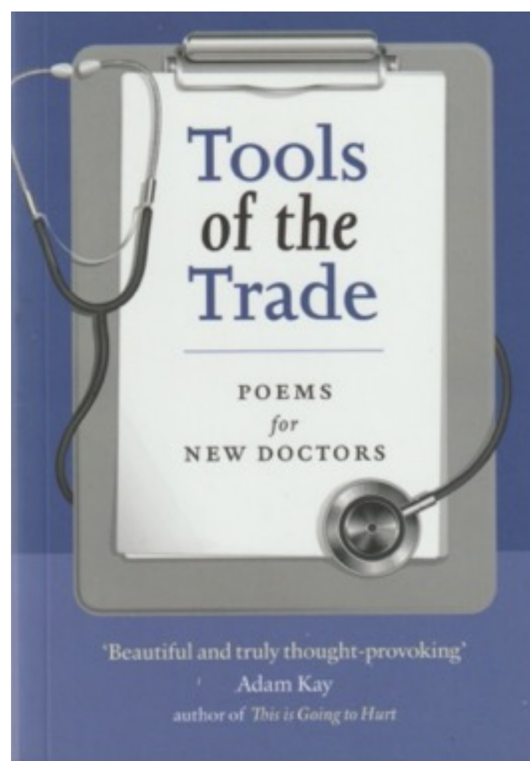
The guest speaker was Dr Philippa Whitford, breast surgeon and MP, whose work in Palestine has drawn attention to the difficulties faced by women trying to access lifesaving healthcare. She has created teams of specialists in Scotland who liaise with and support their colleagues working in very different circumstances in Palestine. Health matters to everyone so, when, as a doctor, she describes the impact of the Occupation on her patients, people understand. The language of health is a universal language, one that connects across races, cultures, social class and political views. Health offers a field in which to meet.

Finding connection with patients is the fundamental work of GPs. Despite differences in class, race and circumstance, the challenge is to find a point of contact, nourish it with trust, care and knowledge and enjoy the relationship developing. As GPs, we gain insight, not just into the life of the patient in front of us, but of their family and their community. Hearing patients' stories gives us a voice to act as their advocate and to work for positive change. Every surgery provides examples of health inequalities and

social injustices and part of our responsibility is to act to address those injustices. According to Desmond Tutu,

"If you are neutral in times of injustice, you have chosen the side of the oppressor".

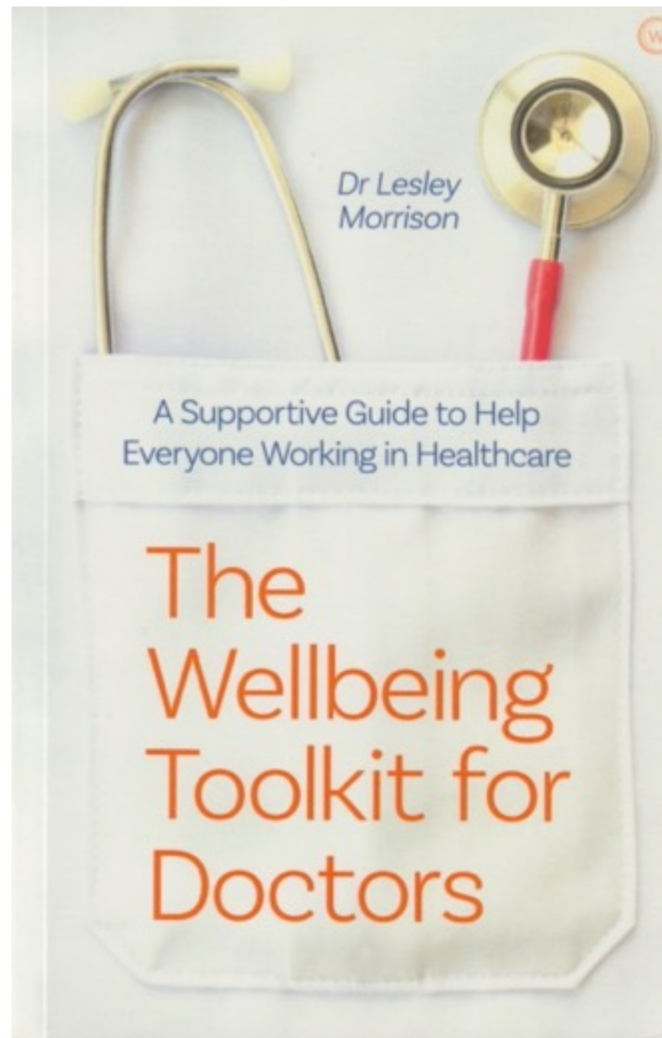
With an awareness of the responsibility to act can comes pressure. Struggling to balance personal, professional, community and health activist demands is stressful and it is imperative for GPs and other frontline health workers to take care, not just of their patients, but of themselves. In order to look after others effectively, we need to look after ourselves. If we are fortunate to work within a network of people with shared values, the sense of common cause can provide strength. For those working in more isolated situations, it can be harder.



No matter how supportive our health community is, we all, at various times, feel lonely and vulnerable and being able to express that vulnerability is crucial to wellbeing. In 2014, in memory of the late Dr Pat Manson, a group of us worked with the Scottish Poetry Library to produce a little book of poetry, *"Tools of the Trade"* (1), which is gifted to all Scottish medical graduates. The poems are all short and accessible and the aim of the book is to be a friend to new, and less new, doctors and to nurture creativity, an essential ingredient of wellbeing.

The book is now in its fourth edition and some of the feedback encouraged me to write a book*, "The Wellbeing Toolkit for Doctors* (2), published last year. It's based on stories and experiences from my years working as a GP in 1980's Hackney and then Hawick, in

many ways very different communities but both blighted by deprivation and both fertile ground for an appreciation of the politics of health and of how social and health injustice are intertwined. In the last decade, the extent to which climate justice fits into this has become increasingly clear and a strong theme of the book is how sustainable healthcare which is good for individual patients is also good for the wider community and for the global community. As GPs, with prescribing power and some degree of control over our working environments, we are ideally placed to contribute to planetary health. The latest Lancet Countdown (3) provides grim evidence of how much this work is needed.



Each chapter of the toolkit offers a “tool” for wellbeing, for example, hope, humour, honesty, silence, teamwork, with ideas for further exploration of those themes. The “c” words of general practice are addressed …. compassion, collaboration, community, curiosity, communication, creativity, connection, continuity. Along with the very important “k” word, kindness. Kindness to others and to yourself.

The potential of general practice, and of GPs, to make a difference is vast. Each one of us will make a unique contribution but, as people first and doctors second, we share an aim, expressed by Jose Saramago, *“Our great task is to succeed in being more human”.*

General practice offers a level field on which to meet our patients, and work on becoming more human.

The great Scottish expression, *“We’re all Jock Tamsin’s bairns”,* we’re all members of the one big family, says it all.

Lesley Morrison

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A GP’S REFLECTION ON WHEN THE FIRST MINISTER DROPPED IN

We were delighted to welcome Nicola Sturgeon, Scottish First Minister to Forge Medical Practice, Parkhead Health Centre in the East End of Glasgow on the 22nd July this year. This came on the day the Scottish Government was announcing an additional £300,000 investment to allow 20 rural and 10 island communities to have access to a Financial Advice Worker in their GP surgeries. We have been lucky at Parkhead Health Centre to have had an embedded Financial Support worker (from GMAP) for half a day a week for about 6 years (since a Pilot was set up following a Deep End round table meeting about the Financial Austerity/benefit changes that were wreaking havoc in the lives of our country's most vulnerable people). We were told the FM was keen to talk to Robert our Financial Support Worker and members of the Practice Team about the service. The visit gave us a good opportunity to discuss and reflect on the Financial Support Worker Service and she heard first hand our thoughts on it.

I have to say we were not slow in ringing the Service's praises and we felt rightly so. The FM herself had previous experience in working in financial welfare when she was a lawyer and it was interesting to discuss the Service in a GP setting. We discussed how the GP surgery setting gave our patients privacy, in a safe trusted environment where fellow patients did not know what they were there for. In Robert's words ,

'"I've seen engagement with people who probably would never have engaged with the service before, people who maybe fell through the cracks or had maybe been too embarrassed to ask for help or didn't know where to go".

We talked of the positive impact the Service has had on GP and Practice Team morale. We know there is so much we as a Team can do for our Patients with their huge unmet need. It has been a very difficult time for the Health Service and its Staff, with needs far

out stripping resource, particularly in our more deprived populations. It is vital for morale and GP/Staff recruitment and retention that we see ‘positive aspects ‘of work and positive outcomes demonstrated in GP Surgeries by our Practice Teams. I also reflected with the FM on the value, and there being a place, for ‘bottom up thinking’ -the Parkhead Pilot, based on the embedded model, evolved from initial conversations and thinking at ‘grass root’ level into a service fit for purpose.

First Minister Nicola Sturgeon meets staff during a visit to the Forge Medical Centre in Glasgow

Gillian Dames and Nicola Sturgeon

We discussed the ‘figures’. When the Deep End Financial Support Worker Pilot started the average annual household income for patients who engaged in the Service was about £10,000. There was an average financial annual household gain of £7,000 per annum following engagement. For every £1 spent on the Service there was a £19/£25 return in terms of patient financial gain in terms of income/debt management.

The figures speak for themselves and we were keen to get this over to the First Minister and her Team. We discussed the importance of the Service being **embedded** in the GP surgery as opposed to being **co-located**. We felt that referral rates and engagement in the Service was an important discussion point. In the Pilot report it is noted that 85% of patients who accessed the service in the GP Practice hadn’t accessed GMAP services before despite it having been available in the area for 5 years. We talked to the First Minister Team about how the Financial Support Worker Service had up until now been

funded by various temporary funding streams and how there is a need for permanent long term funding.

There was obvious awareness amongst our visitors of 'GP's at the Deep End'. During our chat learning from the Deep End Pilot was discussed. I feel there are many relevant aspects of 'Deep End learning' from the Financial Support Worker Service for the FM's plans for putting such a resource into rural/island areas. We can see how learning from a project/service development in one population setting (in our case an urban practice with most of its patient population living in poverty) can be applied to another setting (e.g. rural/island practices whose patients are being hit with disproportionate fuel price rises and whose population demographics show significant pocket deprivation).

The First Minister spent time discussing our work in general. I got a sense of empathy and sensitivity from her to the challenges we are all facing in General Practice. We were able to show her an example what our 'day looked like' by showing her (anonymously) the previous day's on call surgery, and how it illustrated that need far exceeded resource. It gave a taste of the volume and range of health complaints we are seeing daily and it reflected the serious mental health suffering and often suicidal ideation that we are seeing in our patients. We discussed the value of having a Community Link Worker as well as a Financial Support Worker, and how they have worked tirelessly together in synergy, their services dovetailing to the huge benefit of our patients particularly those with mental health issues . I have seen the *'Walking in Partnership with Patients'* type of working that we should be continuing to aspire to as GP's. What I did talk about was how a 'holy trinity' could be completed if we were to have a practice embedded Mental Health Nurse funded for and allocated to the practice along with our Community Link Worker and Financial Support Worker. We feel this would have the huge positive impact that we can see it happening in other practices such at Craigmillar in Edinburgh.

