GENERAL PRACTITIONERS AT THE DEEP END
INTERNATIONAL BULLETIN NO 11
JUNE 2024

We begin this Bulletin with a big welcome to Deep End Canada, the 18th Deep End Project, in our 9th country and 4th continent. See page 28 for news of this exciting new development based on Canada's "*milieux défavorisés*".

Other items on this newsletter are many reflections and reports from the Deep End International Conference *"Wellbeing At The Margins": Kindness, Hope, Joy, Inclusivity & Advocacy* held in Glasgow on 12/13th April.

There are also summaries of the Health Foundation Report on *Tackling the Inverse Care Law in Scottish general practice,* and the RCGP Report on *Breaking the Inverse Care Law in UK general practice*. At long last the Inverse Care Law is getting official recognition and comment.

Graham Watt graham.watt@glasgow.ac.uk **June 2024**

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WELLBEING AT THE MARGINS: KINDNESS, HOPE, JOY, INCLUSIVITY & ADVOCACY

The conference took place at Glasgow University on 12/13 April 2024, with just over 100 participants in person and 20-25 on line. The Deep End Projects which were represented were Plymouth, Cornwall, London, Ireland, Denmark, North East and North Cumbria (NENC), Wales, Greater Manchester (Shared Health), Yorkshire and Humber, and Northern Ireland, with Deep End Australia and Japan joining on line subsequent to the conference. There were eight presentations and nine workshop sessions, plus a ceilidh at the Pearce Institute, Govan, on the Friday evening. Video presentations describing Deep End Projects were provided by Bristol, Yorkshire and Humber, Ireland, Manchester (Shared Health), Cymru (Wales), NENC and Denmark, and shown during the conference.

Carey Lunan opens the conference

CONFERENCE CATCH-UP

For those wishing to catch up on the conference, there are two brilliant videos covering Sessions One and Two which can be viewed at

https://www.gla.ac.uk/schools/healthwellbeing/research/generalpractice/deepend/events/

or accessed via the "Conferences and Events" section of the website of the Scottish Deep End Project at the University of Glasgow (www.gla.ac.uk/deepend).

For ease of access, see the start times of the presentations below. The videos are continuous recordings of both sessions, including introductions, presentations, Q&A, panel discussions and snapshot video presentations by Deep End Projects in Bristol, Wales and Greater Manchester.

Don't miss the opportunity to watch or re-watch the scintillating Saturday presentations by Darren McGarvey, Victor Montori and Euan Lawson.

SESSION ONE: FRIDAY 12TH APRIL 2024

Welcome and Introduction: Carey Lunan, Scottish Deep End Chair (0 min)

The Deep End Story So Far and So What: Graham Watt, Scottish Deep End Project (7 min)

Missingness in Health Care: Andrea Williamson, Scottish Deep End Project (31 min)

Shining a Light on the Invisible: Relational Injury, Access and Care: Adam Burley, Consultant Clinical Psychologist, Rivers Centre, NHS Lothian (57min)

Teaching Relational Practice for Health Inequalities: Is it worth it? Sarah Doyle, Professional Nurse Lead, Queen's Nursing Institute Scotland (1 h 20 min)

Panel discussion with above three speakers (1 h 40 min)

Low Threshold, High Fidelity General Practice: Austin O'Carroll, Grangegorman Family Practice, Dublin (1 h 51 min)

Panel discussion with above four speakers (2 h 23 min)

SESSION TWO: SATURDAY 13TH APRIL 2024

Deep End Bristol (0 min)

Help isn't coming – How declining public faith in the NHS may be the nail in its coffin: Darren McGarvey, Author, Musician, Social Commentator (7 min)

Deep End Wales (39 min)

Building a Patient Revolution (for careful and kind care) in the Deep End. Victor Montori, Professor of Medicine, Mayo Clinic, Minnesota, USA (43 min)

Deep End Greater Manchester (1 h 31 min)

Resisting Enshittification: Advocacy and Activism: Euan Lawson, Editor, BJGP (1 h 33 min)

Closing Remarks: Carey Lunan (2 h 19 min)

WHAT THEY SAID

See the short summaries of their presentations by Andrea Williamson (p 11), Adam Burley (p 12), Sarah Doyle (p 13) and Austin O'Carroll (p 14).

CONFERENCE REFLECTIONS

See also the comments after the conference by Nora Murray-Cavanagh from Edinburgh (p 16), Shona McKinnon from Glasgow (p 21), Marianne Hansen from Denmark (p 23) and Makoto Kaneko who watched from Japan (p 26).

OPENING REMARKS - THE DEEP END STORY SO FAR, AND SO WHAT?

Professor Graham Watt

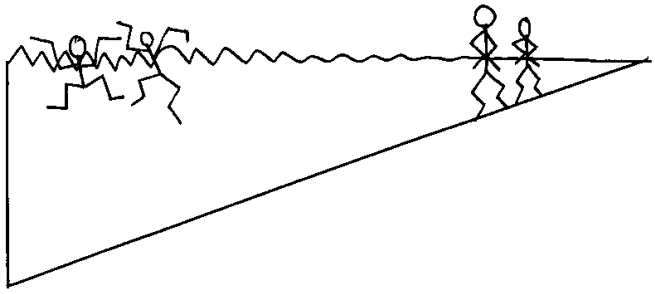
Over the last five years I've been privileged to edit ten editions of the Deep End International Bulletin (See p 34), each edition capturing the enthusiasm and energy of Deep End GPs, an outpouring of positivity, strikingly at odds with the doom, gloom and uncertainty surrounding much of general practice in the UK.

We know from Daniel Pink that the three main sources of professional satisfaction are autonomy, having some control over what you do; mastery, being good at what you do and being valued for it; and purpose, working towards a long term aim, especially with others. To which we might add, if you are passionate about your work, you will be energised by it.

My PhD student Breannon Babbel from Oregon asked GPs working in deprived areas of Glasgow how they saw their role. Everyone signed up to the clinical consultation, involving diagnosis and treatment; some looked further into patients' psychological make-up and social circumstances; others looked out to the local community, both as a social environment and as a well of resources for health and well being; others saw the wider social and economic forces affecting their patients, and wanted to influence that via politics and the media. As the circles broaden, the numbers dwindle to a minority but a minority with a majority of Deep End GPs

The 17 Deep End Projects are all different, big and small, established and new, with different starting points, advantages, constraints and opportunities, but they have common themes, especially the determination to make a difference.

One of Julian' Tudor Hart's cartoons, illustrating social gradients in health, in 1991, is possibly the earliest use of the swimming pool analogy. The first time I used it was in a Milroy Lecture to the Royal College of Physicians of London in 1998.



“General practice is not a level playing field – it is more like a swimming pool. Everyone who can be seen has their head above water, but while practitioners in affluent areas are standing with their feet on the bottom, practitioners in deprived areas are treading water.”

