GENERAL PRACTITIONERS AT THE DEEP END
INTERNATIONAL BULLETIN NO 13
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You got to have a dream. If you don't have a dream,
How you gonna have a dream come true?
Rodgers and Hammerstein, South Pacific

Introduction

When I was head of a department of general practice, my Senior Lecturer the late Stuart Wood was a staunch and loyal supporter – combining the qualities, I thought, of Friar Tuck and Little John. One morning he mentioned that after the previous evening's surgery he had dropped by the home of an elderly woman patient who lived alone and had just been given a cancer diagnosis. The visit had taken an hour. That seemed exceptional but Stuart shrugged his shoulders and simply said *"It's my job".*

Many of the articles in this edition of the Bulletin are individual and group expressions of this powerful idea – that individuals can not only push the boundaries of what they do but also what they aspire to do with colleagues. In the Deep End Movement local heroes abound, such as Austin O'Carroll in North Dublin, Laura Neilson in Greater Manchester and Richard Ayres in Plymouth, to mention only a few.

This edition of the Bulletin includes 11 reports from Deep End Projects (just over half the total number of Projects), ranging from large national projects in Canada, Denmark, Ireland and Scotland; mature regional projects in North East and North Cumbria, London and Yorkshire/Humber; and energetic local projects in Bristol, Cornwall, Nottinghamshire and Plymouth. On Page 48, Caroline Mitchell describes DERA – the Deep End Research Alliance – involving researchers from many Deep End Projects.

Most reports describe the opportunities for shared activity and learning that central coordination can provide, but there are also insights on the importance of individual stories, as shown by the "campfire exercise" in the Denmark report on Page 25.

Ten years ago, a Deep End GP in Scotland's most deprived practice invited me to shadow her for a day – an ordinary day for her but a special day for me, with the opportunity to observe, capture and share the nature of her work in an article in the BJGP. As Petra Sambale retires from practice, after 25 years at the Keppoch Practice in Possilpark Health Centre in Glasgow, it is a pleasure to recall and reproduce that article. (Page 13)

In February this year I was privileged to receive an invitation to attend and present certificates to Deep End practitioners to completing an educational course in North West London. Imagined and brilliantly realised by Chad Hockey (Page 4), who literally got on his bike to visit practices and drum up support, the scheme has been recognised by the Health Service Journal with its Partnership Award for the **'Most Impactful Program Addressing Health Inequalities'.** At the event I attended there was a palpable buzz in the room – a quintessential Deep End project of like-minded colleagues fuelled by aspiration, solidarity and passion.

At the other end of the career journey, I spoke in February at a Glasgow medical student conference on health inequalities - the first time I've ever spoken at a circus school, with trapeze swings hanging from the ceiling (See the photo on page 47) – it just happened that the student organising the meeting trained circus performers in his spare time. A generalist in the making.

A rude shock arrived in March with a letter from a picture agency asking if we had permission to use a photograph which featured in Bulletin No 8, and which investigation determined was a screenshot of a press photo which had appeared on the front page of the *Scotsman* newspaper. The photo had been noticed in Spain by a friend of the mother of the GP who appeared in the photo along side Nicola Sturgeon. By the time the photo had been screenshot and sent from Spain to Scotland, from mother to daughter and from the GP to me, its origins were forgotten. But the incontrovertible fact was that we didn't have permission, and a £575 fine was due. Fortunately, the fine was paid by Glasgow University on whose website the Bulletin had been posted. It turned out that this situation was a familiar one and payment of fines is not unusual. Let this be a warning never to use photographs without permission when permission is due – the oversight can catch up with you, even years later.

Finally – to explain the quote from South Pacific at the top. I'm reminded of *Grey Owl*, the film by Richard Attenborough about the pioneer environmentalist of that name who lived in the Canadian wilderness and lectured to audiences in the UK and North America, dressed as an American native. Only his real name was Archibald Stansfield Belaney, born in Hastings to an upper middle class English family, who fantasised and realised his dream to be a woodsman and trapper. On a lecture tour of the US, he was invited to meet some Indian chiefs. Would they see him as an impostor? Probably they did, but they also recognised a life lived in harmony with Nature. "Grey Owl," they told him, "you have dreamed well".

Throughout the Bulletin I have added some quotes to pepper the mix. Enjoy!

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UPDATE FROM NW LONDON

In March 2025 the NW London Deep End programme received the Health Services Journal Partnership Award for the *'Most Impactful Program Addressing Health Inequalities'.*

Members of the NWL team attending the HSJ Awards ceremony

The aspects that impressed the judges were the grassroots nature of the program and our belief and message that change happens because of people. I think this is the common thread across Deep End groups, so although we were the ones there to receive the award, it felt like a win for the wider Deep End movement.

For us it started in 2018, not with the creation of an organizational strategy or national policy, but with a few individuals connecting over shared values and aspirations.

Inspired by the work of Deep End colleagues across the UK, we created a Fellowship programme that involves regular structured time, during which participants attend a series of evidence-based workshops designed to develop their knowledge and understanding of the causes, consequences and ways of addressing the issues they are facing, whilst enabling them to simultaneously share experiences and connect as a group.

Workshop Series

1. **Understanding complexity**: why it's different in the Deep End
2. **The power of consultations**: the impact of empathy
3. **Understanding vulnerability**: domains of resilience
4. **Understanding dependence**: social constructions and demand
5. **Self-care and wellness**: allostatic load and rational choice
6. **Understanding access**: use of a candidacy framework
7. **Promoting continuity**: relational and narrative care
8. **Mental health and wellbeing**: hope, agency and prescribing
9. **Advocacy**: power, privilege and the perpetuation of passivity
10. **Financial wellbeing**: creation and consequences of poverty
11. **Food insecurity**: social gradients, diabetes and obesity
12. **Living in pain**: threat, exclusion and social distress
13. **Trauma**: adverse childhood experiences
14. **End-of-life**: dying in poverty and community approaches
15. **Data and research**: understanding use of data for change
16. **Peer support**: the role of community-based approaches

Sessions are hybrid, so there is a core group who attend in person, with others joining online. We deliver them from venues such as foodbanks or community centres - we did one very humbling session from a portacabin on a building site run by an organization that supports young adults involved in knife crime to learn trades.

We rotate around every Borough in our ICB and open the sessions to anyone who wants to join, from residents to commissioners, and in so doing have built links and been lucky enough to have heard a wide range of perspectives on the issues being discussed.