The Health Centre as a whole engaged in the visit which was lovely. After over 2 years of the pandemic and a lot of more isolated working it was great to see people mixing (at appropriate distance!) and chatting as a group regardless of political persuasion. We would have her back! (and many others for that matter)

Gillian Dames, GP
Forge Medical Practice, Glasgow.

We have no use for emotions, let alone sentiments,
but are solely concerned with passions
Hugh MacDiarmid

DEEP END WORKSHOP AT THE EUROPEAN FORUM FOR PRIMARY CARE CONFERENCE IN GHENT, 26-28TH SEPTEMBER 2022

In September 2022, a group of Deep End colleagues from Scotland (and one from Northern Ireland!) worked with Belgian counterparts to deliver a workshop at the European Forum for Primary Care (EFPC) conference in Ghent.

This collaboration built upon on the successful Deep End workshop at the EFPC conference in France in 2019 (summarised in International Bulletin No. 2), which led to a delegation of Belgian primary care colleagues visiting Glasgow in March 2020 (reported in International Bulletin No. 3).

[L to R: Dan Butler, Vince McGarry, Alessio Albanese, David Blane, Graham Watt, Kat Paterson, Carey Lunan].

The aims of the workshop were:

1. To showcase primary health care initiatives in areas of high deprivation from Scotland and Belgium
2. To present and discuss a practical framework for starting a Deep End group.

Presentations included:

Govan Social and Health Integration Partnership (SHIP) - Vince McGarry

The SHIP project aimed to; adopt a person-centred, develop collaborative working, challenge silo approaches, and create capacity for GPs to provide support for more patients with complex needs. Key elements were MDT working including health and social

care, aligned social work staff, and locum doctors releasing practice principals to facilitate extended consultations, case review / planning and outward facing activity.

Deep End Pioneer Scheme– Petra Sambale and Helen Richardson

The Deep End Pioneer Scheme was funded from 2016 to 2020 by 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 (the Deep End), involving the recruitment of younger GPs (with a tailored programme of Deep End learning), the retention of experienced GPs (with protected time for service development), and their joint engagement in strengthening the role of general practice as the natural hub of local health systems (by sharing learning within and between practices).

Embedded Mental Health nurses in general practice – Carey Lunan and Katriona Paterson

Craigmillar Medical Group is located in an area of high socio-economic deprivation, with a list size of 12000 patients. Mental health nurses receive additional 'in-house' training in a primary care model. They are embedded within the general practice team, using the same electronic medical records, with a simple internal referral process. The model is based on accessibility, inclusivity and continuity. They have a dual role in management of mental health and substance misuse. Evaluation has demonstrated >50% reduction in external referrals to specialist mental health, and >50% reduction of unplanned presentations of patients with the most complex mental health needs.

Community health workers (gezondheidsgidsen) - CHC Rabot – Thibault Detremerie

To address existing barriers to healthcare access, the city of Ghent set up a community health worker (CHW) project, in which CHWs' main role was patient navigation: guiding patients in overcoming these barriers by contacting patients to arrange health care visits and transportation, reminding patients of appointments and assistance with insurance. This study explored the process of this CHW-project to understand what works, for whom, to what extent, and under which conditions, generating recommendations for future similar projects.

Caring neighbourhoods (Zorgzame buurten) - CHC De Punt – Catherine De Koker and Charlotte Cambier

With our project "Oud Gentbrugge everyone on board", we strive for a caring neighbourhood in which all residents live with a good quality of life and can participate in the neighbourhood. Local residents feel good in the neighbourhood and know each other. Neighbours help neighbours and do so in a self-organizing way. The neighbourhood uses its strengths and those of its residents optimally to promote meeting, involvement and active participation in society. Care and welfare services are aligned and accessible to the neighbourhood. The project will take 2 years. In this workshop we shared our experiences

and goals. A neighbourhood analysis was conducted through informal interviews. The upcoming action plans are drawn up on the basis of these needs and wishes.

A presentation mapping out the process of establishing a 'Deep End' GP group – Dan Butler -Northern Ireland

As part of academic General Practice training with Queen's University Belfast, Dan researched the impact of socioeconomic deprivation on GPs in Northern Ireland. Part of this work has been studying how the Scottish Deep End Project started and then how subsequent Deep End groups have been established. Dan presented findings from a scoping review (recently published in the BJGP), mapping the steps and processes involved.

General discussion

After the presentations, there was time for discussion, covering a range of questions from the audience, for instance: Are patients involved in these projects? – the 'Chance 2 Change' project in Drumchapel (Glasgow) was cited as an example of a patient participation group which became a community organisation/peer support group, recently contributing to Scottish Government policy. There is, however, much more that could be done in this area.

Note: the group of attendees was asked to sit in a big circle. When sitting in a circle, every individual can easily be heard and seen, supporting the Deep End philosophy.

We would like to thank all project leaders and attendees for their contribution.

Dr David Blane
GP in Glasgow and Academic lead for the Scottish Deep End GP Project)
Jessica Fraeyman
Association of Community Health Centers - Vereniging van Wijkgezondheidscentra

EVIDENCE CATCH UP
The Deep End Pioneer Scheme: a qualitative evaluation
Dhanani S and Blane DM. Australian Journal of Primary Health. (PMID:36220129)

Background: The Scottish Deep End Project is a collaboration between academic GPs and GPs in practices serving the most socio-economically disadvantaged populations in Scotland. The Deep End GP Pioneer Scheme was established in 2016 to improve GP recruitment and retention in these areas. The aim of this study was to qualitatively evaluate the experiences of participating lead GPs and GP fellows. **Methods:** Semi-structured interviews were conducted with nine lead GPs and 10 GP fellows, representing 12 of the 14 practices involved. Interviews were audio-recorded, transcribed verbatim, and analysed thematically. **Results:** Five main themes are presented: Recruitment to the Pioneer Scheme; Work motivation and satisfaction; Mitigating health inequalities; Retention and changes in work pattern; and Suggestions for the future. Key ingredients of the scheme were the additional clinical capacity (addressing the inverse care law), protected time for both GP fellows and experienced GPs to lead on service development initiatives and to share learning within and between practices, and the shared ethos and values of the Scheme. **Conclusions:** There was strong support for the Scheme as a mechanism to improve GP recruitment and retention in areas of high socio-economic disadvantage, and to improve quality of care in these areas. As similar schemes are rolled out across the UK, there is a need for further research to evaluate their impact on workforce and patient outcomes in deprived areas.

QUIZ

This is a residential parking zone in Glasgow where neighbours pay an annual fee to park without charge in one of the allotted parking spaces. The picture shows one parking space which is always left unfilled, or filled last, or filled by unsuspecting visitors. So, what is the explanation? See page 64 for the answer.

DEEP END CORNWALL

Cornwall is regarded as a wonderful holiday destination by many. The dramatic landscape and stunning beaches are, on the other hand, also home to areas of deprivation. Cornwall and the Isles of Scilly have a population of 570.4k people (1). The 17 most deprived neighbourhoods in Cornwall are among the 10% of most deprived areas in England. The reasons for this are generally given as the high level of seasonal work, low wages, high housing and living costs, and low benefits allocation.

Our first two meetings of the Deep End Cornwall group focused on identifying common themes that are present in everyday practice in our deprived area.

Reactive, rather than preventative, care disadvantages patients and fragments the continuity of care that is desired by patients and GPs alike, with the associated proven benefits.

- Higher rate of emergency admissions is observed in our patient population.
- Recruitment of General Practice staff to areas of high deprivation is more difficult.
- Highlighting deprivation-related health inequalities during GP training is desired.
- De-medicalising is required.
- A more defined relationship with the newly formed ICB is needed to communicate common challenges regarding funding of General Practice in deprived areas locally.
- An accessible resource bank of deprivation-driven health inequalities or population health management related projects is required, to be able to learn from each other locally without the risk of having to reinvent the wheel, duplicate work or attempting to explore new ways of working that may have been proven unsuccessful before.

We are in the process of liaising with stakeholders, collecting local data that will highlight the deprivation-related health inequalities, exploring approaches to identify ways how the above ideas can be further developed, and plans implemented.

We are looking forward to sharing the progress in the coming months and contribute to the wealth of achievements that Deep End groups internationally have accomplished.

(1) https://letstalk.cornwall.gov.uk/the-cornwall-we-know/stories/insights-dashboard
(2) https://togethernetwork.org.uk/uploads/shared/IMD.-2019.-Cornwall.pdf

Judit Konya
On behalf of Deep End Cornwall

DEEP END DENMARK

Background

People living in deprived areas have more complex health needs, a higher prevalence of multimorbidity, and higher all-cause mortality compared to their more affluent peers. Additionally, they are often served by general practitioners (GPs) who are more likely to be under-resourced, overworked, and burnt out. The 'inverse care law' was originally defined by Julian Tudor Heart in 1971 as he observed that disadvantaged populations need more healthcare and yet are least likely to receive it. Although 50 years have passed since then, and significant efforts have been invested in reducing health

inequality, the disparities in health outcomes are still increasing. Healthcare - and in particular primary health care - has a substantial potential to reduce consequences of social inequality in health. The GP is easy to access, has a continuous relationship with the patients, and knows the local community. The GP is responsible for all listed patients and can take a proactive approach to those who need it. Moreover, the GP serves as a gatekeeper to secondary care, helps patients navigate in an increasingly fragmented healthcare system, and tailors the treatment to best suit the patient individually. The GP working in deprived areas has gained knowledge on how to deliver healthcare in the 'Deep End' and act as a key person in providing good health care for those with limited socioeconomic resources. We need to listen and learn from Deep End GPs because efficient, coherent, and competent primary healthcare is crucial if we want to reduce the adverse effects of the inverse care law.

Aim

In Deep End Denmark, we aim to reduce the effects of social inequality in health for citizens and improve the wellbeing and facilitate competency development among GPs in deprived areas through knowledge sharing, research, and international collaboration. This overall aim will be achieved by:

- Establishing a network of 100 Deep End clinics who serve patients living in the most deprived areas in Denmark.
- Facilitating knowledge sharing and competency development between Deep End GPs.
- Exchanging ideas with colleagues in the international Deep End organization.
- Conducting scientific studies to answer research questions developed by Deep End GPs and the research group in collaboration.
- Supporting the implementation of initiatives in deprived areas to reduce the social inequality of health among patients and to improve the well-being of GPs.
- Evaluating the Deep End Denmark initiative and the effects on the participating GPs and their patients.
- Disseminating the central points of the gained insights and acting on lessons learned.

Perspectives

Deep End Denmark will bridge the gap between Deep End GPs, researchers, and international colleagues by building a knowledge centre to support the production, implementation, and dissemination of knowledge in deprived areas that are usually

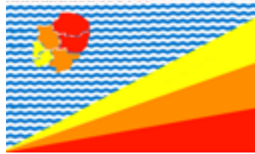
under-represented in research, in quality improvement projects, and in post-graduate training of medical specialists.