It’s a bit cheeky because GPs in affluent areas aren’t twiddling their thumbs. In many ways their articulate, well-informed and assertive patients are harder to satisfy. But the Deep End is where the greatest health gains can be made.

The movers and shakers of the Deep End Movement

So, when in 2009, RCGP Scotland considered what GPs could do to address health inequalities, following a similar initiative in England, we decided three things: not to produce yet another report on health inequalities – there were enough already; not to give GPs a toolkit – that seemed patronising; and to start by listening to what they had to say.

The 100 most deprived practices were all invited to the first Deep End conference at Erskine just a few miles down the Clyde, and two thirds attended – the first time they had ever been convened or consulted.

The seating plan was a circle with everyone in the front row. The conference report recorded everything that was said and set an agenda for a series of roundtable discussions and reports on a host of issues, now numbering 40, all available on the Deep End website.(www.gla.ac.uk/deepend)

The conclusions of this work can be broadly summarised as the need for three building programmes, based not on bricks and mortar but on relationships, the silver bullets of primary care: building strong patient stories, based on increased knowledge, confidence and agency; building strong local systems, with general practices at the hub; and building a network of such systems, to achieve a mass effect.

Several reports drew on GP and patient experience of austerity butut advocacy was based mainly on the NHS, to be at its best where it is needed most.

Project activities included worked examples of what could make a difference, of which the most significant, in terms of impact, have been the roles of community link workers and financial advisors, in both cases embedded within practices, not located nearby, and in both cases leading to national rollouts for larger numbers of practices.

But funding for link workers was recently threatened. Short term funding came to an end and neither Government nor the local health authority wished to pick up the bill. The issue was resolved, but only after a vigorous campaign, involving link workers, GPs, journalists and politicians. I'm not sure how coordinated that was, but it reminded me of Tudor Hart's advice that to achieve political change, the important allies are downwards and sideways to local communities, their representatives and local media, rather than upwards to the establishment, whose default position is to keep things as they are.

The battle was won, but only to re-establish short term funding. As so often is the case with health inequalities, to use a football analogy, we are still playing on the little pitch outside Hampden Park, Scotland's National Football Stadium, and not on the big pitch where all the big players and big resources are displayed.

For those following the footsteps of the Scottish Deep End Project we recommend four basic elements: engagement with front-line practitioners, without whom nothing much may happen; central coordination, from whatever vantage point is available; activities (spanning workforce, education, advocacy, research), to keep the show on the road; and communication, keeping everyone on board.

We have learned that focusing on Deep End practices, while necessary, excludes two important groups – the very many Deep End patients registered in other practices, and practitioners in those practices, with whom there are many points of common interest.

We have learned that advocacy is not only what you say; it is also what you do, and it is a long march, requiring persistence and refusal to be daunted by temporary setbacks.

And sustainability depends on joint ownership – engagement with key partners from the start makes it much easier to keep things going later on.

So here we are, five years on from the last conference in Glasgow in 2019. Then there were 5 Deep End Projects; now there are 17. We're hoping Canada will be the 18th.

To quote Henry Ford (although how he knew this from building motor cars isn't clear) coming together is a beginning, staying together is progress, working together is a success.

A conference is like a caravanserai, those stops on the Silk Road where travellers could rest, re-charge, share stories and news of the road ahead. So, looking ahead, what road are we on?

The Inverse Care Law is still with us, but it's not the difference between good medical and bad medical care. Rather, it's the difference between what Deep End practitioners can do for and with their patients, and what they could do with more time, better connections and more support.

In my experience, addressing inequalities in health is not the main motivator of Deep End GPs. Rather, it is to achieve more for the patients they see every day. Narrowing inequalities is a by-product of what they do.

The Inverse Care Law is often invoked, loosely and imprecisely, as a synonym for inequalities in health, whose origins and solutions go far beyond the context and possibilities of general practice. But general practice can make an important contribution, dealing with problems in the here and now. And unlike most observers, commentators and armchair critics of health inequalities, GPs and their primary care colleagues can, not only make a difference to people's lives, but can do it quickly.

And in doing so, they make what I think is a more important contribution, as flagbearers for the principle that everybody matters, an inclusive principle that was enshrined in the post-World War 2 consensus, but which has been weakened by divide and rule politics, with its playbook of demonising others whether they be people on benefits, asylum seekers, immigrants, the EU etc.

Inequalities in health are important, of course, but a bigger picture and question is whether we are an inclusive or exclusive society, not in abstract terms, but expressed in everyday experience. Hence our thinking behind this …

"By excluding exclusions, keeping everyone on board, and building three types of relationship, inclusive health care can be a civilizing force in this increasingly dangerous, fragmented and uncertain world."

As Oscar Wilde put it, *"The smallest act of kindness is worth more than the grandest intention."*

Or as William Blake said, "*He who would do good to another must do so in minute particulars; the General Good is the plea of the scoundrel, flatterer and hypocrite."*

The strength of the Deep End Movement, for that is what it now is, working to improve health and narrow social division, is that it is grounded in small acts of kindness, and in minute particulars.

Solidarity has been and is an important achievement, connecting otherwise isolated colleagues with similar values and aspirations. But as Taylor and Hunt-Hendrix say in their new book *Solidarity – The Past, Present and Future of a World Changing Idea*, which strikes lots of chords, there are two types of solidarity.

Defensive solidarity is about circling the wagons against hostile forces outside. Transformative solidarity is about change, requiring identity, vision and strategy – where you want to go and how you're going to get there. That requires organisation.

They describe *"Organising is a kind of alchemy. It turns alienation into connection, despair into dedication, and oppression into strength."* Petitions with a million signatures achieve little. Small, well organised groups have been behind many social advances – parliamentary and voting reform, civil rights, the ending of apartheid, Just Stop Oil - just this week, a group of elderly Swiss women took their Government to court on its inaction on climate, and won, with implications for the whole European Union.

John Berger, wrote about the Mexican artist Frida Kahlo

…in the dark age in which we are living, and the new world order the sharing of pain is one of the essential preconditions for a re-finding of dignity and hope. Much pain is unshareable. but the will to share pain is shareable and from that inevitably inadequate sharing comes a resistance.

So, in conclusion, we have two challenges.

To resist – that is, defensive solidarity; and to organize – that is, transformational solidarity

And finally, as the pioneers of old advised, when horsepower was the main means of travel - Full Steam Ahead!

WHAT THEY SAID

MISSINGNESS IN HEALTHCARE

Andrea Williamson, Professor of General Practice and Inclusion Health

Defined as “the repeated tendency not to take up opportunities for care, such that it has a negative impact on the person and their life chances” with an enduring pattern.

Previous epidemiological work about multiple missed appointments found that patients had poor health, higher treatment burden, complex social circumstances and much higher premature mortality- so action to address missingness is vital.

Missingness is caused by an interaction between service- and patient-side drivers, shaped within a wider context; tending to endure over time but can be changed.