The programme includes **'QSIR Practitioner'**, a nationally recognized NHS training initiative that teaches the improvement skills needed to lead on grassroots change projects. Our aim is thus to produce a well-connected, highly trained group of change agents!

Why did we design the program this way? Because health inequity is a complex problem, so can't be approached with methodologies designed to tackle simple problems.

It requires the ability to sense, experiment, continually adapt to local contexts and build partnerships across organizational boundaries based on values rather than contracts.

This means that in complex systems change depends on the people doing the projects more than the projects they are doing.

Instead of creating a program that delivers a specific CORE20Plus5 project, we focused on creating a way to develop the people who can do ANY project - whether at the level of personal clinical practice, in their organization, PCN area or across the ICB.

The Fellows do a project as part of the learning, but we support rather than control this and never know what they will do. We just know they will find and do the thing that matters in their contexts, and that they will share things via their networks.

Examples of Projects

Healthy Lungs Project: This targeted an area of pocket deprivation in a PCN with a specific focus on smoking and associated respiratory conditions. It has led to a practice with a previously lower than expected COPD register becoming a respiratory hub for the PCN, with an active champion programme, community walks, smoking cessation services and strong links to local respiratory consultants.

Deep End Health Checks: Eligibility for the NHS health check starts at age 40, but in Deep End areas this is too late - people have already developed co-morbidities by then. This project created a Deep End check that starts at age 30, can be done by healthcare support workers and includes questions about housing, food insecurity, financial issues and mental health. It has already been seeded to other areas in the ICB via the connections made through the Fellowship.

Targeting the right people is crucial and we soon learned that the best way to do this is by word of mouth. When we started, we didn't have a network, so we simply got on our bikes and went and visited GPs in their practices, but we now have a scenario where everyone who has come through the program knows someone who knows someone. The Fellowship has been oversubscribed every year and for GPs across our ICB it only costs about £15k per Borough per year, plus faculty.

What else have we learned?

- Keep a record but don't record the sessions: people often ask for recordings, but the value comes from participants having honest conversations and to do that they need to have a safe space.

- It needs to be in person: this is about generating trust and connections and it's so much easier to do that in person. Meeting means you can have lunch together and strengthen the bonds - the fellowship has created friendships.

- It needs to be practical: inequity is a change conversation by default and whilst there is space for communities of interest, unless there is a practical aspect the more activist and activated participants will become dissatisfied.

- It needs to be authentic: if part of this is about building connections based on commonalities, then that needs to apply to the faculty. I'm not sure this would be possible without the team also being from the Deep End.

- Two years works best: year one builds the confidence of individuals and the cohesion of the group, but the second year gives time to consolidate, deliver a project and the overlap allows cohorts in different years to form a bigger group.

  Our small faculty is still together and, for us, being able to deliver the scheme has been a joy. We've seen GPs rejuvenated and doubling down on their commitment to work in more deprived areas. We've seen light-bulb moments when it suddenly all makes sense. We've seen friendships form and careers transformed.

  The program was designed and drafted in a garden shed but now has accreditation as a level 7 module at London South Bank University, and we've built a partnership with an NHS Community Trust, so have health visitors, nurses, OTs, dieticians and physios alongside GPs as part of the programme, and have retained the practical approach by making the academic assessments a vehicle to support participants to do local change.

  There is still lots for us to do, we need to be better at linking and maintaining our networks after the fellowship ends, and despite the success each year we are back to square one in trying to scrape together enough non-recurrent funding to keep going.

Chad Hockey speaking to practitioners in NW London on completion
of their award-winning educational course

The challenge is one of systematization. We wanted to create something that could work in other geographies, and our belief is that developing people provides this in a way that focusing on projects doesn't, but this person and social movement approach to change has not yet been adopted as system strategy.

About 80% of the people in England's most deprived quintile live in about 15 ICB areas, and at least 11 of these now have Deep End or emerging Deep End networks. Imagine what we could achieve with the right support.

Chad Hockey

Life is not a matter of holding good cards,
but of playing a poor hand well.

Robert Louis Stevenson

POETRY FOR HEALTHCARE PROFESSIONALS, WINTER 2025

Inspired by the response to our Arts and Humanities workshop at the Deep End International Conference in 2024, the Fair Health team and colleagues set up two online poetry courses for 2025. The first course was held in January and February.

The courses comprise six sessions with the themes of Care, Poetry and Bodies, Health and Illness, Writing Happiness and Joy, Queerness and, finally, Class and Race. Nine health professionals signed up to complete the course, which was facilitated by Jemima Foxtrot, a writer, performer and theatre-maker, originally from Yorkshire, now living in Berlin.

One participant left the following feedback:

"The workshops offered an oasis of creativity, reflection and fun in the middle of a busy working week, giving permission to stop, reflect and connect. Jemima's encouragement ("don't get it right, get it written"), and her skilled ability to create a 'safe space' very quickly to explore important and interesting themes through both reading and writing poetry left me feeling inspired, with wonderful new friends at the end of our six weeks. A beginner to the world of poetry, I also found it a powerful way of helping me make sense of personal and professional experiences and stories".

For busy clinicians, expressing yourself through writing offers a way to process difficult experiences, find catharsis and achieve creative rest.

We will be running a second course in the Autumn (starting 5th November 2025 for six weeks). If you are interested you can sign up here: Writing poetry for healthcare professionals.

The next three pages show a small sample of the work created during the most recent course.

Tom Ratcliffe

Genuine poetry can communicate before it is understood.

TS Eliot

It's time to go

I am lost
in your indifference
I search your face,
for a hidden trace
Of you
Are you still there?
You forget my name.

I distract
from my fear
By combing your hair
And moving it from your eyes,
I see my eyes.
You forget my name.

I paint your fingernails your favourite, old-fashioned, coral pink
Rub perfumed lotion into your still-young skin
It's my skin
You forget my name.

I show you photographs of worn family stories
Of places you have known, and faces you have loved
My face,
my sisters' faces,
your daughters' faces.
You forget my name

I go quiet. I hold your hands.
They are my hands
My eyes fill with tears, I blink them gone
It's time to go.
It's time for this to end.
You forget my name.