Status

- Deep End Denmark has been supported by a large 5 year grant from the Danish Regions and the Danish Organization of General Practitioners covering all expenses for Deep End GPs including locums, transportation and meeting expenses.
- In mid-November, we submitted applications to two private foundations to raise money for the Deep End Denmark including the salary for Nynne Utoft and Mogens Vestergaard. We will take responsibility for running the Deep End Denmark, perform research based on bottom-up ideas and evaluate the effect of Deep End Denmark.
- We have been invited to participate in a large national survey on well-being, job satisfaction and burnout in Danish GPs. The research group will invite all Danish GPs to participate in the survey and collect data in 2023, 2026 and 2029. These data will give us the possibility to study the well-being of Deep End GP's before and 3 and 6 years after the first Deep End meeting.
- We are in the process of applying for permission to establish a large cohort of all Danish citizens by linking several nationwide registries using a unique Danish Civil Registration number. The cohort will - for example - include data on education, income, GP, municipality, diagnoses, mortality and health care services. We aim at using the cohort to identify the Deep End GPs and to conduct clinical epidemiological studies on the inverse care law. Authorities will anonymize the data before we get access to the data.

Mogens Vestergaard and Nynee Bech Utoft
On behalf of Deep End Denmark

DEEP END: EAST OF ENGLAND



Since our launch in September 2021 Deep End: East of England has been fairly busy.

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- We are thrilled to have 170 different people connected together via groups for each of the six regions (Integrated Care Systems) across our geographical area
- We have identified and reached out to all Deep End Practices across the East of England
- We reviewed and adopted the various 'Deep End' workstreams from other Deep End groups – describing these as "A-CREW" – Advocacy; Climate Change & Environmental Sustainability; Research; Education & Training; Workforce & Wellbeing.
- A Steering Committee was created and our website is incrementally improving(!)

Education and Training

A significant proportion of our work has been in 'Education & Training' – describing Deep End patients, practices and communities. We have taught GP trainees, trainers and the wider primary care team and 'System Leaders' on tackling health inequalities. In March we presented at the Health Education England East of England Trainers Conference on the importance of "trauma-informed care" and how trainers can best educate this to their trainees. We also presented our Deep End network at our local Trailblazer Fellow Conference – where we met and Deep End: EoE was born! It was great to connect with familiar faces and reflect on our year as Trailblazer Fellows and what we had achieved. In May we presented to the new Trailblazer Fellows and introduced them to all things 'Deep End'.

Over the Summer we started launching local groups in each ICS, inviting every Deep End practice to a virtual meeting with good attendance, connecting through local system's 'Training Hubs' and Primary Care Teams. This enabled informative discussions around local issues, shared struggles and successes and started to bring awareness of 'Deep End', of each other and the opportunity to Collaborate, Support & Advocate together.

We also presented and ran a Health Inequalities workshop at the joint annual RCGP/WONCA conference in London *"Trailblazing into the Deep End: Primary Care at its best where it is needed most"* and it was great to meet so many people who share our passion!

Our Annual September Symposium considered "What does good look like at the Deep End?" and "How best can we support our most challenged patients?" introducing the importance of the RCGP curriculum topics in Population and Planetary Health. We were delighted that the Peterborough VTS scheme attended this event, along with GPs and practice staff from across the region.

Additionally, we have presented to Ipswich VTS this Autumn; Colchester VTS used our Symposium videos for their teaching and we have plans to reach out to every VTS across EoE! We are also delighted to have influenced HEEoE to create Heath Equity Fellowships for GP ST1 Trainees across the region and have taught them; and subsequently local systems have developed ST2 innovative posts, focused on Health Equity.

Each ICS has its own WhatsApp group that anyone with an interest in tackling health inequalities can join. CPD events are shared. We are delighted that we now have over 170 members of these groups across our patch, and were pleased to be able to meet in person in October with our BLMK colleagues, over a hot dinner!

Workforce and Wellbeing

In April this year, Gilly and I began in a new part-time role as GP leads for *"Advanced Practice in the Deep End*" – working with HEEoE to develop Advanced Practitioner roles in Deep End surgeries, and to encourage practices and PCNs to become 'Learning Organisations'. This has been challenging as many practices/PCNS have neither the time nor head nor physical space to take on the necessary training needed to become a Learning Organisation. However, this role has enabled us to network across the region and grow our Deep End: EoE support. HEE which funds the project have recognised the strength in these connections and the job role has been modified to allow us to continue this important work – which ultimately means that our Deep End work is partially funded!

Advocacy

We have presented to various ICS' 'Systems' about the Deep End – two in particular have really engaged with us – Mid & South East Essex and Cambridgeshire & Peterborough. Jessica briefly described the needs of Deep End patients and surgeries at the LMC England conference, and also presented at the national 'Eclipse' conference about the importance of using data to inform and target clinical care.

In wider news, several of our local Deep End Champions have volunteered to take on the new Core20plus5 Ambassador roles – representing our named ICS. At the virtual launch in November, it was good to understand the national vision from the national HI team and to connect with regional ambassadors... and see how many of them we already knew! We will also be attending the Royal Society of Medicine Health Inequalities conference in early January, and have an Ambassadors face to face meet in Leeds in the spring – both are great opportunities to connect and advocate!

We have started a monthly Deep End "Sounding Board" open meeting via 'EventBrite' – anyone can attend and pick our brains on all things 'Deep End' – whether AHSN investigating how CQC can better support Deep End surgeries ; or an inquisitive Junior doctor – all are welcomed and we have had some inspiring conversations!

Research

We are delighted that both Norfolk & Waveney and Cambridgeshire & Peterborough have been successful in obtaining funding to support improving research in currently under-represented communities – both these bids are connected with our local Deep End networks! Dr Emily Clark is our Deep End: EoE Research Lead and a NIHR In-Practice Fellow, so is busy co-ordinating and connecting folk across the region.

The new Core20plus5 'dashboard' on Eclipse has some exciting potentials that we are exploring….

Going forward! Much of the same, building on all the above – thanks to all of the Deep End networks – we learn so much from you; sharing your ideas, events & passion to all who will listen!

Dr Jessica Randall-Carrick & Dr Gilly Ennals
Co-ordinators Deep End: East of England

LAUNCH OF DEEP END PROJECT FOR CHESHIRE AND MERSEYSIDE

GPs at the Deep End

RCGP

Cheshire and Merseyside

Edge Hill University | Health Research Institute (HRI)

DEEP END MERSEY EVENT

Thursday 3rd November

6:30pm-8:30pm

The Spine, Liverpool

With Keynote Speaker

David Blane

Deep End Team, Glasgow

Establishing The Deep End Mersey Project

We invite invite you to help establish a Deep End Mersey Project with a view to:

- **Improving general practice workforce and recruitment**
- **Providing relevant educational sessions**
- **Acting as advocates for vulnerable patient groups and their health care professionals**
- **Looking at how best to research and record the experiences of Deep End practitioners and their patients**

There are longstanding inequalities in health in Cheshire and Merseyside. Many health outcomes are lower in the region compared to the national average and health inequalities wider. Within each of the nine boroughs of Cheshire and Merseyside, there are pockets of marked deprivation. The Deep End movement has the aim of raising the profile of and championing General Practice in the most socioeconomically deprived areas. We look forward to meeting you.

TO REGISTER, PLEASE CONTACT:

healthresearchinstitute@edgehill.ac.uk

There are long standing health inequalities across Cheshire and Merseyside. Many health outcomes are lower in the region compared to the national average and health

inequalities are wider. Within each of the boroughs of Cheshire and Merseyside, there are pockets of marked deprivation. Local colleagues have been aware of other regional and international Deep End projects for some time and so the suggestion to start a Deep End project, to raise the profile of and champion General Practice in the most socioeconomically deprived areas, was met with a lot of positivity.

Funding and support for the launch was provided by the RCGP Mersey Faculty Board, Edge Hill University, Cheshire & Mersey Integrated Care Board, the NIHR North-West Coast Clinical Research Network and Health Education England North-West. This gave us the resources for a launch event to spark interest and gather colleagues to share ideas on how to proceed and take the first steps to co-designing our local projected. Organisation was facilitated by admin support from the Health Research Institute at Edge Hill University. We decided to run a hybrid event to try and facilitate colleagues and public advisors to attend from anywhere within the large geographical footprint of our ICS.

We met at a new facility in Liverpool, The Royal College of Physicians Spine building in Liverpool, for refreshments and presentations to help set the scene for our own project. It was a privilege to have David Blane (See picture below) from the original Deep End project in Glasgow give a keynote speech to start the evening and share his experience of setting up a Deep End Group. We followed the finding from the Scoping review by Butler et al on establishing a Deep End Group. Using the W-E-A-R acronym, different colleagues then shared local information and ideas around the themes of Workforce, Education, Advocacy and Research. There was a short time for questions and discussion at the end. This included discussions on how Deep End Cheshire and Mersey could potentially link with Cheshire and Mersey ICB initiatives such as the ‘All Together Fairer’ strategy developed by Sir Michael Marmot for the region. In total 36 people attended, most were in person with a handful via Teams.

As a follow up to the launch event we have sent out an open survey to gather views on what the priorities for our expression of Deep End should be, as well as preferences on how often and what format to meet, and to allow us to create a directory of people who wish to be involved. We have kept the invitation open because we wanted to be inclusive and give colleagues, trainees or medical students the opportunity to be involved even if they are not currently working in a 'Deep End' practice. We hope to find a consensus among those who are interested as to whether to proceed with an open approach, or to target 'Deep End' areas more exclusively. Ensuring we communicated the launch event details and survey link to all who are potentially interested within the ICS footprint was a real challenge, especially at a time of flux. We are hopeful that our open approach will facilitate collaboration and engagement.

https://research.sc/participant/login/dynamic/95C23906-D38F-43C3-BB22-9A1ECE202D9D

Feedback from the launch event included a sense of hope around the opportunity. There was appetite for more conversation and roundtable discussion than we had time for that evening. This and the results of the survey will help us plan how and where to meet in future for maximum engagement and benefit.