SHINING A LIGHT ON THE INVISIBLE: RELATIONAL INJURY, ACCESS AND CARE

ADAM BURLEY, Consultant Clinical Psychologist

The talk started with an overview of the basic position of human beings as being relational from birth, and introduced the idea that our health and wellbeing might be largely dependent on the quality and nature of our relationships across the lifespan.

It then spoke about how developmental trauma can have profound and long-lasting negative impact upon the quality and nature of people's relationships across the lifespan, and how this can be particularly pertinent in the healthcare relationship where need and vulnerability are so central to the dynamic.

The talk introduced the concept of a 'relational injury' as a way of making visible the impact that developmental trauma can have on individuals, and as a way of allowing a benchmarking against the provision, adaptation and accommodation that we make for more visible physical injuries.

The various difficulties encountered by those with severe relational injury were discussed, including how some of the relational dynamics do not always evoke sympathy, how the

injury is invisible and so can be easily missed, and importantly how it can leave the person unable to 'relationally access' care. A comparison was made with how it might be hard for someone who was wheelchair dependent to physically access a clinic that required an ability to climb stairs, and how we are often asking those with severe relational injury to climb 'relational stairs' that their injury makes impossible.

Various approaches were discussed that might go some way to providing appropriate adaptation and accommodation for those with severe relational injury such that they could access the care that they often need disproportionately more than those who can more easily relationally access care. A question was posed as to what the relational equivalent of a wheelchair ramp would look like?

TEACHING RELATIONAL PRACTICE FOR HEALTH INEQUALITIES:

IS IT WORTH IT?

Dr Sarah Doyle, Professional Nurse Lead, Queen's Nursing Institute Scotland

This talk reported on the evaluation of a novel online workshop programme for community nurses and midwives in Scotland, aimed at supporting them in their work in socioeconomically deprived areas where people struggle with poverty, adversity and multimorbidity.

The programme sought to help promote and maintain therapeutic optimism and aimed to deepen professionals' understanding of relationship development.

Evaluation showed increased levels of compassion satisfaction, reduced levels of burnout, and reduced levels of secondary traumatic stress.

The conclusion is that even in the face of overwhelming workforce need, it is possible to deliver an intervention, with modest funds, and still to have meaningful impacts on participants and on their approach to care.

WELCOMENESS, FAITHFULNESS & FORGIVENESS: A NEW LOW THRESHOLD / HIGH FIDELITY PHILOSOPHY FOR THE PROVISION OF GP CARE TO MARGINALIZED POPULATIONS

Austin O'Carroll, General Practitioner, Dublin

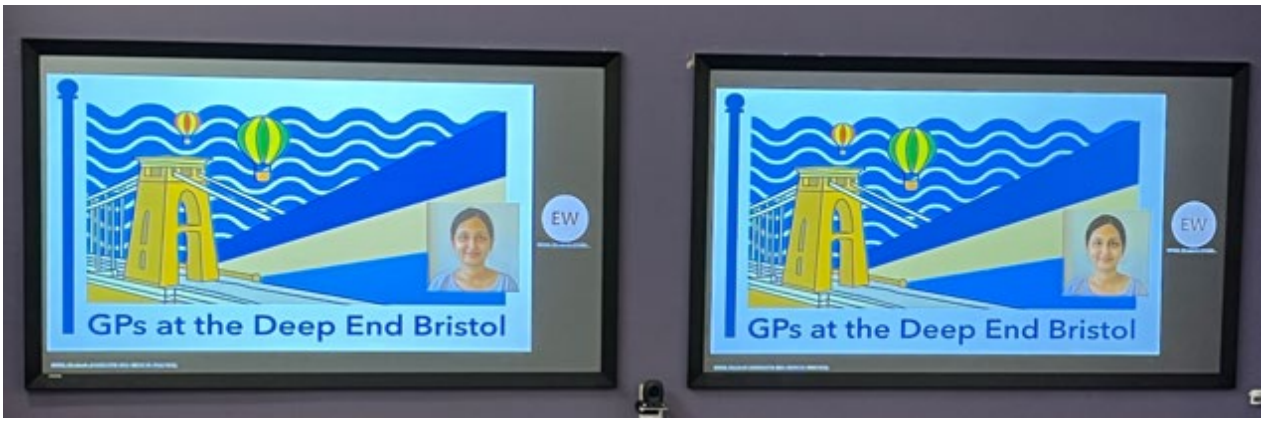
Having access to general practice and experiencing continuity of GP care have both been associated with a wide range of health and social benefits. Despite greater health needs, patients from marginalized groups have poor access to and poor experiences of continuity of GP care.

This impacts negatively on patient health and welfare; secondary care usage and health-system costs. A low-threshold approach requires GPs and their practice staff to display welcomeness to marginalized patients and to review their practice systems and procedures to ensure they are not creating avoidable physical, geographic administrative, attitudinal barriers and that they can overcome any patient internalised barriers to accessing GP care.

A high-fidelity approach requires the doctor to display faithfulness to their marginalized patients, seeking to protect and maintain the doctor -marginalized) patient relationship. Marginalized patients can display behaviours that arise from their experiences of child adversity that can threaten their relationship with the practice.

The GP and staff need to learn how to manage any challenging behaviours in a manner that maintains the relationship and may need on occasion to display forgiveness in order to maintain faithfulness.

The Friday night ceilidh at the Pierce Institute, Govan



The start of the video report from Deep End Bristol

REFLECTIONS OF AN EDINBURGH GP

Nora Murray-Cavanagh is a Deep End GP at Wester Hailes in Edinburgh, Scotland, who was featured in the November 2023 edition of the BMA magazine *The Doctor.* Below she gives her impressions of the Glasgow conference, the speakers and three workshops. In feedback to her Edinburgh colleagues.

NOTES ON SPEAKERS 12/4

The Deep End story so far: Professor Graham Watt

Always inspirational, wonderful expansive speaker; worth knowing about the Deep End back story if you're not familiar, great to hear an 18th geographical group in the pipeline (Canada); multimorbidity(lancet paper); Inverse Care Law; Care Plus study; The

Exceptional and Equitable Potential of General Practice; Solidarity (book); Bevan/Starfield/Tudor-Hart/Marmot

Missingness in healthcare: Professor Andrea Williamson

Sobering, illuminating, stark research presented by Andrea–looking at how our "missing" patients suffer significantly worse health outcomes. A call to arms to examine our practice and systems. *"The repeated tendency not to take up opportunities for care, such that it has a negative impact on the person and their life chances";* looking at 136 Scottish GP Practices, over 9 million consultations covering 550K patients; DNAs – 0 (54%) 1 or more (46%) 2+ (19%); maps to SIMD1 and 16-30y/90+y; urban; appt delay (2-3d); more deprived patients registered with GP practices in more affluent setting have the highest risk of missing appointments; correlation with #LTCs; much greater risk of all-cause mortality (risk increases with number of missed appts) Patients with long term mental health conditions missing >2 appts/yr had 8x risk of all-cause mortality compared with those who missed no appts.