Carey Lunan

What you let me carry

I don't think you ever knew,
How much you kept from me.
I could see it eating away at you,
Distracting you,
Detracting from you,
And then...
You're back in the room,
Here with us again,
Laying out the meal,
Fixed grin,
Maybe on your second (or third) gin,
Embrace enveloping,
Always welcoming,
But sometimes the edge would cut through.

I don't think you ever knew,
How much you had kept from me,
But when you let out all that you had lived through,
When I was old enough,
Broken enough,
"Round the block" enough,
To hold it myself,
And sit with you, be there with you,
You let me carry it too.

John Hardman

Requiem for the junior hospice doctor

The first time we met
I found you out of bed
part naked
like a solitary Scots Pine
imposing
angry at my intrusion.

I saw the cancer's marks.
I thought my job
was to help you mend.

After morning rounds
we always talked
there was no point dwelling
on drugs that no longer helped.
Instead
we spoke about music –
found we both loved
Faure's Requiem.

I brought in the CD from home.
Thinking it might help.

I remember pressing play
you being floored by the choir
turning to the wall
saying
switch it off
for God's sake
make it stop.

Tom Ratcliffe

Out of Hours

Discretion is the better part of general practice

I shadowed a GP working in one of Glasgow's most deprived areas. She arrived at 7.20 am on a Monday morning to deal with 38 items of correspondence, all needing to be checked and prescriptions altered, a patient phoned, or arrangements made, before the day even started. The telephone calls to patients all began the same way: 'This is Dr xxxxx, Hello John, Hello Helen etc'.

As the on-call doctor on a busier day than usual, she completed seven house visits that morning, each taking 30 minutes. It took an hour to enter all the details back in the practice and make the necessary arrangements, leaving 5 minutes for lunch. A colleague who took over the on-call for the afternoon made three more home visits, dealt with 22 telephone consultations and six emergency appointments.

The afternoon surgery ran for 3 hours, and would have lasted longer if all the booked patients had attended. Problems addressed included: cancer, depression, agoraphobia, asthma, self-harm, bereavement, domestic violence, heart failure, alcohol abuse, dementia, social neglect, and so on, often in combination. She left for home after a 12-hour day, with 61 items of correspondence yet to deal with.

I didn't see any short or trivial consultations. There were no 'worried well' patients, but a worried doctor leaving no loose ends when dealing with a series of patients with complicated health issues and other problems, all of whom she knew well. One patient said 'Dr xxxxx' is the only person I can relate to'. Another came in grim-faced, avoiding eye contact, almost in tears, but left 15 minutes later, beaming a smile.

I was struck by the intensity of the day, every patient getting the same attention. The doctor was too busy to put on an act: 'We have to focus on every single patient and listen. A lot feel they bother us and we cannot fob them off by being stressed or not dedicating time'. The practice has learned from experience that it is unsafe to assume that if problems are serious, patients will consult in time.

There are three GP partners and none work full-time: 'You cannot work fully concentrated for a whole day without recovery time'. The practice is wondering whether it might attract more students to their list to dilute the clinical load. Burn-out is an ever-present hazard. The level of work is hard to sustain.

> *"'We have to focus on every single patient and listen. A lot feel they bother us and we cannot fob them off by being stressed or not dedicating time'."*

The consultations I observed showed a GP at the top of her game. Previous contact, shared knowledge, and trust were fundamental to what could be achieved in a short space of time. Despite the pressures of practice in a deprived area,[1] the GP was ambitious for what she could achieve with, and for, her patients.

One seldom gets the opportunity to observe a GP through a whole working day. What I saw in Glasgow reminded me of working with Julian Tudor Hart at Glyncornwg in South Wales. He is best known for research on high blood pressure, but his daily practice and long-term achievements were characterised by his unconditional approach to all patients, whom he came to know well, whatever problems or combinations of problems they had. In the BBC documentary series on the NHS *Pioneers*, Mary Hart said 'Many people sentimentalise us, but we were just doing our job, for which we were paid, providing the NHS for our patients.'[2]

In an article with Paul Dieppe, Tudor Hart described the poisonous effects which can arise when, for whatever reason, health professionals become indifferent to what happens to the patient in front of them.[3] I remember him talking of the importance of finding something to like about every patient. There was no-one about whom there wasn't something to like.

In the 1950s, Collings described poorly-resourced areas of general practice as 'sufficient to turn a good doctor into a bad doctor in a short period of time'.[4] Such gross effects are less common today. A more subtle effect is whether practitioners set the bar high or low when dealing with patients.

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The incentives of the Quality and Outcomes Framework, involving only 12.7% of GP consultations,[5] have little to do with this aspect of practice. Professionalism and caring for patients are what matter, and both are at the discretion of individual practitioners.

Consultation rates are used as crude measures of practice activity and proxy indicators of health need. Such data convey nothing of the duration, content, quality, or consequences of consultations, and their use sustains the inverse care law.[6] What I saw in 1 day in one practice in one part of the country goes unrecorded in the scheme of things, reflects poorly on the NHS commitment to equitable resource distribution, but spoke volumes for the professionalism of one GP.

Graham Watt,
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BRISTOL

Since launching the Deep End network in Bristol in May 2023 we have continued to grow our community of frontline primary care staff and community organisation representatives to build a brilliant community that is passionate about tackling health inequalities. We have hosted six face-to-face events, and two webinars, with representation from the most deprived 17 surgeries in Bristol and Weston-Super-Mare as well as Homeless Health and The Haven refugee and asylum seeker specialist services. Recently we have launched roundtable discussions, with guidance from the Scottish Deep End network, and focused break-out sessions including work on continuity of care. Attendees were engaged at all the events and offered valuable contributions (see summarised visual minutes from our last meeting).

Grassroots research ideas

Three GPs from our Bristol Deep End network, with little previous experience of research, have put forward ideas for new research projects and they have been awarded Research Capability Funding from the Integrated Care Board focusing on: 1) the menopause, 2) continuity of care and 3) HRT prescribing. All GPs have been linked up with academics from the University of Bristol to start developing their grass-roots deprivation focused ideas into research proposals for NIHR funding. We have also been able to collaborate with excellent community partners, including Black Mother's Matter, to support their academic journeys and publish their amazing achievements.