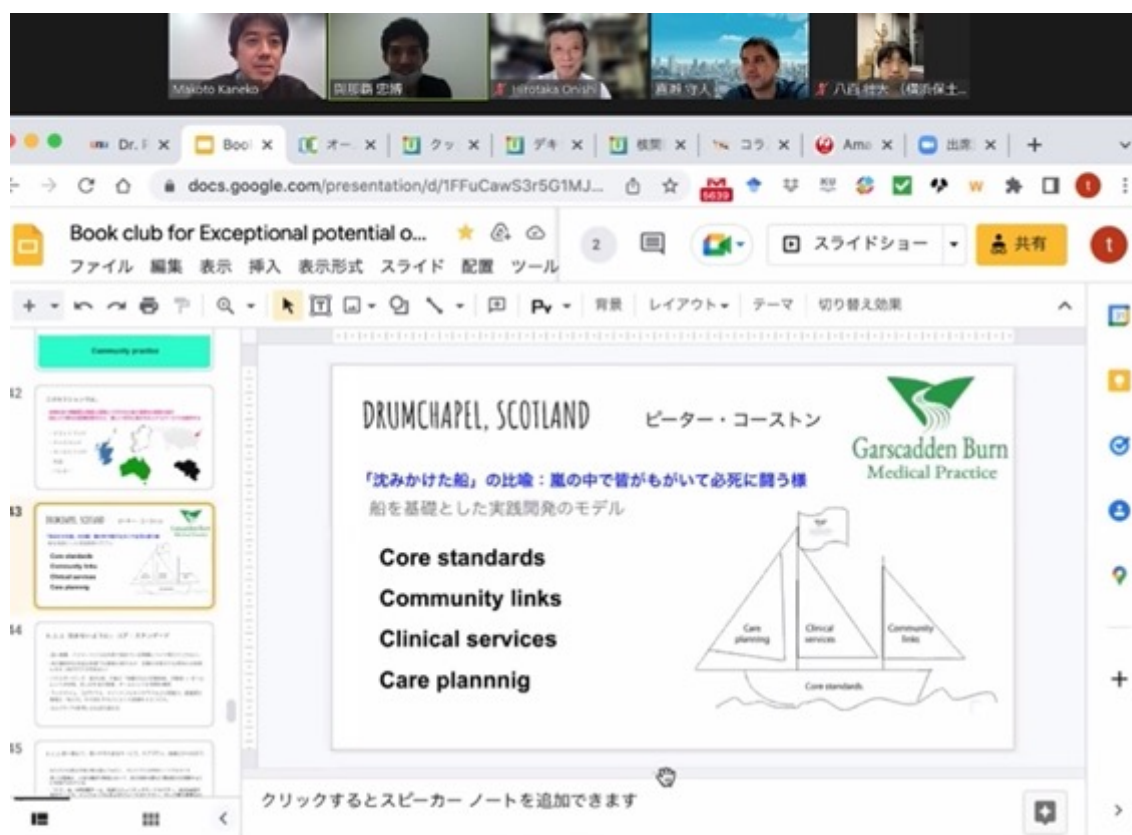
Anna Evans, GP in Liverpool
Greg Irving, GP in St Helens

CATCH UP

General Practitioners at the Deep End. A talk given to the Royal Philosophical Society of Glasgow in November 2022 by Professor Graham Watt
https://youtu.be/Z3t792e5dBY

Dr Julian Tudor Hart is best known for first describing the inverse care law whereby the availability of good medical care tends to vary inversely with the need for it in the population served. Somewhat ironically one of the best examples of general practice making a difference to population health comes from his own practice over 25 years in one of the most deprived communities in South Wales. His example has inspired "General Practitioners at the Deep End", an international movement of general practitioners, beginning in Glasgow but now involving 14 networks in 7 countries, all working to address the inverse care law. But this is just one of many challenges facing general practice in the National Health Service as it faces an uncertain future.

DEEP END KAWASAKI/YOKOHAMA



As an activity of Deep End Kawasaki/Yokohama, we have conducted a monthly book club looking at *"The Exceptional Potential of General Practice"* which is a textbook for general practitioners and other healthcare providers who offer care for marginalized populations. The book club has been continued on the third Thursday of every month online. We have shared the link not only with members of the Deep End project but also everyone interested in the book. We have translated each chapter into Japanese and discussed the contents considering the Japanese context. The photo above is a

screenshot of the book club. To date, we have run the event 11 times and gradually the number of participants has increased. Moreover, after the book club, we conducted a meeting with the core members. We share each recent experience and read recent articles or reports from the international Deep End project. Also, in 2023, I will edit an issue of a Japanese journal about general practice and the issue will feature urban primary care such as care for a marginalized population, immigrants etc. In the issue, I will introduce our activities to the readers.

Now, I am negotiating about coordination/integration between one of the surgeries in the Deep End Project, a university and a local government. If the project were realized, the surgery and the local government could ensure human resources and the university could participate in the field for clinical practice and education seamlessly. I hope I can describe the details in the next article in the Deep End report.

Makoto Kaneko

DEEP END NORTHERN IRELAND

Deep End Northern Ireland is in its infancy. Through collaboration with the General Practice Academic Research Training Scheme (GPARTS) in Northern Ireland, academic GP trainee Dr Daniel Butler, with the support and supervision of Prof Nigel Hart, Prof Diarmuid O’Donovan and Dr Jenny Johnston, has been building the case for increased focus and investment on GP at the Deep End.

Inspired by the work of groups that have gone ahead of us, we have looked at the principles of W.E.A.R - Workforce, Education, Advocacy and Research. The following streams have guided our focus over the last year.

Workforce

Are current GP trainee posts inadvertently widening health inequalities?
GP training numbers have been successfully increasing year on year in Northern Ireland, but that risks inadvertently widening the health inequality gap if GP trainees do not have opportunities to work in practices of high deprivation. We know that in any area, there is a clear link between exposure and experience directing future medical career choices. We found that Deep End practices did train more trainees than initially expected, with almost half of all DE practices registered as training practices. However, training practices were still statistically less deprived. We hope this work will direct future work and support the engagement of DE practices to become training practices.

This work compliments an exciting new inclusion health GP training scheme which will be piloted from February 2023, hopefully engaging junior colleagues, providing focused training and exposure to the challenging yet rewarding work of GP to marginalised groups.

Education

Are Northern Ireland's Deep End practices taking medical students proportionately? Or are students more likely to experience healthcare in more affluent areas?
Building on our work on workforce, as described above, ensuring medical students get the opportunity to experience and potentially develop an interest in general practice in high need areas is essential. We found Deep End practices were under-represented as teaching practices. Ensuring practices in high-need areas are proportionately represented is one way we can direct action in addressing the 'Inverse Care Law'. This analysis has been timely with the launch of a new curriculum at Queen's University Belfast and the launch of a new medical school at the University of Ulster, both increasing medical student's time in GP.

Advocacy

How do GPs find working at the Deep End of General Practice in Northern Ireland?

Work has started looking at the lived experiences of GPs working in areas of deprivation, uniting their voice and advocating for the broader issues at the Deep End of Northern Ireland.

Research

A review has been published around Establishing a Deep End GP group: a scoping review | BJGP Open, as well as publication of Do undergraduate general practice placements propagate the 'inverse care law'? (tandfonline.com)

What will 2023 bring?

- Hopefully our first in person Deep End meeting bringing together colleagues to hear their perspectives, challenges and solutions to then guide future development of the group.
- Continued academic collaboration, with Daniel's academic work around investigating and reporting the issues that GPs at the Deep End are facing and GP led innovation and solutions to these.
- The launch of an inclusion health-focused GP training pilot

Daniel Butler and Nigel Hart

DEEP END WALES LAUNCH

On Thursday 24th November 2022, the Welsh Deep End project was launched in Abergavenny. It was decided to hold a face-to-face meeting, to encourage rich discussion, give space and thinking time away from busy practices and foster a supportive network in a safe environment.

The top 50 practices from the Welsh Index of Multiple Deprivation (WIMD 2019) were identified and invited to engage with the project. This was subsequently extended to the top 100 practices - a group which represented all Welsh health boards except Powys Teaching Health Board.

Twenty-three GPs and five practice managers attended the event, representing twenty five Welsh practices. Of the eighteen practices in Wales that have over 60% of their patients living in the most deprived 20% (60 - 82%), eleven (61%) attended the launch.

A further eleven participants represented the project team (RCGP Wales), Public Health Wales, the Welsh Government and health boards.

The afternoon started with a buffet lunch which enabled everyone to introduce themselves and make conversation. Participants were also asked to identify five key issues which were affecting their practices on to post-it notes. These were then collated into seven common themes for later discussion (ranked in order of importance):

Programme

Dr Rowena Christmas, Chair of RCGP Wales, introduced the event and thanked everyone for coming. Dr Christmas highlighted the importance of sharing best practice to support patients in the most deprived areas.

Dr Mair Hopkin then gave a brief overview of what the Deep End means - referring to the patients who lack a sound financial and social base, struggle to keep their heads above water and drown at an earlier age. More than fifty years since Dr Julian Tudor Hart described his “Inverse Care Law”, there is still inequity in health care provision:

The availability of good medical care tends to vary inversely with the need for it in the population served

Whilst it was a pleasure to have Mark Goodwin, GP from Tudor Hart's Glyncorrwg practice at the launch, it is a reflection on our society that his remains the most deprived practice in Wales.

Dr Carey Lunan, a Deep End GP in Edinburgh and Chair of the Scottish Deep End Steering Group, gave a presentation on what the Scottish Deep End project has meant to those involved via a live link, followed by a Q&A session. Dr Lunan added the current cost of living crisis to the issues affecting Deep End communities.

Some of the key messages arising from the Deep End project in Scotland include:

- The inverse care law manifests as lack of time and resource in disadvantaged areas.
- Extended consultations (and continuity) for selected patients.
- Bottom-up integrated care via MDT meetings.
- Team wellbeing was the first step of most projects (needs proactive support).
- Shared learning within and between practices.
- Involvement of the next generation of GPs.

Finally, Dr Lunan summed up what the Deep End project has meant for her:

- Solidarity
- Identity
- Purpose
- Collective voice
- Professional support
- Shared learning
- Friendship
- Hope

Professor Sir Michael Marmot gave a recorded presentation where he talked about the three recent major threats to health equity, a decade of austerity, the pandemic and the cost-of-living crisis. He pointed out that the latest figures from the Food Foundation in England showed that 1 in 4 families with children have food insecurity. Adolescent mental health is damaged through living in impoverished conditions as is adult health. Professor Marmot first came across Deep End practices in Edinburgh and was impressed by the committed GPs who were aware of the effects of social determinants of health on their patients. As former President of the World Medical Association, he encouraged the association to engage in addressing the social determinants of health and outlined five actions:

1. Education and training
2. Seeing the patient in a wider perspective
3. The health care institution having an impact on the community and environment
4. Working in partnership
5. Advocacy

Professor Marmot believes that Deep End practices are in a position to address all five. They form an important link in the connections of how we take action to reduce health inequities and create a fairer more just society.

Julie Morgan, Deputy Minister for Social Services, addressed the audience in a recorded message, showing her support for the project. Ms Morgan highlighted the social injustice

of those in deprived areas living fewer years and in poorer health than those in more affluent areas of Wales. Ms Morgan added that tackling health inequalities was a priority for Welsh Government.

The final speaker was Helen Howson, Director of the Bevan Commission. The Bevan Commission was originally established in 2008 by Professor Sir Mansel Aylward to provide advice and consensus on health and care-related matters to the Welsh Government. It is made up of an independent panel of 24 internationally renowned expert Commissioners who give their time freely to Wales. These are drawn from a variety of disciplines including industry, NHS, local government, armed forces, academia and the third sector. Its mission is to challenge thinking and practice in health and care, creating a growing movement for change with the people in the system and those who use the system. The Commission hosts a series of programmes including Bevan Fellows, Bevan Advocates and Bevan Exemplars.

Discussions on key issues

After a short break, participants broke out into smaller groups. The aim was to discuss their chosen issue, look at how these could be addressed by support from the Deep End and to give a summary at the end of the session.