Shining A Light on the Invisible: Relational injury, Access and Care": Dr Adam Burley

If you ever get a chance to listen to Adam –do it! Speaks so clearly and powerfully how relationships are completely essential and fundamental, and we simply cannot do our jobs with any degree of efficacy if we do not prioritise this. Relationships are like air.

Adversity and Complexity: Teaching Relational Practice practice for HI: is it worth it?" Professor Sarah Doyle (Nursing)"

So affirming to hear this calm assured speaker sharing the evidence base for reflective practice (supervision/psychotherapy) to support practitioners at the Deep End. Talking specifically about midwives and nurses.

Low threshold, high fidelity general practice: Dr Austin O'Carroll

Engaging, entertaining and inspiring GP from North City Dublin working with patients experiencing highest levels of socioeconomic deprivation. Urging us to turn our systems on their heads, and speaking from both researched and personal experience of just that. Our current setups are increasingly hard to access (high threshold) and with poor continuity/engagement from patients (low fidelity) This MUST change.

NMC Question to panel – *What sustains you to do this work?*
Answer – *The patients! The relationships.*

NOTES ON WORKSHOPS AND SPEAKERS 13/4

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Keynote Speaker - Darren McGarvey, Author | Musician | Journalist

A fiery call to arms questioning if the NHS (and public sector in Scotland/UK) is past the point of no return? Check out his fringe show, new BBC series and new book "*The Social Distance Between Us*" (and previously his "*Poverty Safari")*

Darren McGarvey: Trauma Industrial Complex –Trauma and Oversharing in the Age of Lived Experience -The Stand Comedy Club// BBC iPlayer -Darren McGarvey: The State We're In.

Keynote speaker –Professor Victor Montori: The Patient Revolution: (and book)

"We must transform healthcare from an industrial activity into a deeply human one."

For me, the most powerful quote of the conference –in answer to my question asking for hope (one of conference themes) and asking how we can do "the work", he responded,

"Nora, the work of justice is hard, the work of peace-making is hard. But what other work would you rather be doing?"

Keynote speaker –Professor Euan Lawson (Editor BJGP)

Resisting enshittification – reflections on advocacy and activism. Super, challenging talk, and loads of reading recommendations. (including a second for "*Solidarity*", sounds like a must read) "*Academic Activism*"–research-based policy and where does the action line start/stop for academics / HCPs?

Workshop : Building Equitable Primary Care

Fantastic jampacked intro to, and worked example of, using the EQUALISE principles and FAIRSTEPS framework to address health inequality in primary care. Ben Jackson and Josie Reynolds (GP Academics, Sheffield) were well organised, engaging, enthusiastic presenters.

The FAIRSTEPS Study: Framework to Address Inequities in primary care using STakEholder PerspectiveS - short report and user guidance (shef.ac.uk)

1

STEP 1 - Define the group(s) experiencing the inequity

- May be more than one group

2

STEP 2 - Consider the issues

- Access and engagement
- Structures and processes of care
- Patient experiences
- Staff training and development

3

STEP 3 - Ensure key ingredients are included

- What ingredients need prioritising to make it work?
- How should we implement any change to make it work?
- How and why do we think this intervention will work?

4

STEP 4 - Co-design the intervention

- Involving service users wherever possible.
- Plan the evaluation of the intervention

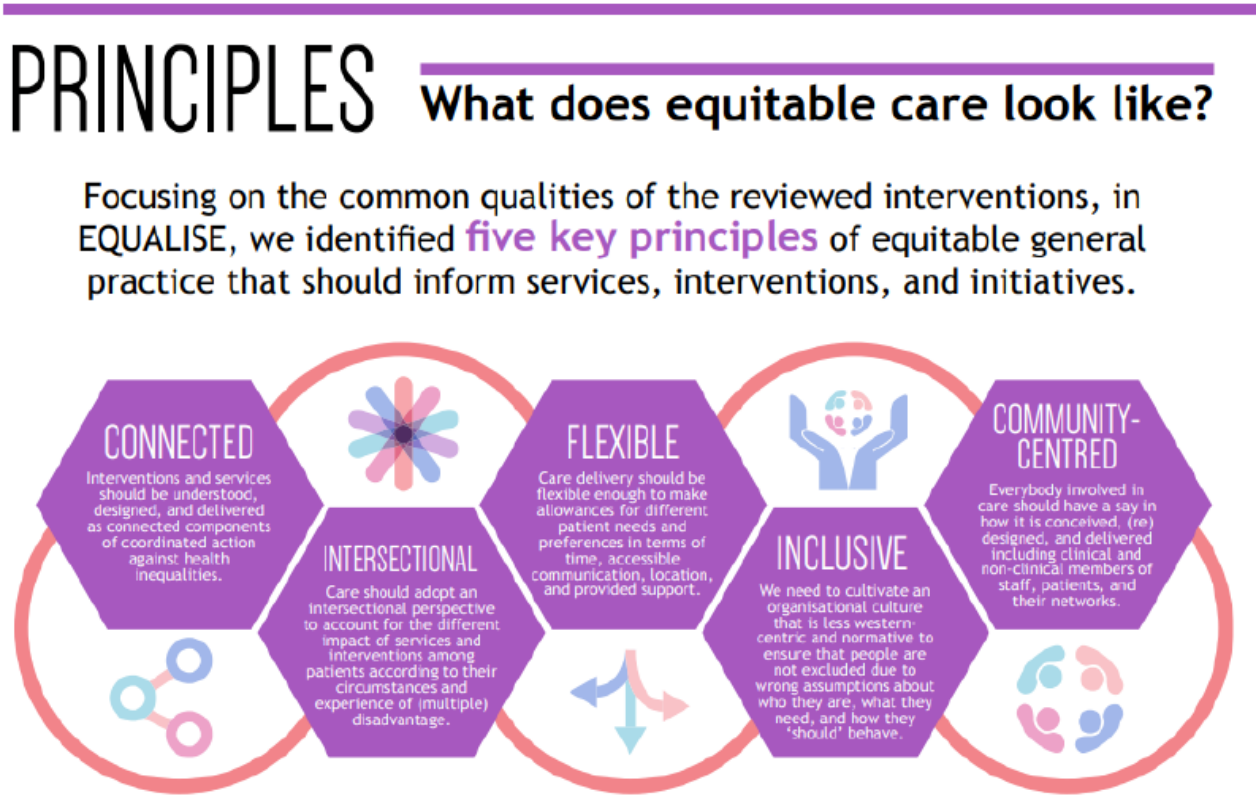
Figure 2. The FAIRSTEPS framework

Table 4 – An illustration of how the FAIRSTEPS framework could work for three contrasting examples from the prioritised interventions