Health Inequality Fellows

Over the last two years the BNSSG training hub have funded 13 health inequality fellows (six in year one and seven in year two) - qualified GPs working in Deep End practices funded one day a week to deliver a project focused on reducing health inequalities. Their contributions have tackled key areas of inequalities at practice, PCN and ICB level and included a range of topics including reducing CVD risk, staff recruitment at the Deep End,

mental health in minoritised groups, continuity of care and food education. The fellows also undertook RDN research studies as participants in their practices, improving representation,

Power Up Passion Projects

The Deep End network received £60,000 of funding from BNSSG ICB for continued professional development (CPD) and we decided to launch **"Power Up Passion Projects"** (PUPPs). A grant of £3000-£6000 was awarded to thirteen individual Deep End clinicians to fund CPD in an area of interest related to health inequalities. The PUPPs aim to bring about positive change within Deep End practices, including helping staff retention. Awardees were encouraged to share learning from the projects with other practices within the network.

PPI

Using links with existing community groups and building on new links, we have established a Patient and Public Involvement (PPI) Group for the network with representatives from fourteen different organisations. We undertook a joint Bristol and Sheffield GPs at the Deep End PPI meeting in March 2024. This provided the PPI contributors the opportunities to learn from each other and find out and learn about experiences of PPI contributors who have been involved in a similar initiative for over 7 years in Sheffield.

A key issue raised by the PPI members during a subsequent PPI meeting was difficulty accessing GP practice appointments. PPI contributors discussed a lack of appointments, difficulties in accessing appointments digitally and language barriers. Non-English speaking PPI members experienced specific difficulties (e.g. not being able to read appointment reminders written in English). These were subsequently discussed during our Roundtable Deep End meeting in December 2024.

Collaboration

We have developed collaborations with other Deep End networks across the UK (e.g., Newcastle, Sheffield, Plymouth, Wales, Scotland and Glasgow). The Society for Academic Primary Care (SAPC) now has a 'Inclusion health/GPs at the Deep End' special interest group, co-led by Beth Winn (co-lead for the Bristol network). This provides a fantastic opportunity to collaborate with other UK Deep End networks, sharing ideas for research project development and delivery.

Medical School Programme

We have recently launched our first Deep End Student Selected Component (SSC) at the University of Bristol and are offering 4 students an insight into life as a clinician serving our challenging but incredibly rewarding populations. We are also hosting Masters health professional research students from UWE with an interest in representative research in the community.

Beth Winn recently was invited to join the podcast: **Aural Apothecary Edit** to discuss GPs at the Deep End. She also presented to the Department of Health and Social Care on the potential that GPs at the Deep End have to be part of the solution to more representative research. BNSSG created a short film about our Bristol Deep End network, available on our website. Please click on the link to view the website and logo: [GPs at the Deep End Bristol.]

Graphic showing key messages from the Bristol Deep End Project

PRIMARY HEALTH CARE AT THE DEEP END CANADA

Primary Health Care at the Deep End Canada First Year Report

Joseph O'Rourke,[1] Aaron Switzer-Rodriguez,[1] Isabelle Fortuna,[1] Kimberly Manalili,[2,3] Stephanie Garies,[2,3] Janet Reynolds,[4] Wendy Blunt,[2,3] Amy Ferris,[2,3] Jazmin Marlinga,[2] Kerry McBrien,[2,3] Allison Soprovich,[5] Nick Kates[6]

1. Upstream Lab, St Michael's Hospital, Unity Health Toronto
2. Department of Family Medicine, University of Calgary
3. Southern Alberta Primary Care Research Network
4. Calgary Foothills Primary Care Network
5. Alberta PROMs and EQ-5D Research and Support Unit (APERSU)
6. Faculty of Health Sciences, McMaster University

Primary Health Care at the Deep End Canada had a busy start since our first coalition meeting in June 26, 2024. We have grown to approximately 10 organizations and 5 patient partners, representing around 25 individual clinics, from seven provinces out of thirteen provinces and territories. Our members include clinicians, researchers, and staff working in diverse primary health care settings, including family health teams, hospitals, community health centres, community pharmacies, provincial health authorities, and research teams.

Why Deep End Canada?

Deep End Canada is a network of primary health care teams, including health professionals, researchers, patient partners, and decision-makers, working with patients who may face social and/or economic disadvantages. We advocate for addressing health inequities in primary health care at individual, organizational, and policy levels through

the collection and use of social determinants of health data and the sharing of ideas and projects. Our network is guided by the following pillars:

1. Data-driven local solutions
2. Community and key actor engagement
3. Social action and advocacy

Currently coordinated by Upstream Lab, our goal is to ensure the sustainability of this network after the end of its current funding from the Canadian Institutes of Health Research and Canadian Primary Care Research Network (CPCRN). See the Deep End International Bulletin from November 2024 to learn more about our first few months.

What have we done?

- We have had respondents from over 160 clinics or organizations complete part of our SPARK Reach and Adoption survey to learn more about the use of sociodemographic data collection tools (including the SPARK Tool) across Canada.

- We have had 10 organizations join Deep End Canada, and fulsome conversations with several more about the collection and use of demographic and social needs data in primary health care. We continue to meet with and recruit new members across Canada as people reach out to the Upstream Lab or Deep End Canada with interest in the SPARK Tool, sociodemographic data collection and/or health equity.

- We presented a poster in November 2024 at NAPCRG in Quebec City, QC on "Primary Care at the Deep End Canada: SPARK Scale-up study protocol to build a pan-Canadian coalition of primary care clinics", and disseminated an infographic for new potential members (see below).

- We expanded the resources on our website to over 30 and created separate pages for providers and clinics, patients and the public, and for Deep End Canada members.

- We have engaged with existing networks or Communities of Practice with goals related to Deep End Canada by giving presentations and attending meetings, such as at the University of Toronto Department of Family and Community Medicine Mentorship Program and Community of Practice on Collecting Social Demographic Data in Primary Care Clinics.

- We have maintained relationships with patient partners since the start of the SPARK study in 2017 and featured many of these collaborators on our website. Deep End Canada patient partners attend intake and coaching meetings with individual clinics,

participate in data analysis and contribute to the overall direction of Deep End Canada. For instance, a patient partner from a Deep End Canada member research team in Calgary, Alberta, created several infographics describing the SPARK Tool and demographic and social needs data collection. Members of the same research team also created a video describing the SPARK Tool and its benefits for patients.