1. Patient Literacy and Advocacy Group Findings:
2. Recruitment and Retention Group Findings:
3. Workload Group Findings:
4. Mental Health Group Findings:
5. Complaints and Low Morale Group Findings:
6. Elderly and Co-morbidity Group Findings:
7. Education and Training Group Findings:

Lack of funding was a core theme throughout most issues. The cost-of-living crisis was addressed on many occasions. Participants reported that inequalities are their priority but were frustrated that nothing has happened and that there is no additional funding.

Discussion around the Carr Hill formula demonstrated that it was not working as it does not adequately represent deprivation. Weighting of patient lists is not accurate. There should be proportionate allocation of funding. It was stated that the BMA has refused to review this formula in negotiations with Welsh Government. Practices in England receive on average £152 per patient whilst Wales receives £98.

Cluster funding is not proportionate as it funds per population not weighted population. If this were addressed, then some Deep End work could be supported by the cluster.

Employer pension contributions of 14% make engaging locums very expensive.

In order to help change this, it was suggested that discussions should be held with the following organisations:

- LMCs
- GPC Wales
- Welsh Government Ministers
- Public

The need for additional funding for services included:

- Double appointments for those who do not speak English
- Extra sessions to for homeless, vulnerable, etc. patients
- Extra clinicians to support workload generated by vulnerable patients

Other suggestions were:

- Fines for inappropriate use of services e.g. 111 or ambulance
- Cuts in funding to more prosperous areas redirected to areas of need
- Reducing costs such as restricting the prescribing list

What did you most enjoy about the event?

Enthusiasm and ideas of fellow GPs - some brilliant ideas
Opportunity to stop and reflect
The talk and feedback from different tables was superb
Listening to motivational speakers
Meeting other delegates in a relaxed event
Completely non-judgemental atmosphere
Camaraderie
Collaboration
Net working

Peter Saul
On behalf of the Wales Deep End Group

DEEP END CANBERRA

Deep End Evolves – A Community of Practice

Deep End Canberra continues in its fifth year as a small but passionate group of DE practitioners, who meet 6 weekly to support and inform each other and advocate for our populations. We have expanded to include general practitioners, nurse practitioners, psychiatrists and allied health workers practising in the Deep End. We are unfunded but some of us count meetings towards ongoing professional education requirements. We are a ‘community of practice’ – a group with common concerns and set of problems who come together to fulfil individual and group goals. Deep End continues to build a local profile and is increasingly approached for input by policy makers, researchers and community organisations. One of our members, Tanya Robertson, has joined the local AMA Branch Board, to help advocate for DE concerns. Longstanding Co-Convenor Sue Baglow is retiring from regular practice and Deep End next year, and we give her our heartfelt gratitude for years of chairing our meetings.

Deep End Gets Social – Liz Sturgiss

The Deep End in Canberra had the opportunity to host the @WePublicHealth twitter account. This account is hosted by a different organisation or individual each week and is coordinated by the journalists at Croakey, an independent, not-for-profit-media team focused on health issues and social inequity. The large twitter following can be a great way to get new messages out there.

Melissa Sweet (Editor-in-Chief at Croakey) summarised the week's tweets into a blog: [Take a dive – into the Deep End's work tackling health inequalities – Croakey Health Media]

Homelessness Advocacy, Peer Education, and Mental Health Reform

Deep End Canberra met with other stakeholders for a Health and Homelessness discussion day at the beginning of the year. Key priorities identified were housing issues (supply, repair, land release), gaps in existing programs and outreach, and the need for wraparound support (e.g. Legal, Disability support) for clients. Deep End has had ongoing input into a follow-on Housing for Health working group which has met with the relevant Minister and lodged an ACT Budget submission.

Deep End Canberra met with our territory branch of the Australian Medical Association and Psychiatry representatives to begin discussion on sorely needed local mental health system reform. Next steps are to survey MH consumers, providers and primary care workers on their experiences, and to use the findings in our advocacy with politicians and health services, and as a foundation for an article for Medical Journal of Australia.

Also envisaged is a follow-on meeting with representatives from psychiatry, primary care, MH consumers, health services and policy makers to sketch out what a person-centred, caring and collaborative MH service which works better for all involved might look like.

Deep End held a well -eceived education session for members on managing high risk/violent clients from Bree Wyeth, a psychiatrist and DE member with long experience in community mental health and forensics.

Abortion Access and Provision Advocacy – Mel Dorrington

There has been ongoing work in the Australian Capital Territory (ACT) with regard to improving access to abortion. As a result of the overturning of Roe v Wade in the USA, the ACT Legislative Assembly held an inquiry into "the accessibility, affordability and legal protections for abortion and reproductive health services" in the ACT

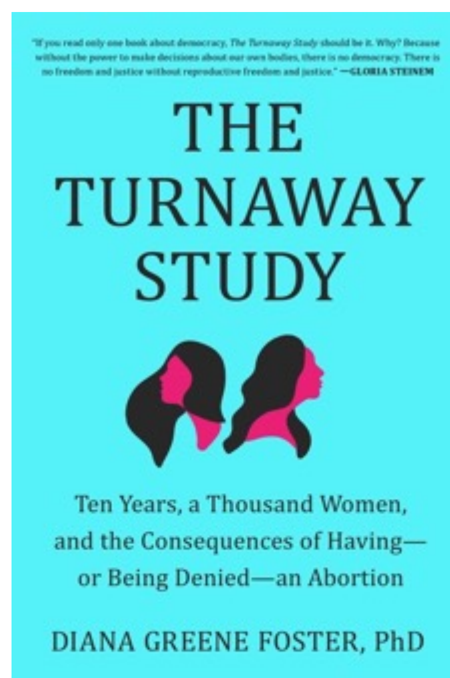
.(https://www.parliament.act.gov.au/parliamentary-business/in-committees/committees/hcw/inquiry-into-abortion-and-reproductive-choice-in-the-ACT).

Given that pregnant people who have sought an abortion may fear stigma in presenting their difficulties to such an inquiry, and pregnant people from vulnerable populations experience more barriers, we felt that a submission supported by Deep End was important.

Just before the submission date the ACT government announced that from mid-2023 it will provide free abortions up to 16 weeks gestation, including for ACT residents without a visa (and therefore no public health cover), and also provide free long-acting reversible contraceptives to those who have accessed an abortion. The details of how this will work are still being established.

You can find our submission here https://www.parliament.act.gov.au/__data/assets/pdf_file/0006/2071815/Submission-43-Dr-Melanie-Dorrington-Deep-End-GPs-Canberra.pdf.

Mel Dorrington was spurred on by the individual stories of patients, and also evidence from the USA's TurnAway Study - *"ANSIRH's prospective longitudinal study examining the effects of unwanted pregnancy on women's lives. The major aim of the study is to describe the mental health, physical health, and socioeconomic consequences of receiving an abortion compared to carrying an unwanted pregnancy to term. The main finding of The Turnaway Study is that receiving an abortion does not harm the health and wellbeing of women, while being denied an abortion results in worse financial, health and family outcomes" https://www.ansirh.org/research/ongoing/turnaway-study*.



Following on from the submission, we were invited to attend the Legislative Assembly hearing into the Inquiry. Dr Mel Dorrington and Dr Tanya Robertson attended on behalf of Deep End. You can hear Mel and Tanya's presentations here:

https://broadcast.parliament.act.gov.au/vod/player/72de8bdf2a1ded3291bab927f1061acc?i=80e284c4f3e74f1995911db13ee6dd59-8

The questions we faced demonstrated a lack of understanding of the barriers that face pregnant people seeking abortion day to day - finding a provider, accessing blood tests and ultrasound (currently standard 4 week wait in ACT without individual advocacy for an urgent appointment), accessing a dispensing pharmacist, etc. Reading through the other submissions, and seeing both a lack of evidence base from those not supporting access to abortion, as well as a lack of clinical understanding of day to day on the ground needs and experiences from those supporting access, really emphasised the need for us to raise our voices on behalf of our patients.

Mel was able to talk to the media about our submission. As well as being on the local TV news, it was reported online: https://www.abc.net.au/news/2022-10-29/act-abortion-inquiry-hears-of-difficulty-in-access/101588636; https://the-riotact.com/role-of-religion-in-accessing-abortion-services-in-canberra-questioned/607855; https://ustoday.news/1-in-3-women-will-seek-an-abortion-in-their-lifetime-this-woman-felt-punished-for-seeking-hers/

Mel says *'if it were not for reading "The TurnAway Study" book, and the support of my Deep End colleagues, I don't believe that I would have felt strong enough to risk confronting this issue which can be seen as controversial. I really want to say THANK YOU to my Canberra Deep End colleagues. I am now preparing for a Federal Senate Inquiry and am trying to encourage as many others as possible to also submit'*.

Mel Dorrington outside the ACT Legislative Assembly hearing.

DEEP END IRELAND

Systematic Review of Link workers and Social Prescribing

Deep End Ireland GPs and researchers have recently published a systematic review exploring the effectiveness of link workers delivering social prescribing with a particular focus on searching for evidence for multimorbidity and for programmes in disadvantaged communities. (https://bmjopen.bmj.com/content/12/10/e062951) The review concluded that we need more evidence to support its benefits before widespread implementation

GPs working in Deep End practices will be very well aware of the social determinants of health and many will have considered social prescribing and referred patients to link workers in an effort to provide more holistic care.

There has been significant policy support and investment in social prescribing based on an expectation that it will deliver improved health and wellbeing, potentially reducing health inequalities and saving money by diverting people to more appropriate care in the community. Our systematic review was conducted to see what evidence there was to demonstrate its clinical and cost effectiveness. We searched 12 databases from inception and only included studies that had a comparison group. We were particularly interested in whether the studies had measured quality of life or mental health, and if they had included people from disadvantaged areas and people with multimorbidity.

We found eight studies in total. Three were published in the US and five were published in the UK. The length of time people could meet the link worker varied. Most of the studies were quite short (less than six months) and people only met the link worker a couple of times. Because there was so much variation in the studies it was hard to find consistent evidence that link workers made a difference to quality of life, mental health, social contacts, physical activity or primary health care use.

Three US and one Scottish study included people from disadvantaged areas, who also had more than one health condition. Two of the US studies had longer and more

intensive programmes where the link workers met people weekly for six months and worked closely within the healthcare system. These two studies found that people reported higher quality care and there were also cost savings because of fewer days in hospital. The third US study found a reduction in emergency department attendances, but an increase in primary care visits. The Scottish study found that people who met the link worker three or more times had improvements in quality of life, mental health and exercise.

Overall evaluating social prescribing link workers in this way would appear to show limited benefits, though does give us some evidence that can guide policy around intervention duration, intensity and targeting. However, we acknowledge that a systematic review exploring effectiveness only gives a partial picture. Social prescribing is designed to be different depending on the needs of the person and the resources in the local area so determining if it works or doesn't work on a larger scale is challenging. This evaluation approach is also very health focused and social prescribing is likely to have wider benefits for communities and society, which may be captured with different approaches including qualitative studies.