Inequity		Issues to Address				Key Ingredients	New Intervention
Which groups experience the inequity that needs addressing?		What problems do these groups have accessing services?	Which processes of care contribute to the problem?	Which patient experiences need to be improved?	What staff training and development is needed?	Which key ingredients should be included?	What changes will we make to address the inequity?
1	Victims of domestic violence and their families	Integration between health and housing services	Lack of 'safe' places for victims	Resistance to discuss sensitive subjects Listening	Wellbeing workers Trauma informed care Emotional burden	Confidentiality Safety Anti-stigma Integration	**Targeted support for domestic violence victims and their families from trained health and wellbeing workers, including access to support about safe housing, family support and general advice.**
2	People who are homeless	High personal thresholds for seeking healthcare Lack of opportunity to access care and medicines	Lack of capacity for services traditionally carried out by GPs	Easier access for regular routine care, but not necessarily to a GP	Other practitioners: to deliver physical examination; diagnosis; prescribing; onward referral; and clinical follow-up	Access barriers Continuity of care Community engagement	**Increase capacity with pharmacists delivering services for people who are homeless so that the level and intensity of care is appropriate. Awareness & signposting-Promotion to community organisations to encourage equitable access**
3	Trans-patients	Structural discrimination	Services not aligned to gendered health risks	Non-judgemental	Gender and sexual identity	Awareness of Pt characteristics Cultural safety and sensitivity Anti-stigma	**A systematic programme of flagging trans-patients in the practice during cancer screening to identify if need recall or not for cervical and breast screening.**

Workshop : Health Inequalities and the Humanities

Absolutely brilliant workshop with Tom Ratcliffe (Fairhealth –100% worth checking out) involving discussion, poetry, song, visual art, written reflection, television series. Examining how the arts are a powerful force for supporting our resilience and understanding our humanity as practitioners, healthcare professionals, people working with people in a challenging system. Happy to discuss how this could be usefully facilitated within our different environments.



Workshop : What Does Meaningful Community Engagement Look Like?

Really enjoyed and was very moved by the community group speakers who joined us in this workshop with the fantastic GP academic Marianne McCallum. Chance 2 Change, and Men Matter –groups she worked closely with during her PhD. The power of community-generated projects, and the importance of co-production were considered. And, of course, the age old issue of funding and sustainability – frustrating. Groups felt very engaged with and supported by their local Deep End GP practice (Dr Peter Cawston, Garscadden Burn)

Resources

https://youtube/gRPB6Ktks98?feature=shared“The Wee Club That Saved Our Lives”, CHANCE TO CHANGE, Drumchapel
MEN MATTER SCOTLAND Peer-led, men’s mental health, Drumchapel

The two toolkit/report resources I thought were super, from the Sheffield/Cambridge workshop FAIRSTEPS (framework for designing/assessing interventions with a health inequalities lens) and EQUALISE (5 guiding principles for equitable General Practice)

The FAIRSTEPS Study: Framework to Address Inequities in pRimary care using STakEholder PerspectiveS - short report and user guidance (shef.ac.uk)

EQUALISE Building Equitable Primary Care -a practical toolkit -Clinical Effectiveness Group (qmul.ac.uk)

REFLECTIONS OF A GLASGOW GP

Dr Shona Mackinnon, Clinical Lecture in General Practice, University of Glasgow

I am extremely grateful to have had the opportunity to attend the Deep End International Conference 2024 - bringing together a community of healthcare professionals and activists, who are dedicating their careers and lives to highlighting and tackling the injustices in society.

My day began with a walking tour of Drumchapel, the area in which I work in Glasgow. I had the opportunity to learn more about the Community Links Worker Programme and to meet some hugely inspiring members of the community, working to support each other to improve their community’s access to vital services as well as its quality of life. It struck me that there are so many truly inspiring people in communities, dedicating their lives to

helping their peers and yet how undervalued their lived experience is, how many struggles they face to obtain ongoing funding, and how the third sector is often left to try to mitigate the devastating impact austerity is having on their community. Like so many of us, they have to do more and more with fewer and fewer resources.

The first session of the conference solidified these sentiments, putting into stark relief the evidence about the impact of growing inequalities in society. It also discussed the role of the Deep End clinician - not only focusing on individual clinical care and social issues, but also reflecting on our role in the wider community, policy and politics. We were reminded that health is political, and that we need to consider our moral responsibility to use our collective voice to advocate for evidence-based improvements in society. The session also explored key concepts around missingness and its causes, the requirement of relational capital to access services and challenges around relational injury, highlighting the need to rethink our services if we want them to be truly accessible and equitable, through the provision of low threshold, high fidelity care.

In the evening, I attended the conference social. This was held in a community space and was catered for by a local social enterprise. The main event was a ceilidh – centred around traditional Scottish dance – and the atmosphere was one of inclusivity, joy and connectedness, the perfect accompaniment to the conference.

Day two of the conference was equally inspiring – focused on lived experience and enabling change. We heard from activists and people with lived experience, emphasising the importance of collaboration, peer support and community-led activism in affecting social change, and the need to address what matters to people most. The "*Health in Humanities"* workshop was a highlight for me. I was in awe of my colleagues' talents, and the session demonstrated the potential for art to be a source of comfort, a space for reflection and – at times – escapism, but also as a force for social change, and a way of expressing concepts and ideas in a way that words alone cannot.

Other workshops were similarly engaging and thought provoking. The "*Climate Health Creation in the Deep End*" workshop made me reflect more deeply about the intersection of climate justice and social justice, and how to re-think healthcare using a planetary health lens. We were also able to share practical examples of how to improve the health and wellbeing of both patients and the planet. The *"Responses to the Inverse Care Law: Danish and Scottish Approaches"* workshop was also enlightening – it gave me the opportunity to learn more about different health systems, and consider the importance of global solidarity and shared learning in the face of many similar challenges.

The keynote speeches were inspiring and motivating – exploring how to effect change, and our role in "*Building a patient revolution (for careful and kind care) in the Deep End",*

and reflecting on the role of academia in advocacy and activism. I felt encouraged and inspired to keep writing, be brave and continue to work in solidarity with others.

All in all, this was one of the best conferences I have ever been to. As well as emphasising the importance of community collaboration in tackling health inequalities, I believe it has also helped me to find my own community – of healthcare professionals and activists, intent on creating a more equitable and socially just world.

A DANISH DEEP END GP'S PARTICIPATION IN THE INTERNATIONAL DEEP END CONFERENCE IN GLASGOW

Does a welfare society like Denmark have patients who can be described as Deep End patients? As a Danish GP, I do experience that we have opportunities to help socially and economically needy patients through legislation and with broad support of the population. Despite this, my work life in a social housing area with 60 nationalities shows that there are vulnerable patients whose intentions are difficult to fulfil. Where the patient shows difficulties in seeking help, and where trauma, abuse, loneliness and financial problems make it difficult for me to succeed in my medical efforts. At the meeting in Glasgow, I was therefore excited to see if there were proposals for solutions and whether there were more similarities than differences.

The conference in Glasgow provided a fantastic introduction to the Deep End movement. The size of the meeting was appropriate for discussing experiences and lecture content with like-minded people. Similar to the first national Deep End meeting in Denmark, the uniformity among participants were a strength. In my work as a general practitioner, I have attended countless meetings and conferences focused on specific organs, specific diseases, communication and management. However, I haven't encountered many meetings where the theme is a special group of patients and a group that takes up a lot of space in my clinical everyday life. This conference was an eye-opener and a valuable supplement to all my previous educational activities.