- The University of Calgary is working in partnership with Primary Care Networks and ten primary care clinics serving diverse populations to study the implementation of the SPARK Tool in Alberta. We are in the process of facilitating co-design sessions with each primary care clinic to tailor the implementation of the SPARK Tool, including patient engagement, integration into Electronic Medical Record systems, data presentation, and use of the data. We are currently conducting an environmental scan of community resources that help to address the Social Determinants of Health (SDoH) in Alberta, which primary care providers can connect their patients to, and also exploring opportunities to link this work with provincial priorities focused on integrating health and social care.

- The Alberta PROMs and EQ-5D Research and Support Unit (APERSU) and Edmonton North Primary Care Network are facilitating the implementation of the SPARK Tool spread to fostering engagement with communities to ensure the tool reflects local priorities and insights.

- Teams at the Faculty of Health Sciences, McMaster University have received funding to ask what community members think about the climate crisis and what could be helpful for them and facilitate engagement in co-designing health-related responses to the climate crisis.

What are we working on right now?

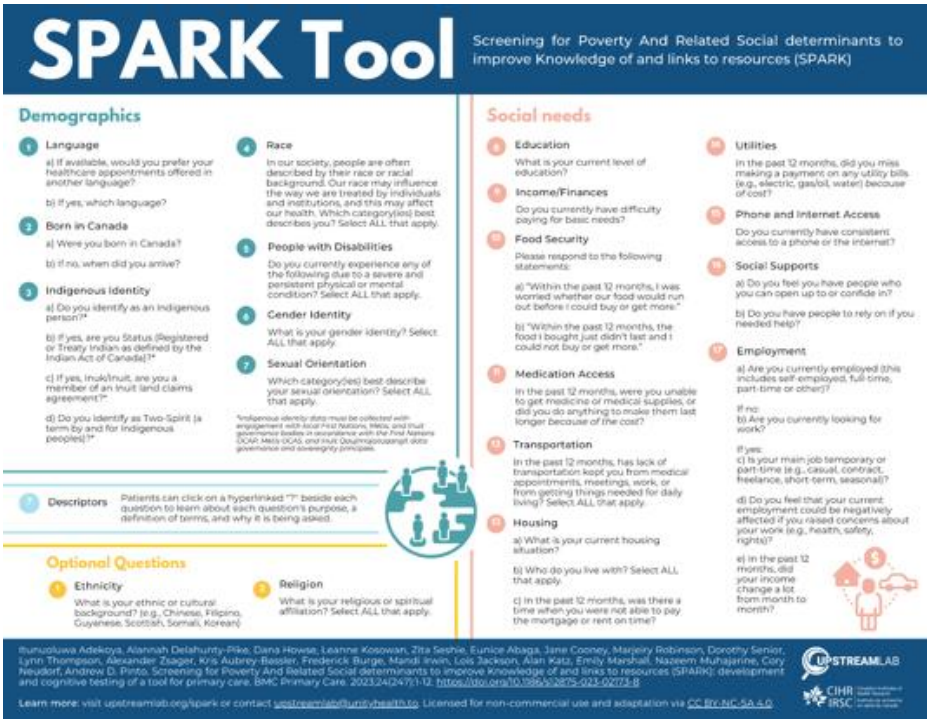
- We are building the internal portal within our website for members to access meeting minutes and share resources across the network, as well as the public-facing page to showcase our members and the work they are doing.

- We continue to meet with primary health care teams and networks across Canada to orient them to the network and identify opportunities for collaboration and support to advance health equity in primary health care.

- We continue to support existing members through facilitated coaching and providing resources.

What are our goals for the rest of 2025?

- We will continue to adapt our development evaluation of the network, including inviting members to participate in focus groups to share their experiences of being part of the network, seek opportunities to learn from Deep End Networks internationally, as well as seek funding opportunities to support central coordination of the network.
- We will identify opportunities to engage in advocacy, such as advocating at policy levels for financial, logistical, and digital infrastructure support to collect and use social data, or national efforts such as the "No One Left Behind" campaign in response to the ongoing tariff emergency, or local advocacy efforts in particular regions such as the implementation of the Community Information Integration (CII) / Central Patient Attachment Registry (CPAR) Data Elements in Alberta to ensure sharing of important health care data within a patient's circle of care.
- We will launch a follow-up survey regarding the Reach and Adoption of the SPARK Tool, to understand any changes in how organizations are collecting and using social data to address social determinants of health.
- We will host a Deep End Canada Learning Series on topics relevant to network members.
- We plan to identify other commonly used languages into which the SPARK Tool can be translated to increase the collection of demographic and social needs data.



Member Spotlight

HEALTHCARE AT EVA. – Bringing Primary Care into a Community Centre

The Eva Rothwell Community Centre is located adjacent to one of the most disadvantaged neighbourhoods in the City of Hamilton, Ontario and provides a wide variety of programs, especially for local youth, for a catchment area of 33,000 people of whom 20% have no family physician.

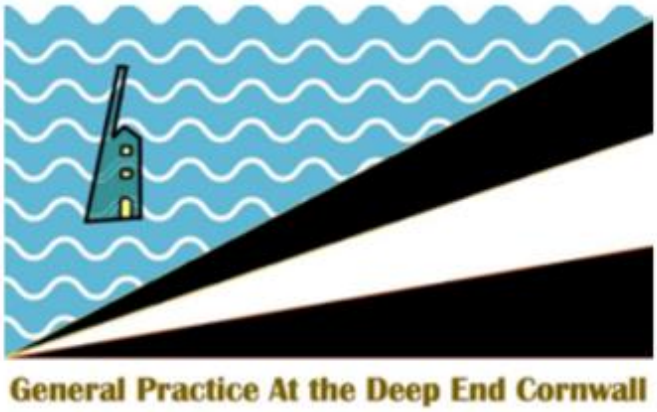
In response to this the Hamilton Family Health Team (HFHT), which integrates nurses, mental health counsellors, dietitians, pharmacists and other health professionals into the offices of 165 family physicians in 80 practices across the City of Hamilton, has worked with Eva Rothwell to design, build and staff a new primary care clinic within the Centre. **"Healthcare at Eva"** not only offers comprehensive primary care for local residents who have no family physician, but is also developing a wide assortment of health promotion and disease prevention programs, along with other programs that aim to enhance the local environment and expand the range of activities available for local residents, all in partnership with community groups and agencies.