What our findings do suggest is that longer, more intense support from link workers working closely with healthcare providers probably benefits people with complex needs, such as those who live in disadvantaged areas and with multiple health conditions. At the moment there are very few link workers per head of population. In Ireland, for example, a national Social Prescribing system is being introduced which will have one link worker for every 50,000 people, regardless of community needs. Going forward, to see changes in health inequalities and cost savings, our review suggests that there needs to be a focus on intense support for a smaller number of people or an expansion of the availability of link workers. Either way it is important to keep learning about how social prescribing works best so the potential benefits can be realised.

After the review was published it received some publicity, which led to a Guardian Science Weekly podcast exploring the evidence for link workers and social prescribing and included the key point that these resources should be prioritised for those with the highest needs and a mention of Deep End GPs. You can listen to the podcast here, though we are not sure that the surfing image really reflects most of our experiences of available community resources and support in disadvantaged communities.

https://www.theguardian.com/science/audio/2022/nov/01/could-a-prescription-of-surfing-help-with-depression

Dr Bridget Kiely and Prof Susan Smith

DEEP END LONDON

There is lots going on in London. Chad Hockey sent us the revised Deep End London logo. Hina Shahid and Camilla Gajria report on activities in the North West while Lili Risi reports on three different health equity festivals.

Deep End Report RCGP NWL Faculty

The RCGP NWL Deep End project restarted in March 2022 to respond to colleagues in outer North West London (NWL) Deep End practices who wanted a peer support network. Led by two local GPs with support from the RCGP NWL Faculty, the project aims to create a community of practice, spotlight innovation, support joined up working and promote wellbeing and resilience among colleagues in outer NWL working in areas of deprivation and superdiversity characteristic of Deep End practices. Supporting colleagues working in challenging conditions to address inequalities (or more accurately, inequities) in health and healthcare is at the core of this project through providing a safe space for rich, meaningful and deliberative discussions and inspired action.

Since our last report, we have arranged a variety of events for our community of practice and continued to promote the Deep End approach in our daily work and with others.

For example, we worked with Dr Sharon Raymond and Dr Victoria Tzortziou-Brown to present *"Dream it, do it"*- a socio-cultural approach to addressing health inequalities in primary care to 200 delegates at WONCA 2022. Our key learning points were:

- Build trust
- Reach out to communities with barriers to accessing healthcare
- Verbalise the public health approach e.g. no-one is safe until everyone is safe
- Scale by commitment, collaborating, and allyship
- Consider sustainability either within the project and/or by inspiring other projects

We held a reading group around the themes brought up in *The Beekeeper of Aleppo* by Christy Lefteri. The discussion demonstrated practitioners' commitment and we all valued the opportunity to share with understanding colleagues. Take home points included exchanging ideas around creating psychological safety and trauma informed consultations, innovative models of care, support with registration and navigating services, patient champions and advocates, and the importance of c lived experience.

We have planned a theatre visit to support and further promote reflection and insight.

For 2023 we plan to focus on homelessness and culturally diverse populations. We also plan to run locality-based networking sessions where participants share their work.

Dr Hina J Shahid & Dr Camille Gajria

LONDON DEEP END HEALTH EQUITY FESTIVALS

Festival 3: London Health Creation Spring Festival: Regenerating ourselves, our systems, our world. May 2022
https://www.bbbc.org.uk/insights/news-and-resources/health-creation-festival/

Festival 2: Health Equity London Festival: Harvesting Sustainable Seeds of Change. September 2021
https://www.bbbc.org.uk/insights/news-and-resources/news-resources-health-equity-london-festival/

Festival 1: Restoring Hope – Health Equity Festival & Celebration February 2021
https://www.bbbc.org.uk/insights/news-and-resources/news-and-resources-health-equity-festival/

I took on the new health equity lead role in my local training hub and joined the West London Deep End programme. This learning experience enabled me to explore many of the issues I witnessed in my daily work and to consider how I could, individually and collaboratively, act to improve health equity. Alongside the WhatsApp group, these sessions provided a safe space for me to connect with colleagues, share experiences and seek inspiration. I have led a local change project to support all GP surgeries in the borough to sign up to the Doctors of the World Safe Surgeries Initiative to promote inclusive primary care. I also contributed to the Equity Festival in February 2021.Overall, this experience has restored my hope and equipped me with the skills and confidence to step up and work collaboratively in my locality to develop and deliver projects that improve health equity.
LUCY LANGFORD Newham Health Equity Lead

https://features.kingsfund.org.uk/2021/02/covid-19-recovery-resilience-health-care/

Figure: The path to recovery is not linear, and people experience a range of emotional responses at different phases of a disaster
Covid-19 recovery and resilience: what can health and care learn from other disasters?

Dr Liliana Risi / Provost RCGP NEL Faculty / LRISI@nhs.net

London Deep End Health Equity

Leading for health equity: Owning the problem and growing agency for fairer systems and healthier places

Phase 1: Proliferation of virtual connections. WhatsApp allows easy connecting and sharing of information
Phase 2: Sense making. Covid-19 death data highlight disproportionate impact of racism and deprivation on outcomes
Phase 3: Fragility of trust. Emergence of a new social justice movement after from Black Lives Matter.
Phase 4: Owning the problem. Agreement to initiate a Deep End movement in September 2020 inclusive of support; learning; improvement and advocacy. Six people connect on 12/9/20
Phase 5: Beacon in the storm. Fortnightly nurturing Deep End Change Program starts which allows for connection and catharsis. (Baseline: Word Cloud). Aim to increase trust by 10% in every conversation. Three Boroughs agree to test funding Health Equity leads to attend Deep End Program in Nov 2020. The Medical School initiates a Community Diagnosis Health Equity Module.
Phase 6: **Integrating Narratives.** Climate Health becomes a theme. Name of WhatsApp group changes to Deep End/Health Equity
Phase 7: Restoring hope. Evidence of high levels of social capital in communities in response to Covid-19 emerges. Curation starts for a first Health Equity Festival in Feb 2021. (Word Cloud: Share your ideas for moving forwards). Virtual group opens to include wider primary care team – nurses, social prescribers, commissioners, secondary care but still within the local geography. Group grows to 56 people after restoring hope in the first Festival One [27/2/21]
Phase 8: Harvesting sustainable seeds of change. Completion of Deep End programme prompts a second Health Equity Festival in Oct 2021 located in two sites which have established health creation: Story Garden and Bromley by Bow. (Word Cloud Three). Group widens geographically to become London wide. And includes 71 people after harvesting sustainable seeds of change in Festival Two [14/10/21]
Phase 9: Regeneration and restoring trust. Trauma informed resilience-orientated approach defines the third Health Creation Festival in May 2022 (PDSA 3) with a focus on healing from individuals to the climate. Group grows to 119 people after regeneration Festival Three [27/5/22]
Understanding a Syndemics & Health Creation (PDSA 4) becomes important and a focus for a symposium in October 2022. Group grows to 136 after event four i.e. Syndemics & Health Creation Symposium [13/10/22]
A virtual mechanism is introduced to enable contributions for cocreating the future for the leadership platform.

Word cloud Baseline | Festival : Restoring Hope | Festival: Harvesting Change | Symposium: Syndemics & Health Creation

Dr Liliana Risi
Provost RCGP North East London Faculty

DEEP END INTERNATIONAL BULLETING NOS 1-7

News from : Scotland, Ireland, Yorkshire/Humber, Greater Manchester, Canberra, Australia, Plymouth, London, North-East and North Cumbria, Nottinghamshire, East of England, Cornwall, Japan, and Denmark

www.gla.ac.uk/deepend

DEEP END GREATER MANCHESTER

We are continuing to try and support practices working in the Deep End in the Manchester area and have undertaken the following in the last few months.

PCN deprivation training day

We put on a free training day for PCNs in Greater Manchester looking at issues within deprivation with the emphasis on how PCNs can be useful in tackling some of the issues. We looked at dental deserts in Manchester, childhood respiratory conditions and poverty, the effect of institutional responses to racism and what we all need to do next during the first 1000 days of a baby's life as part of the infant parent project. In the afternoon we spent time as PCNs thinking of our own local solutions. From this we have seen several new initiatives at PCN level including actively following up every baby born in a PCN.

GP Deprivation Training Scheme

This continues to grow and has more trainees. We are on the lookout for trainers who want to join our scheme as we need more placements. So if you know anyone who is, or wants to become a trainer. please let us know. https://www.docsindepgpst.org.uk

> Home | Deprivation-Focused GPST Programme
> Welcome to the Greater Manchester Deprivation GP Specialty Training (GPST) Programme. Learning inclusion health in a deprivation setting. There has been a strong call to increase GPST programme capacity to provide more doctors to meet the growing needs of the UK population.
> www.docsindepgpst.org.uk

Focused Care

This approach is now being evaluated by Cambridge University which has been a journey in looking at how data analysis shows the impact of in intervention in a complex interconnecting system. We are very excited that Focused Care has just been launched in North Manchester and now covers all deprived practices in Central Manchester and most of Oldham. We are continuing to explore funding sustainability. Any tips welcome. https://focusedcare.org.uk

Poverty Truth Network

We have been working with the Poverty Truth Commission in various areas of Manchester to support this innovative approach, where local residents who are experts in their experience and area come together with senior public sector and private sector leaders and together look at issues arising from, and aggravating poverty. https://povertytruthnetwork.org

Infant Parent Project

This has been piloted in primary care with the aim of expanding it out to other practices. The model supports parents at risk of significant safeguarding or who have had children previously removed. The service offers support, psychology, friendship and space to reflect. We have supported increasing numbers of mothers through the first 1000 days and are seeing improvements in outcomes. https://sharedhealthfoundation.org.uk/our-work/perinatal-health-outcomes/

Edge Hill University

We are lucky to be supporting Edge Hill in its new curriculum ensuring deprivation medicine is always present and we get to teach these amazing students who all come from the most interesting non-traditional backgrounds.

Our next bits of activity

We want to raise awareness of the negative impact the new QOF framework is having on practices and immunisation rates and that there is even less incentive to try and catch up vaccinations outside of the tight timescale, and over penalises practices in deprived areas who are simply unable to achieve any QOF points for these domains with a significant reduction in funding, If there are proper academics (unlike me who is an activist) out there who want to help write on this please let me know.

We want to arrange another Deep End event for February to support any doctors working in deprivation. Anyone who fancies a visit will be really really welcome. Just email me Laura.neilson1@nhs.net

Laura Neilson

EDITOR'S NOTE

To see Laura and her colleagues in action, here is a recent talk and link

https://www.youtube.com/watch?v=FxsGBmJUuRY

Health Inequalities in General Practice with Dr Laura Neilson

Doctors Sara and Lisa talk to Dr Laura Neilson the founder of Hope Citadel who is passionate about tackling Health Inequalities. She talks to us about the importance of addressing them, what the inverse care law is, and skills that people will find useful working in areas of deprivation.

www.pckb.org

https://www.pckb.org/e/health-inequalities-in-general-practice-with-dr-laura-neilson/

NORTH EAST AND NORTH CUMBRIA DEEP END

It has been an extremely busy year for our Network in the North East and North Cumbria (NENC). A look back at our last year…

We hosted our 6th webinar at the end of March, the theme of which was 'Education,' specifically what barriers do practices in the Deep End have in engaging with education and workforce development and how can we address this? Our keynote speakers

included Dr Rob Carter who spoke about Hub and Spoke Models for Teaching Placements; Dr Hussam Mohamed who gave a presentation on International Medical Graduate Family Physicians; and Dr Claire Norman who presented the 'Roadmap to the Deep End' and discussed how we can harness enthusiasm and promote working in the Deep End to students at all stages of their journey into medicine. A recording of the webinar is available here.