Our visit to Drumchapel Health Center introduced the work and experiences of link workers. In Denmark, support for vulnerable patients often comes from municipal mentors and personal tutors through social centres. In Drumchapel, we discussed the good experiences of link workers where help is integrated into general practice. How the general practitioner as the patient's own doctor, where a relationship has already been created, is the link between the social worker and the patient. This is a great strength and can often create trust and belief in the patient that help is available. We also learned about their challenges, such as short-term employments and limited time available for assistance or that help may only be provided for specific areas.

Dr Sarah Doyle presented her research and findings on teaching support staff, providing a concrete assessment of what teaching in working with Deep End patients means. Several factors define the patient group and are particularly important to understand for optimal patient care. Her recommendation based on her research showed that special supervision is important for support staff. It was a useful point to take back to Denmark. This insight is important to me in my daily work and can also be lifted to a more generalized Danish effort.

I spoke with two young GPs, Liza and Lindsey, who had both participated in the Pioneer Scheme. The project had been part of the recruitment of doctors who choose to work with patients living in socio-economically disadvantaged areas. They expressed joy and naturalness in working with this patient group. The model involves a nine-month paid placement with an experienced Deep End practitioner along with one day a week of training on topics that are relevant for working in the Deep End. For both Liza and Lindsey, the appointments were examples of their choosing to continue their work in a Deep End Clinic. Given Denmark's similar challenges in attracting GPs to socially and economically burdened areas, this model seemed like a promising approach to work with.

Finally, my participation in Tom Ratcliffe and Dom Patterson's workshop: *Arts and humanities in medicine* was an immersive experience. Several participants presented in music, words and pictures how they draw on their own or other people's art in their work with Deep End patients. It was a great experience to feel the participants' understanding of my own presentation, as I shared my and my patient's reflections on a picture painted by his sister Jasmina Malkov. The patient, who suffers from chronic paranoid schizophrenia and does not want medication for his dysregulated diabetes, gave me this picture without much explanation. Though I often struggle to understand his logic and often become the listening party, he expresses that we talk well together and that means a lot to him. I have asked him about the picture, and this is what he said:

"The picture shows that you take care of many patients. And shows that the patients also support you. The picture looks like you. I think it shows you. When you're sad and worried or radiant - I don't know how my sister knew. When the energy that is in our world and society and art rises to power, then it becomes like the entire universe is connected. Like a God's power. You make it work for me. I can't put that into words. But we can try to gather attention together. I am happy when we understand each other, and I trust you. I am happy about the mail correspondences when you answer my mails. I am glad that you, as my doctor, can remember my activities such as my car game. The car game where I drive down through Europe as a truck driver. You remember that. I was worried that they would cheat me in the psychiatric ward. I come from Bosnia and my mother tongue is another. But there is more to the relationship between doctor and patient than what language can explain. As a patient I know that I only have limited resources compared to you as a doctor. But still Doctor and patient can share something, something that is not in language".

As a GP I wonder - Who am I - to know - how and in what way relations are made to my patients. Little did I know - but Elvedin showed me one way through art and spiritual reflection in his psychotic medicated brain. And at the two last diabetes controls he was well regulated - also for reasons I do not understand...

Marianne Hansen, MD Copenhagen

Deep End Denmark: Marianne Hansen, Mogens Vestergaard and Nynne Bech Utoft

THE VIEW FROM JAPAN

I really enjoyed the conference. It is very stimulating. Many GPs and other professionals shared their experiences and academic achievements from the Deep End project, and although all the presentations were great, the research on missed appointments was particularly impressive. This is because missed appointments are also a problem in Japanese primary care, and exploring the epidemiology, associated factors, reasons and experiences of missed appointments gave me inspiration for research in Japan. The training program for GPs in deprived areas is also attractive. I would like to offer a similar course in Japan. The conference is a great resource for international colleagues working in deprived areas.

Makoto Kaneko, Deep End Kawasaki-Yokohama

A SELECTION OF DEEP END LEADERS AND COORDINATORS

Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.

Margaret Mead

There are five vertical columns, from left to right, front to back:

Stewart Mercer (Scotland), Judit Konya (Cornwall), Carey Lunan (Scotland), Susan Smith (Ireland)

Ruth Gilbert (Cornwall), Laura Nielsen (Manchester), Richard Ayres (Plymouth), Patrick O'Donnell (Ireland), Martin Weatherhead (North East and North Cumbria – NENC)

Austin O'Carroll (Ireland), Sameena Hassan (NENC), Lili Risi (London)

Peter Saul (Wales), Brid Shanahan (Ireland), David Blane (Scotland), Ryan McHenry (Emergency Medicine)

Ben Jackson (Yorkshire and Humber), Graham Watt (Scotland), Euan Lawson (BJGP), Mogens Vestergaard (Denmark)

DEEP END CANADA

We are pleased to announce the launch of *Primary Health Care at the Deep End Canada / Soins primaires en milieux défavorisés Canada!* Inspired by the tremendous work and advocacy of Deep End networks worldwide, we aim to bring together primary health care settings from across our vast and diverse country in a coalition to tackle health inequities.

Our mission statement: Deep End Canada advocates for addressing health inequities in primary health care at individual, organizational, and policy levels through collecting and using social determinants of health data and sharing ideas and projects.

Although Canadian health systems (ten provincial, three territorial and one federal) are publicly funded with universal coverage for medically necessary healthcare services, we have seen inequities in primary care grow wider. Yet, routinely collected data and action to tackle the social determinants of health remain rare in primary care in Canada. This lack of robust data makes it challenging to identify unmet social needs, to understand patterns of health inequities or systemic racism, nor track progress towards improvements. The COVID-19 pandemic has shown how important this data is to inform equitable and fair action during a crisis and beyond.