Our priority, however, has been to establish a smoothly running primary care clinic, led by a nurse practitioner with 3 part-time family physicians each attending for half a day a week, and in our first 8 months we have enrolled 550 patients. We also have regular visits from a psychiatrist, mental health counsellor, dietitian, pharmacist and community connector and are establishing links with another HFHT practice on the other side of the catchment area.

We are now using the SPARK tool for all enrollees in the clinic, finding it easier to implement it proactively at the time of registration and this information (100 completed so far) will be used to guide both the initial assessment and ongoing care. We also intend to combine SPARK data with data from our electronic medical record to build as comprehensive as possible a picture of who we are seeing from the local community, and to help us identify who we may not yet be reaching.

Nick Kates
Psychiatrist for Healthcare at Eva
Hamilton Family Health Team

DEEP END CORNWALL



Deep End Cornwall was established in 2022 by bringing together 10 practices with the greatest ‘blanket deprivation’ (utilising IMD scores) with the goal of creating a collective voice to the specific issues of practising in the Deep End in Cornwall.

In May 2024 four health inequality clinical fellowship posts were offered and funded by the local training hub and one of these posts has been used as a clinical lead role for Deep End Cornwall. This has allowed Deep End Cornwall to further develop, and we have seen significant momentum and progress in the past 12 months, including engagement from all our practices.

We have had three ‘round table’ afternoon meetings with representation from the Deep End practices. These have been invaluable in developing relationships which foster support as well as the sharing of ideas and opportunities for collaboration as we consider how we deliver healthcare, mindful of the unique challenges faced by the rurality of our coastal county.

Partnerships have been developed with Public Health in providing an opportunity for practices to engage in the inHip project optimising hypertension control and with the NIHR RDN to help practices consider and take steps towards becoming research active to facilitate increased research representation of deprived communities in Cornwall.

This momentum and increased visibility have promoted advocacy and this year there has been a series of meetings between the ICB and Deep End practices considering a local fairer funding model. This has resulted in a small amount of increased funding for practices. Dialogue continues around a more long-term solution to the disparity in funding for Deep End practices.

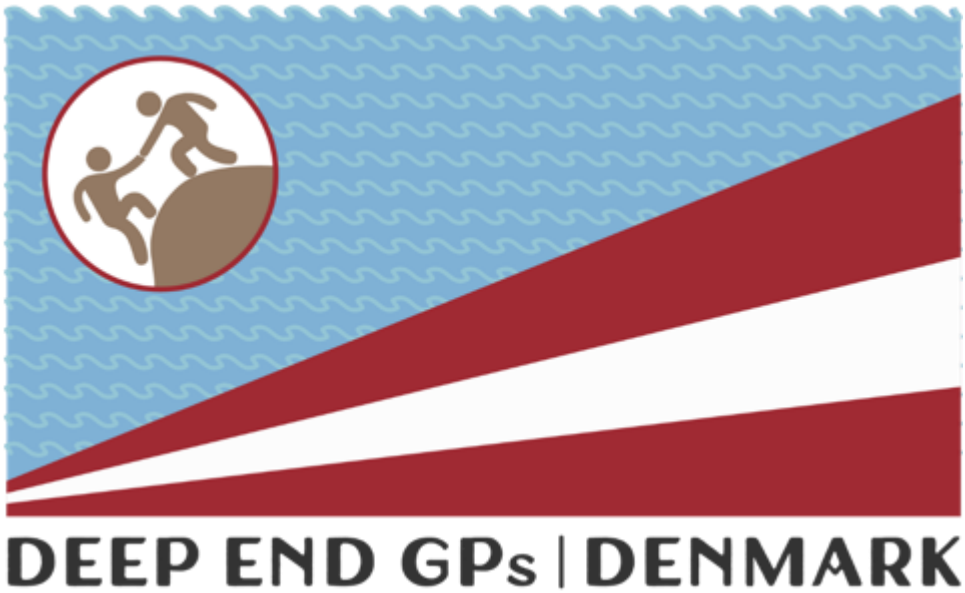
We were thrilled to host 'Paddling Out' our second Cornish Health Inequalities Symposium in March 2025 with over 90 delegates, again with wide representation from stakeholders working in areas of deprivation across Cornwall. Attendees represented a diverse background including public health, the integrated care board, medical educators, the third sector alongside GP colleagues and trainees. Bringing people together to reduce health inequalities across Cornwall, to collaborate, to be a collective voice and to find creative solutions. Austin O'Carroll, a fellow Celt, did not disappoint in bringing his unique ability to encourage and challenge us on how we provide care to the most marginalised in our society. It was an inspiring day, showcasing some of the work that is taking place across the county and fostered collaboration.

The audience at Deep End Cornwall's 2nd Symposium in Match 2025

As a result of the symposium, as a Deep End group, we have been working alongside the GP training scheme and the Medical School to consider how we might increase the representation and participation of Deep End practices and are excited to see increased funding and support to facilitate this. Also in the area of education, whole practice half day teaching on health inequalities has been delivered, with the goal of creating compassionate cultures and helping everyone in practices to understand the important part they have in reducing health inequalities.

At our last round table meeting we collected responses from practices to specific questions, hoping to gain a better understanding of the issues Cornish practices face working in areas of deprivation. As we look forward, we hope these themes might create a narrative that shapes the future for Deep End Cornwall. Over the next year, we hope to see a further round of clinical fellowship roles offered and following on from the success of the symposium, we are looking forward to developing a health inequality network bringing together colleagues working in inclusion health and with specific groups such as fisherman, to promote improved integration and collaboration.

Ruth Gilbert and Judit Konya on behalf of Deep End Cornwall



Deep End Denmark is in a positive phase of development. We have now existed for two years and are steadily growing, currently comprising 77 general practitioners.

We host two national and four regional meetings annually. The national meetings are 24-hour residential events, where we gather to discuss overarching themes, share experiences and network. When relevant, we invite professional facilitators to guide our discussions.

Over the past year, topics have included the implications of the national health reform for Deep End practices, the concept of a fulfilling professional life in the Deep End, and strategies for improving the financial sustainability of Deep End clinics.

Trust and strong relationships have been established among Deep End doctors. This was evident at our most recent meeting, where we engaged in the "campfire exercise" developed by Norwegian psychologist Per Isdal. In this exercise, each doctor shares their personal story in their own way and at their own pace, without interruption. Listeners are instructed not to comment or offer advice—only to listen. This exercise was a powerful experience, and participants have requested it be a permanent feature of future national meetings.