Following on from this, we have successfully appointed Dr Vivienne Branton as our NENC Deep End Educational & Development Lead, who will be leading our Education workstream moving forward. Vivienne also works in a Deep End practice and we are really excited to have her on board to push forward our education workstream plans. Viv has included some words below:

"With teaching on health inequalities high up on the agenda from Medical School to GP training and beyond, now is a really exciting time to be joining the Deep End Network NENC as Educational Lead. I have been meeting with key players in the North East medical education sphere and already have several teaching sessions on Deep End working in the diary. We know that trainees who have had exposure to Deep End working during their training are more likely to take on jobs in Deep End practices. In our efforts to combat recruitment issues that are common across the Deep End, I am exploring ways to help practices engage with training opportunities (which could range from hosting a medical student SSC - which doesn't require training practice status - to taking on a final year GP trainee who is keen to understand Deep End working in more detail through an Integrated Training Post (ITP)) - and multiple other options between. "

Health Inequalities Summit – 9th November 2022

Our Network was delighted to be asked by our ICS to host the next in their series of Health Inequalities Summits via a free online webinar focusing on Primary Care. The Deep End of Primary Care Summit took place on 9th November 2022.

Attendees were able to listen to live presentations from our clinical leads on their experience of inequalities in primary care, the impact of funding inequalities and an insight into the Deep End perspective and the role of the Network in addressing the Inverse Care Law. We also had a number of guest speakers who presented examples of projects they have implemented locally, where they have used innovative approaches to take into account socio-economic factors and health inequalities in primary care and the tangible outcomes / actions that they delivered.

The Summit was a huge success with over 400 attendees, including clinicians, public health, strategic leads and voluntary sector to name a few, from within and outside of our ICS! It was a great opportunity for us to raise awareness of the challenges faced in the Deep End as well as to promote the work we are doing as a Network to address this.

A recording of the Summit will shortly be available to watch on our website - Deep End GP Network for the North East and North Cumbria (NENC) GPs at the Deep End NENC - and we will be sharing any feedback and frequently asked questions.

Pilot Programmes

Over the course of this year, we have successfully launched a number of pilot initiatives – a summary of these are listed below:

Project / Summary	Linked Research / Evaluation
Clinical Psychologist Pilot - Embedding psychologist support in primary care to get psychological support closer to the patient - Currently involves 2 DE practices - We are exploring options with Trusts CNTW & NuTH to roll out a similar model in 4 other practices imminently	Quantitative evaluation led by NECS BI Team Qualitative Evaluation (MINDED) led by Newcastle University
Reduction of Opioid & Gabapentinoid Prescription Rates - Network provides funded support to practices to give GPs/pharmacists protected time to review their prescription rates and address this via patient reviews - 6 DE practices involved	Quantitative evaluation led by NECS BI Team Qualitative Evaluation (TAPER) led by Newcastle University
Childhood Immunisations - NHS England Public Programmes Team made a funded offer of support to DE practices to take part in work to help improve processes and uptake rates for 0-5 routine childhood vaccinations. This involves support from the team, a short audit and workshop. - 10 DE practices involved	NHSE will feedback outcomes / learning
Deep End Fellowship Programme - Working in partnership with Health Education England to recruit our first DE Fellow who commenced in post in April in Linthorpe Surgery. The fellow works 1 session per week in a neighbouring DE practice, who is not a training practice, and would not ordinarily benefit from fellowship schemes, whilst also giving the Fellow a broad range of experience. - 2 DE practices involved	Internal evaluation of programme via network

If you would like any further information regarding any of our pilot programmes please get in touch at: necsu.deependnenc@nhs.net

Research Update

The co-design research process undertaken October 2020 - March 2021 under the auspices of the NENC NIHR Applied Research Collaboration (ARC) forms the cornerstone of all programme activity now being developed and implemented within our NENC Deep End network. You can read more about this co-design research here.

We now have active research projects supporting across our NENC Deep End work programmes. We are continually building upon our strong research-practice collaborations, with the aim of ensuring all activity within our NENC Deep End network:

a. Is informed by available evidence of 'what works and why' to address health inequalities in primary care
b. Builds upon the existing evidence-base in an applied way that involves our Deep End practitioners and patients

Our research team is led by Dr Sarah Sowden at Newcastle University and supports the co-design, implementation and evaluation of Deep End NENC network and its associated work programmes. Collaborating with partners, we build research capacity and capability in Deep End general practice where health needs are greatest. You can meet the whole Deep End Research team here.

Our current research activity includes the following:

1. MINDED (evaluation of Deep End pilot initiative)
2. TAPER (evaluation of Deep End pilot initiative)
3. Research to inform efforts to improve GP recruitment in the Deep End
4. Research to inform efforts to improve health literacy in the Deep End
5. Patient, public and community involvement in Deep End research activity

We also support a number of other research projects involving or aligning to our NENC Deep End network activity and aspirations including:

- Deep End Primary Care Research Activity and Engagement Review
- Building and evidencing community asset partnerships in housing and health to address health disparities in NENC

You can find out more information regarding all of the projects listed above by visiting our website here.

What next?

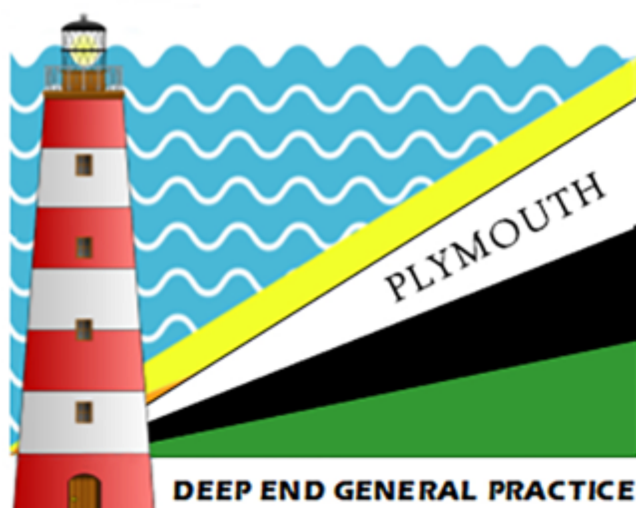
We have recently been successful in bidding for recurrent funding from our ICB that will fund our Network until 2024/25. This is a huge success for our Network and an incredible vouch of support from the ICB that they are supportive of the work we are doing to address socioeconomic inequalities in the Deep End. This investment will enable us to really push forward with our workplan and pilot initiatives, targeting workforce, education, advocacy and research.

We are excited to see what the next year has in store and to continue to make inroads with supporting our Deep End practices and patients where they need it most.

Dr Martin Weatherhead & Sameena Hassan
Co-Clinical Leads, NENC Deep End Network

Rachel Henwood NENC
Deep End Programme Manager

DEEP END PLYMOUTH



We have had an eventful year at Deep End Plymouth, as we continue to work on our priorities of workforce, education, advocacy and research.

There have been great successes and huge disappointments.

The biggest success has been our Deep End GP Fellowship scheme. Soon after we started Deep End Plymouth 2 years ago ,we managed to get money from Devon CCG (local NHS) to pay for a scheme both to attract new GPs into Deep End practices and (unusually) to support existing doctors doing Deep End work.

We recruited to 8 out of the 10 Deep End practices, (including to my own practice in Stonehouse). All fellows were supported by an educational package and with mentoring from senior GPs. We also ran very well attended conferences. Fellows were encouraged to use the Fellowship time to undertake projects, several of which have been truly ground-breaking and have changed practice.

Examples are a project on trauma-focussed care, working with the Plymouth trauma-informed network to design and roll out training in trauma-informed practice for GP teams (see poster on Page 55), working with fishermen in Brixham to tackle serious health issues among that group, and setting up clinics in Plymouth for Asylum seekers and Refugees.

We have just been collecting feedback from the Fellows at the end of the first year of the scheme. Here are some quotes from recent feedback;

- *"I had the opportunity to develop cross sector professional relationships, deepen my learning of health inequity from a lens of listening and apply this to a co-designed nature-based programme - Since this I have secured Health Equity Funding to innovate in the region. I have valued the professional networks enormously"*
- *"It's had an incredible ripple effect into so many other opportunities going forward, I really appreciated the time and support and encouragement of the fellowship"*
- *"My project looks to inspire other practices across the PCN to adopt similar training plans, so hopefully it will get to that level of widespread impact"*
- *"My project has a double focus on staff wellbeing (including my own) and patient engagement and outcomes"*
- *"I feel part of national movements, feeling more equipped to bring about impact on a much larger scale than I previously imagined"*
- *"I feel much better equipped with the confidence and skills to expand on my ideas, share and promote them and take on higher responsibility roles"*
- *"The Fellowship has provided me with a great and very timely opportunity to upskill, to have protected learning time, to learn about local services and to spend time looking into and learning more about Health Inequalities and the social*

Trauma Informed Primary Care

Dr Elpitha Bruce, Deep End Fellow (Oct 21 - Oct 22)

Context

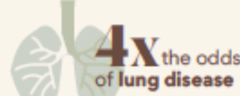
Trauma is now largely acknowledged as **one of the greatest public health threats.**[1]
The groundbreaking studies on **Adverse Childhood Events**[2,3] demonstrating the correlation to poor health outcomes and reduced life expectancy has revolutionised thinking globally. These concepts have yet to be integrated into **primary healthcare settings.** A shift in healthcare culture, policies and clinical practice are needed to address this invisible pandemic.

Trauma and Healthcare

- Recognise adversity as a **physiological** risk factor
- Alter our approach to **chronic illnesses** and **medically unexplained symptoms.**
- Move away from 'fix it' mindset. Recognise the importance of **safe space** and feeling of being heard.
- Pave the way for new **preventative and therapeutic** approaches
- Reduce **burnout** stemming in feelings of helplessness
- Revitalise **work satisfaction** and enhance **retention**

1 in 8 of the population have **4+ ACEs**

2X the odds of **any cancer**



4X the odds of **lung disease**

2X the odds of **heart attack** or **stroke**

7X the odds of **alcoholism**

people with **6+ ACEs** can die **20 years** earlier than those with none

Aim

- Introduce key concepts of Trauma Informed Care to GP surgeries
- Enhance understanding of how trauma impacts health (neurological, immunological, epigenetic and behavioural)
- Encourage a shift in culture
- Apply a trauma lens to staff wellbeing

Method

- Offer pre-recorded learning module on Trauma Informed Primary Care to all staff at Adelaide St
- Conduct short, small group sessions for facilitated discussion
- Encourage personal reflection and goal-setting

Plan → Do → Study → Act

Feedback

- Use feedback to improve future training sessions
- Identify ways to foster ongoing progress
- Inform wider roll out to other practices

Follow-up

- Short interview follow-ups
- Support ongoing action
- Assess impact and progress

Progress so far

- **Building relationships**
  - Trauma Informed Network Plymouth
  - Wolseley Trust Social Prescribers
  - Zebra Collective
  - CareNest Trauma Sensitive Therapy, The Plot
  - Devon CCG Domestic Abuse & Sexual Violence Lead
- **Collaborating** with Trauma Informed Network Plymouth: adapting their pre-existing training module to focus on **primary healthcare**
- **Delivered** 90min Trauma Informed Primary Care session to nurses on Transition course run by Devon Training Hub

Challenges

- **Change of culture** is difficult, challenging our preconceptions, our training and familiar clinical practice
- **Time pressures** - unprecedented patient demand
- Staff perception of other priorities taking precedence
- **Misconception** that trauma cannot be treated
- Poor access to **trauma specific services** for onward support of patients (ie. **trauma focused therapists**, psychotherapists, physiotherapists, occupational therapists, social prescribers, community groups, etc)
- Leap of faith required to believe that this new approach will ultimately **save time, improve staff wellbeing** and **improve health outcomes**

References: [1] Dr Robert Black, former president of American Academic of Paediatrics. [2] Felliti et al 1998. [3] Bellis et al 2014.