Primary Health Care at the Deep End
Soins primaires en milieux défavorisés Canada

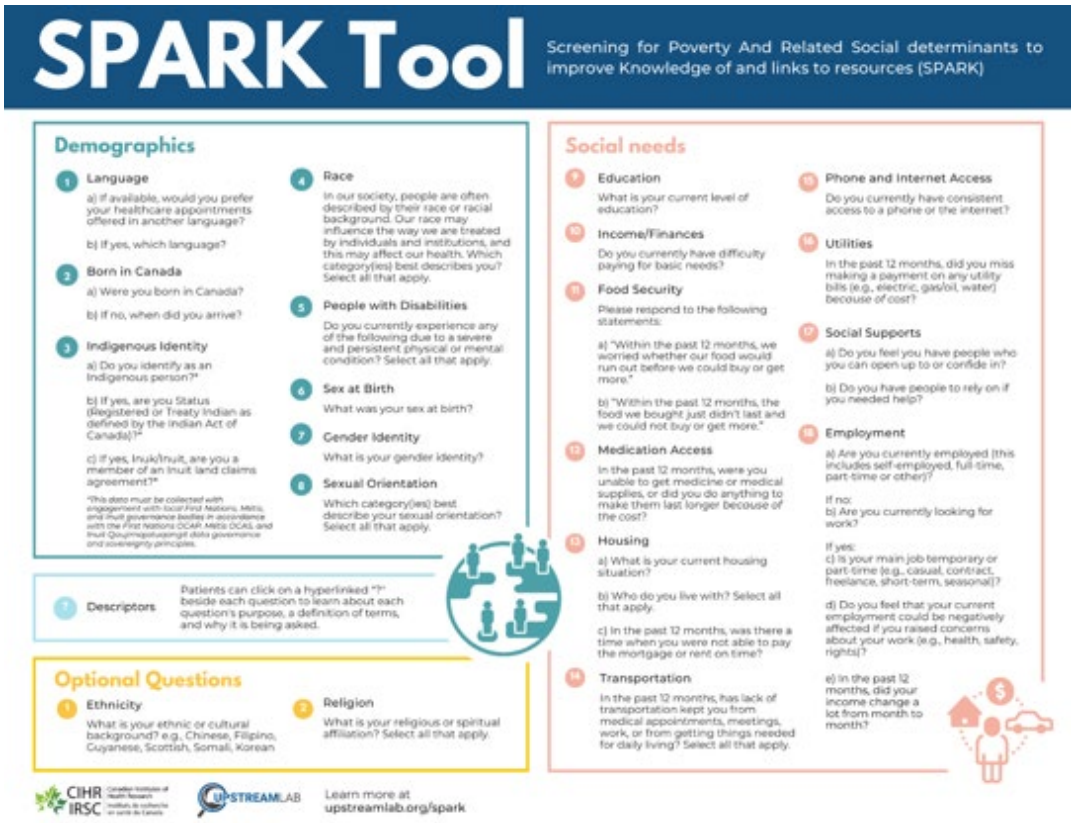
Adopting the World Health Organization's definition of primary health care as a "whole-of-society" approach to ensure "all people, everywhere, have the right to achieve the highest attainable level of health", our name and logo resemble the (often uphill) movement towards interdisciplinary and equitable primary health care that adheres to the OurCare Standard.

Primary Health Care at the Deep End Canada (Deep End Canada) is being initiated by Upstream Lab: a non-profit research lab dedicated to improving the health and well-being of the population by addressing issues related to social determinants of health. Founded and directed by family physician and Public Health Specialist, Dr. Andrew Pinto, Upstream Lab is based in Toronto, Ontario and has strong ties to primary health care across Canada.

UPSTREAMLAB

Upstream Lab operates on the traditional territory of many nations including the Mississaugas of the Credit, the Anishinaabe, the Haudenosaunee, and the Wendat. Tkaronto/Toronto is covered by Treaty 13 known as the Toronto Purchase of 1805 and the Dish With One Spoon Wampum Belt Covenant. We acknowledge that First Nations, Métis, and Inuit peoples are the traditional guardians of the land known as Canada on which our network operates (both unceded and Treaty territories) and these lands are home to many diverse Indigenous people from across Turtle Island. We acknowledge the oppression of the lands and cultures of the Indigenous peoples of this country. As health professionals, we all have a role to play in the path to decolonization and a duty to fight for Indigenous sovereignty rights.

Upstream Lab has led the development of a set of standardized questions – the SPARK[1] Tool - to collect demographic and social needs data in primary health care routinely and systematically. Over the past decade, this tool has been developed and refined (originally called the Toronto "Health Equity Questions"), undergone psychometric testing and validation with a large national sample, and has been implemented in five primary health care clinics in five provinces with over 2,060 patients completing the SPARK Tool. Over 96% of providers found the tool useful and over 84% of patients had a positive experience completing it.



The SPARK Study was funded by the Canadian Institutes of Health Research. From this work, we learnt that routinely collecting data about social determinants of health is deemed acceptable by patients and providers, and has potential to drive actions to improve health equity in primary health care. However, there are some challenges in implementing this data collection (completion rates varied by site from 9-48%) and more support is needed to address identified social needs through individual, clinic, and policy level actions. We are grateful to many Patient Partners who are central to the SPARK Study. Many have been involved for several years, providing valuable contributions to shape this project. Of note, the SPARK Study received the 2019 North American Primary Care Research Group (NAPCRG) People's Choice Award for commitment to patient-entered outcomes research.

By launching Deep End Canada, we believe we can support more primary health care sites to collect data on the social determinants of health routinely and systematically, foster exchanges and learning across sites, and drive collective action to improve health equity. We have received support from the Canadian Primary Care Research Network (CPCRN) to spread the SPARK Tool to 20-25 primary health care sites across Canada over the next three years. This will include primary care teams, community pharmacies, and nurse-practitioner-led clinics, reflecting the diversity of primary health care that serve patients in high deprivation areas across Canada. Primary health care sites involved in Deep End Canada will be invited to:

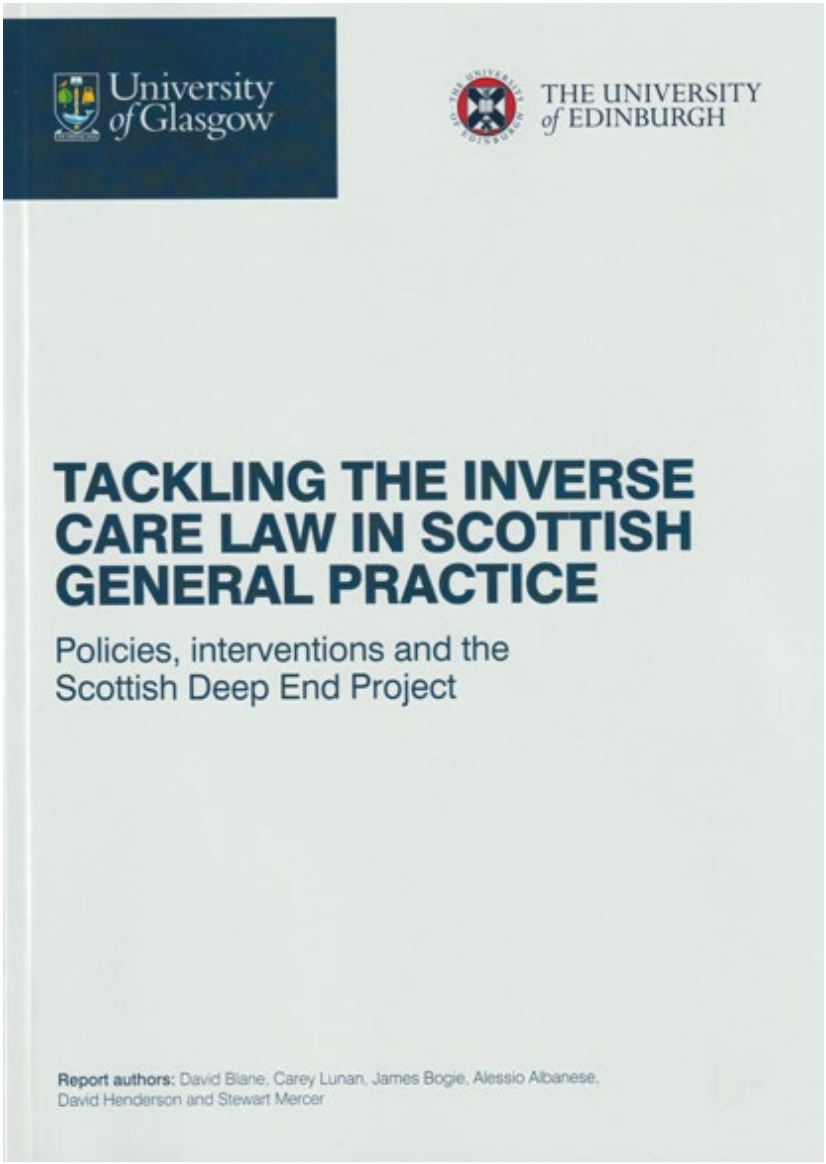
- Receive support to collect demographic and social needs data from their patients (survey tool, materials, coaching, and lessons learned)
- Meet with an implementation coach to interpret data and develop local interventions to address identified needs
- Share challenges and strategies with other sites across Canada during facilitated meetings
- Participate in advocacy for health equity in primary care and beyond
- Contribute to a developmental evaluation of Deep End Canada to learn from this network and prioritize future action on health equity.