Deep End doctors are beginning to find their collective voice. We have agreed on the importance of actively sharing the positive narrative of working in Deep End practices. We want to emphasize that choosing to work in the Deep End is a deliberate and meaningful decision—motivated by the challenge and satisfaction of caring for patients with complex needs. Our ambition is to make Deep End work prestigious. As such, we are working to increase our visibility in the media.

Deep End GPs at a National meeting in Denmark

One of our active members, Dr. Berit Lassen, was awarded the prestigious Mahler Prize in November 2024 for her work at a Deep End clinic in Korsør. Her efforts, and those of her colleagues, were subsequently featured in a well-received three-part national television documentary titled “Lægerne på dybt vand” (“Doctors in Deep Waters”), which is freely available for streaming [link].

https://play.tv2.dk/serie/laeger-paa-dybt-vand-tv2oest

A podcast series of two to three episodes is currently in development, aiming to portray life in Deep End clinics. The journalist behind the series explores the philosophy of the Deep End movement and features interviews with Professor Graham Watt and various Deep End GPs, both from major cities and rural communities.

We are actively working to secure funding for several initiatives: publishing a book about Deep End Denmark, creating an online supervision group for GP trainees in Deep End clinics, and inviting trainees to participate in our national meetings.

Denmark is on the verge of implementing a major health reform that will significantly reshape the healthcare system. The reform includes a substantial strengthening of general practice, with a planned increase in the number of GPs from 3,600 today to 5,000 over the next decade. As the number of GPs grows, general practice will take on more responsibilities, with hospitals increasingly supporting our work.

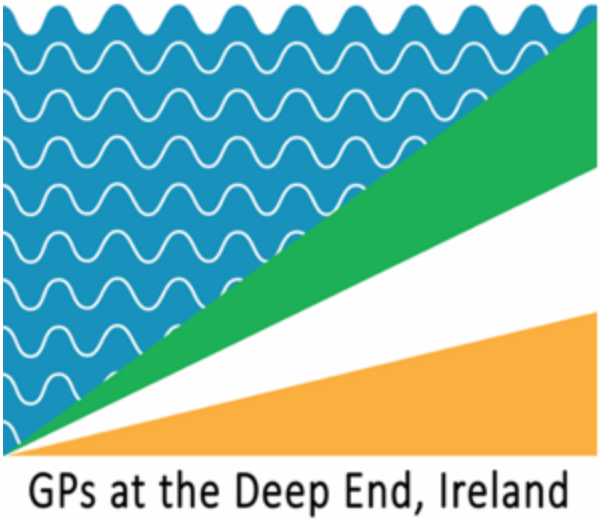
This reform marks a paradigm shift in resource allocation — moving toward a needs-based model. Practice list sizes and remuneration will in the future reflect the complexity of the patient population. Clinics with high numbers of patients with complex multimorbidity, low socioeconomic status, or limited health literacy will receive greater funding and serve fewer patients, allowing more time per patient.

The reform also allocates significant resources to recruiting doctors into Deep End areas. We believe these developments will soon lead to a substantial improvement in working conditions for Deep End GPs.

Professor Mogens Vestergaard, a Deep End GP, served on the national health structure commission that prepared the reform. He has now been appointed by the Minister of the Interior and Health, Sophie Løhde, as the Expert Ambassador for General Practice. In this role, he will support the reform's successful implementation by facilitating dialogue between authorities and GPs, and by promoting the sharing of best practices.

Deep End GPs at a national meeting in Denmark

IRELAND



Round Table Meeting on Child Poverty

In November 2024, Deep End Ireland hosted a roundtable event focused on child poverty, bringing together general practitioners working in deprived communities alongside experts in child poverty. The event provided a platform for Deep End GPs to share their experiences and insights, and to contribute to recommendations on reducing the impact of poverty on children.

Deep End Ireland has had a particular focus on tackling child poverty for several years, recognising its profound and lasting impact on health outcomes. The resulting report highlights the devastating effects of poverty on child health and development and outlines clear and specific recommendations.

These include a call for the fair allocation of resources based on need, support for GP recruitment and retention in underserved areas, the development of social prescribing initiatives for children and families, and the creation of a centralised referral pathway for children's services and supports.

The report has been submitted to the Irish Department of Health, with the aim of informing future policy development and ensuring that the voices of GPs working in deprived communities are reflected in national strategies to combat child poverty.
To read the full report and recommendations from the child poverty roundtable, visit:
https://www.deepend.ie/blog/roundtableonchildpoverty

Attendees at the Deep End Ireland Round Table on Child Poverty

Trauma Informed Care meeting

Since the last newsletter update, Deep End Ireland hosted a Zoom meeting on trauma-informed care, exploring practical ways to implement it in our surgeries and strategies to try to avoid clinician burnout. The session was inspired by some of the presentations at the 2024 Deep End International Conference in Glasgow, particularly Dr Sarah Doyle's talk, "*Teaching relational practice for health inequalities: Is it worth it?"* which introduced the concept of improving compassion satisfaction as a way to sustain relational, trauma-informed care in challenging settings.

Managing Menopause at the Deep End

Deep End Ireland has also secured funding for a pilot project to provide dedicated clinic time for menopause care to women living in areas of deprivation. The pilot began in April 2025 and will run for 22 weeks across eight participating practices. It aims to address unmet needs in this area and provide evidence to support more equitable access to menopause care. A full report on the outcomes of the project will follow.

Thought for the Day

It is immoral to delude yourself that you're doing good
when what you are doing is making yourself feel good.

Andrew O'Hagan, Caledonian Road, p 146

Enhance Programme

North East London ICB has been working in collaboration with the London Enhancing Generalist Skills Team (https://www.hee.nhs.uk/our-work/enhancing-generalist-skills) to pilot the delivery of a thought, learning and change program to support **Neighbourhood Working.**

The learning journey has travelled through the North East London Boroughs, sharing stories of hope and change against a background landscape of the **Enhance** domains: person-centred practice, complex multimorbidity, population health, system working, social justice and health equity, and environmental sustainability. **All the named contributors below are London Deep End members but many more contributed to the success of this programme. Huge thanks to all.**

A piece of music from the borough to inspire, opened the first session at Barking and Dagenham (B&D), where we heard about personalised integrated pop up clinics, outreach work which has served 1000s, permanent shower boxes, work that has been recognised nationally and internationally. Dr Jagan John and Dr Nadia Saeed and the whole B+D team showed what agency and collaboration can achieve.