- *determinants of health. I feel reinvigorated and re-energised as a GP. Prior to the Fellowship I was contemplating leaving clinical medicine. Now I can realistically see me spending the rest of my GP career working in Deep End practice(s).”*
- *“I have learnt a lot about health inequalities as a direct result of the time the fellowship has provided me with. I feel that I have improved my skills and knowledge for addressing the health needs of the patients in this practice.”*
- *“I feel that I have developed more of an interest and understanding of population health issues. I'm not sure I have the answer about how to address or influence it though!”*
- *“Much more likely to stay working at the Deep End Practices in Plymouth.”*
- *“It has enabled me to move into a significant role within public health where I advise the complex lives team on clinical matters. I have connected through the fellowship with key partners within the ICS and public health / NHS”*
- *“I am now clinical advisor to Devon Public Health 'complex lives' team covering inclusion health/ homelessness”*
- *“I am now working in public health alongside GP work”*

We are hoping to continue the Fellowship programme into next year, but the recent re-organisation of the NHS in England has wiped away the CCG and our funding with it – the new structure (called an “Integrated care System”) has yet to really function – much like the UK government.

The second major area of work has been around premises.

3 of our Deep End practices, all in the highest deprivation area in Plymouth ,are housed in small, old and inadequate buildings - looking at GP premises across Plymouth is a great illustration of the inverse care law!

Working with our city council, NHS partners and huge community involvement, we applied for a new scheme called “Cavell Centres”. These are proposed super health hubs. Here was part of our pitch;

The super health hub is to be built in Stonehouse, a community with extreme levels of poverty and deprivation. It is an area full of life and full of good people, but the economic and social picture is challenging and the cost-of-living crisis is making it worse. Stonehouse is in the bottom 0.2% of communities for super output in the entire country, and in the bottom 1% for nearly every other major economic indicator.

Life expectancy in that community is a full 7.5 years lower than the national average; health outcomes are poorer; cardiovascular and heart disease are found in younger people than elsewhere. A third of our private rented homes are classed as non-decent in that community, school grades are a third lower than the city average, and crime is a considerable scourge. Health problems are exacerbated by poverty. This community is responsible for approximately 20% of Derriford Hospital’s emergency admissions.

At least three GP surgeries in substandard accommodation, currently with large lists of patients would relocate to the health hub where they could see more patients. There would be space for 24/7 out-of-hours GP surgeries and pharmacy and X-ray facilities, enabling earlier diagnosis and better management of conditions, such as weight management, smoking cessation, district and practice nursing facilities, physiotherapy and occupational therapy space, mental health services, drug and alcohol treatment, and nutrition. Importantly, alongside that would be advice and information services, debt assistance and housing support, and access to training and employment, volunteer support, social care and prevention services, all under one roof with a single entrance. People would not have to travel miles and miles and fork out for buses or taxis to see someone who can help. In short, the super health hub in Plymouth is about giving people better chances to live longer, healthier and happier.

We were successful in this bid, one of 6 in the country, and we rapidly became much the most advanced – conducting a proper, thorough community consultation, then producing a very detailed, innovative business case and finally appointing architects and coming up with detailed plans (see picture above)

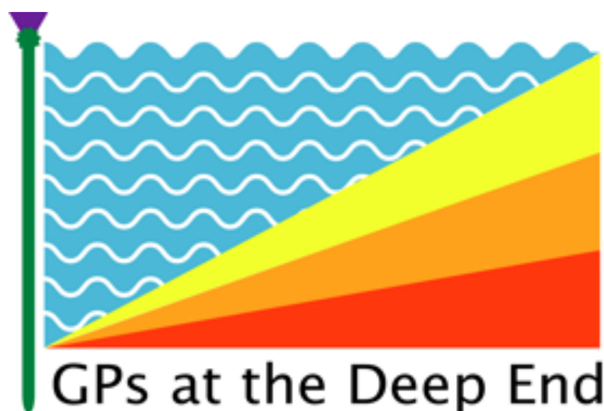
The site has been prepared, old buildings demolished, all partners signed up, we are so excited - and then we just heard that our “new” government is set to axe the funding!

So, we are in full political activity mode to keep this amazing Deep End project on track. Hopefully I will be able to report in the next letter that we have managed to make it happen.

Healthcare is a fundamentally "political" activity, and providing healthcare for Deep End populations especially so. This has come home to us very clearly over the last year in Plymouth.

Dr Richard Ayres

THE SCOTTISH DEEP END PROJECT



Perhaps, now more than ever, I have valued the friendship and the professional community that is the Deep End group in Scotland. These are challenging times for our patients, for our teams, and for us. Having a sense of collective voice, identity, and purpose has been invaluable.

Reflecting on the last year, there are a few key activities and developments that I'd like to share.

In March, we hosted an online roundtable discussion on prison healthcare. This work was led by Dr Jag Hillhouse, then a GP in HMP Barlinnie. It was well attended, with frontline GPs, and representatives from relevant departments in Public Health Scotland and Scottish Government. The intention was to explore the very significant challenges faced by patients and clinicians in secure environments, where the Inverse Care Law is very acutely felt. It was a productive and hard-hitting discussion, with a number of concerns raised around leadership, professional vulnerability, and variation in practice. There was also a specific focus on how to better support the recruitment and retention of GPs within the prison healthcare system. These themes were captured Deep End Report 39, which made a number of recommendations and was shared widely with stakeholders, all with different roles to play in influencing change. In the months that followed, we have met with the RCGP, the BMA, NHS Education for Scotland and

Healthcare Improvement Scotland. We were also invited to deliver a session at the RCGP secure environments conference.

Also in March, the Scottish Government produced their report on Primary Care Health Inequalities, based on collaboration (as a Short-Life Working Group) from across different professions, sectors, and interests. The Deep End group in Scotland were actively involved in this work, and in the creation of the report which made 23 high-level and aspirational recommendations, and importantly, included the 'community voice' of an established community group, called Chance 2 Change, in a powerful accompanying report. The SLWG recommendations support the wider roll out of many of the early Deep End projects such as Community Links Workers and Welfare Advice & Health Partnerships, and proposed to incorporate key learning from the Govan SHIP Project and Pioneer Scheme into future initiatives such as a multi-disciplinary postgraduate training fellowships, another key recommendation from the group. We have continued to actively contribute to the work of the new Development Group. Ironic although it sounds, it has become more challenging, in these difficult financial times, to continue to make the case for additional resourcing of deprived-area general practice (another of the key recommendations) but we are very committed to making this happen. We met with the Cabinet Secretary for Health and Social Care, Humza Yousaf, earlier in the year to discuss the recommendations from the report, and have recently requested a follow up meeting to discuss progress.

In April, we held our third Medical Student Conference as an in-person event in Glasgow. Postponed because of the pandemic, this was a fantastic opportunity to get together and meet with medical students from across the undergraduate curriculum. There were sessions on Mental health and adverse childhood experience, the new Edinburgh University Inclusion Health Society, Social prescribing and Community Links Workers, the work of Medics Against Violence, Opportunities for Student Advocacy, Recovery from addiction and Gender based violence .

In July, one of our steering group hosted a visit by First Minister for Scotland, Nicola Sturgeon, to her practice (See page). The First Minister met the practice team, including the Financial Support Worker, and discussed the practice-embedded Welfare Advice Service which the practice became involved in initially as part of a Deep End pilot several years ago. This initiative has now been rolled out widely across Scotland.

Throughout the year, members of the Deep End steering group have also presented at a number of external events, and many of the links can be found here. One of the highlights was our Deep End workshop at the European Forum of Primary Care annual conference in Ghent, Belgium, with the chance to meet with and learn from our international colleagues and friends. (See page)

We've also contributed to a number of Government consultations and Parliamentary enquiries on topics such as vaccine hesitancy, climate change, health inequalities, and mental health, and gave presentations to the Cross Party Group on Health Inequalities on community-based approaches to addressing health inequity.

Our Deep End steering group has met on three occasions over the last year, with our last meeting being held in person, in Glasgow. After almost three years of meeting online, it was a joyful occasion to all be in the same room. It can be easy to forgot the importance of taking time out to meet face to face. The energy in the room was palpable. And I can't believe I forgot to take a photograph!
In recent months, much of our focus has been on the cost-of-living crisis which is disproportionately affecting our patients, and the role of general practice in providing support, sharing resources and advocating on behalf of patients. I presented at the Energy Action Scotland (EAS) conference last week on the impact of fuel poverty on health, and the urgent need for cross-sector collaboration.

By the time this Bulletin goes to press, we will have hosted our final Deep End event of this year - a roundtable discussion on the Cost of Living Crisis and the Role of General Practice. We have confirmed attendees from multiple sectors, including EAS, Women's Aid, Cyrenians, the Poverty Alliance, Welfare Advice Partnerships, Community Link Workers, and the Glasgow Community Food Network. We will capture the key themes and make recommendations in what will be 'Deep End Report 40' with the hope that we can share practical resources and approaches with practices on how to support their patients, and agree approaches for effective lobbying.

Until next year, Carey.

Carey Lunan

EDITOR'S NOTE
Congratulations to Carey on being appointed as the Scottish Government's Primary Care Lead for Health Inequalities. Significantly, the Scottish Government has welcomed Carey staying on as Chair of the Scottish Deep End Project until her term ends.

QUIZ ANSWER

When waiting in Dublin to be picked up in his car by the inestimable Austin O'Carroll, he arrived in a car looking very like the one shown above, as if a wedding cake had been deposited and splattered on the roof of his car from a great height. Immediately, I knew the situation – the dilemma that occurs when a privileged disability parking spot just happens to be situated below a tree inhabited by magpies.

Parking at your convenience but at the heavy cost of regular car washing, let alone damage to paintwork. Which is why the parking slot outside our house, while available for everybody to use, is used by hardly anyone.

So, the lesson to be learned from the Quiz picture is that official parking regulations and guidance are secondary to the importance of local knowledge – a message well known to Deep End practitioners.

QED **Graham Watt**