To learn more about Deep End Canada or Upstream Lab or to explore potential collaborations, visit https://www.deependcanada.org/ or contact us at info@deependcanada.org.

Melanie Ann Smithman, Joseph J. O'Rourke, Geil Astorga, Isabelle Fortuna, Andrew D. Pinto

Adekoya, I., Delahunty-Pike, A., Howse, D. et al. Screening for Poverty And Related social determinants and intervening to improve Knowledge of and links to resources (SPARK): development and cognitive testing of a tool for primary care. BMC Prim. Care 24, 247 (2023). https://doi.org/10.1186/s12875-023-02173-8

TWO NEW REPORTS ON THE INVERSE CARE LAW



TACKLING THE INVERSE CARE LAW IN SCOTTISH GENERAL PRACTICE.

This report, based on research funded by the Health Foundation, was launched at the Deep End conference in Glasgow on 12/13th April.

The research, by David Blane, Carey Lunan, Stewart Mercer and colleagues at the Universities of Glasgow and Edinburgh, explored responses to the inverse care law in Scottish general practice. It included: 1) Systematic scoping review of academic and grey literature, 2) Qualitative interviews with key stakeholders, and 3) New analysis of publicly available data.

It found that, despite numerous policy commitments, there remains a major implementation gap between policy ambitions to strengthen general practice in deprived areas and sustainable delivery on the ground.

The report concludes that policymakers in Scotland need to take steps to ensure practices in more deprived areas are resourced in proportion to the needs of patients. Where interventions are working well, policymakers need to ensure long-term sustainable funding. The upcoming second phase of the 2018 GMS contract is an important opportunity to take lessons forward.

The timing is good, as a more recent report (below) from the Royal College of General Practitioners echoes many of the recommendations. Momentum to address the inverse care law is building…

David Blane

BREAKING THE INVERSE CARE LAW IN UK GENERAL PRACTICE

This Report from RCGP (UK) mentions the Deep End in the following selections of text.

Deep End projects have pioneered work on health inequality reduction in many parts of the UK, particularly in Scotland. These projects seek to draw together GPs working in areas of socioeconomic deprivation to identify practical ways to address health inequalities, and to learn from each other.

Key recommendations from the Scottish Deep End project include:

- *Prioritising advocacy and amplifying the patient's voice*
- *Embedding Community Link Workers, Financial Inclusion Workers, and Mental Health and Alcohol nurses in practices*

Deep End projects are increasingly spreading across England and a pilot in Wales has been funded by Welsh Government and delivered by RCGP Cymru Wales since 2022. Similarly, RCGP Northern Ireland is now looking for support to start their own Deep End project.

However, in the case of Wales, the future of funding is uncertain, as well as in other places across the UK. The funding and access challenges are greater when Deep End projects want to successfully include rural, remote, and coastal practices.

It is important that general practice staff in all areas of the UK can benefit from coming together in Deep End projects and that this is appropriately resourced and supported.

There are also relevant programmes across the UK that have improved the ***recruitment*** *of GPs in disadvantaged areas, which deserve expansion and secure, long-term funding. The* ***Scottish GP Pioneer Scheme*** *supported the recruitment of younger GPs and retention of experienced GPs in Deep End areas.*

This scheme delivered excellent outcomes but is no longer funded, which was a disappointment to many hoping to scale up its success. This scheme was part of the inspiration for the English Trailblazer programme.

Recommendation:

Governments across all four nations of the UK should commit ring-fenced funding for Deep End projects, which bring together GPs working in areas of socioeconomic deprivation to identify practical ways to address health inequalities, and to learn from one another.

NEXT TIME

We look forward to a report of the first meeting of Deep End Emergency Medicine. Meanwhile, here is an article describing its background. To see the full article, see

McHenry R, Aspden C, Quinn J, et al.
Emerg Med J Epub ahead of print: doi:10.1136/emermed-2024-214155

At the deep end: towards a social emergency medicine

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Handling editor Ellen J Weber

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ABSTRACT
People experiencing the highest levels of social deprivation are more likely to present to emergency care across the spectrum of disease severity, and to have worse outcomes following acute illness. Emergency medicine in the UK and Europe has lagged behind other regions in incorporating social emergency medicine into practice. There is evidence that emergency clinicians have the potential to mitigate health inequalities, through advocacy and intervention supported by high-quality research, while also acknowledging the limitations intrinsic to the environment in which they work.

Julian Tudor Hart proposed the Inverse Care Law in 1971,[1] a year before the appointment of the first consultants in A&E medicine in the UK. However, more likely to make an unplanned return to the ED, and are more likely to die from critical illness.[4–6] Together, these factors shape the experience of emergency care, impairing access to a full range of services and worsening outcomes.

The wider determinants of health are well-established. Public health institutions rightly highlight the injustice of their role in driving chronic multimorbidity and lost years of healthy life.[2] However, while there has been some recognition of the influence of social deprivation on emergency attendance, policy has not yet addressed the associated increased risk of death in acute and critical illness.

While emergency clinicians must focus on the central task of preserving life and limb in time-critical illness, we are not powerless to challenge

HUNGRY FOR MORE?

Deep End International Bulletins 1-10 can be accessed via the International Section of the Scottish Deep End Project on the University of Glasgow website https://www.gla.ac.uk/schools/healthwellbeing/research/generalpractice/deepend/international/