We then travelled to Tower Hamlets and heard from Dan Hopewell (Bromley by Bow) about creative health approaches. Bromley by Bow have been pioneers of the integrated neighbourhood approach for decades. Then to City and Hackney (*'Start small but start somewhere') where* Stephanie Coughlin shared her insights of their relationships and trust journey. Stopping then at Waltham Forest with Dr Janakan Crofton focusing on the importance of sitting with your communities. Then to Newham where Dr Cat Gaynor, Dr Amit Sharma and Rebecca Waters shared sustainability projects.

And to the next stop a supported change programme. We are very excited to see how these projects impact in due course on health inequalities, Deep End and neighbourhood working. Huge thanks to the team and steering group and Deep End Members (in bold), **Ellie Hobart**, Lauren Moy, Gita Malhotra, **Dr Rupal Shah, Dr Jeyapragash** Jayapala and **Dr Kavita Gaur**.

Online Community and Solidarity

The online community continues to share resources and find its path. Solidarity is a pillar of the Deep End and has been a recurrent theme in our group over last few months. *'Transformative solidarity with its porous boundaries, expanding people's identities to build a bigger we'* - Leah Hunt Hendrix & Astra Taylor. We have come together as a collective voice on issues like contracts for Private Providers and Global Injustices.

Deep End Book Club

"The Deep End book club continues! Reads so far this year have been *Unheard - the medical practice of silencing* by Dr Rageshri Dhairyawan and *The Age of Diagnosis* by Dr Suzanne O'Sullivan"

Podcasts

A Deep End London Member, Dr Selvaseen Selvarajah was featured on the podcast series, *The Business of Healthcare*, talking about creating healthy communities. #344 Creating Healthy Communit…–The Business of Healthcare Podcast with Tara Humphrey – Apple Podcasts

The Fighting for the Soul of General Practice podcasts continue, with guests talking about issues ranging from power, surveillance, AI and the value of the therapeutic alliance. Check out the episode featuring Glasgow Deep End Colleagues, Stewart Mercer, John Gillies and Carey Lunan.

https://www.youtube.com/playlist?list=PLQ7L4Dw8A266inuM0fN_MwCw5OIyinPWp

Healthy Lungs in North West London

Dr Sabby Kant and Dr Rajivi Sanjeevi from Harefield in a deprived area of North West London are attempting to foster a unique community-led Health and Heritage approach through guided themed Historical Health walks by community champions. For those interested in ethnographic research and intergenerational inequalities, Harefield has a rich story of struggles, resilience and triumphs! They would be keen to connect with any person or organisations who could help sustain, promote or help with funding this inequalities project. (Ed Note: this is one of the projects described by Chad Hockey, P4)

'Deep End' Kenya

The London Deep End Group Members have also been taking a journey to support a 'Deep End' Kenya Project, which has involved supporting the setting up of a 24 bed hospital, primary care and outreach facility and a community based organisation. Maternity mortality rates are 583/100000 compared to 12.7 in UK. Infant deaths are 10 times higher. 65% live in poverty and an estimated 15% are single or double orphaned. There are high levels of vulnerable women and young females, high rates of teenage pregnancy. 20% of females between 15-19 having a live birth and there are high rates of sex working. Kenya has huge economic issues and as always there are global factors that have impacted https://debtjustice.org.uk/blog/debt-and-kenyas-economic-crisis. Please contact Kavita.gaur@nhs.net to donate/partnership queries. https://www.justgiving.com/crowdfunding/kavita-gaur

Poster for the "Deep End" Kenya Project

NORTH EAST AND NORTH CUMBRIA (NENC)

The NENC Deep End Network continues to be committed to supporting our members, advocating for proportionate universalism and addressing the Inverse Care law despite significant financial challenges in the NHS. Following the recent UK government announcement, we are unfortunately currently facing uncertainty about the future funding of our Network.

Network Engagement

At our last quarterly engagement event in October '24 (photo below) we welcomed a keynote speech on Public Health Priorities for South Tees & links to Deep End presented by Public Health Consultant Dr Stamp. This was followed by roundtable discussions covering member-led and new priorities in Mental health, Women's Health, Practice Nurse Network, Deep End Network Priorities and Training Programme.

NENC practitioners attending an engagement event

We are due to have our next Deep End engagement event with our members on 4th June, where we will focus on the upcoming challenges in NHS reform and the implications this may have on Deep End primary care as well as an opportunity to discuss specific project ideas in roundtable discussions.

Our Network

Deep End North East and North Cumbria (NENC) has grown to include 52 GP practices covering a wide geography in the largest Integrated Care Board (ICB) in England. Here is more about our Network and what we do: https://deependnenc.org/about-us/what-we-do/

A series of pilots have been developed and implemented under the WEAR acronym originally used by Yorkshire and Humber's Deep End Network (Workforce, Education, Advocacy and Engagement, Research). These have been funded by the NENC ICB:

Our Pilots/Initiatives

Workforce

IMMSDEEP: The Immunisation Catch-Up Team provides a service for Deep End practices unable to meet pre-school vaccination targets. Practices receive support from a third-party provider who work with and in the practice for two weeks, putting on additional clinics in practices, community settings or through carrying out home visits. We are currently in Phase 4 of the pilot which is focused on increasing vaccination rates for all-age children with opportunistic vaccination, including for influenza, of other household members.

CareDEEP: taking action to address the wider determinants of health in general practice. CareDEEP pilots started with 10 practices who received funding to employ or commission a worker to address social determinant of health needs. Practices are able to identify both the needs and the form in which to meet these and therefore we have had a wide range of pilots including projects focused on improving health literacy, addressing barriers to uptake of AAA and cancer screening, improving safeguarding, supporting mental health and improving physical activity. The number of practices involved in this initiative now totals 44, including an 11-practice strong partnership.

MINDED: Embedding Clinical Psychology in primary care has involved running a number of pilots with our Mental Health and Acute hospital partners. The evaluation is providing evidence of positive experiences both for patients and practices by embedding psychological therapy into primary care and delivering interventions that address both mental distress and social exclusion as well some of the challenges experienced in

implementing this new way of working, which we have been actively addressing as the intervention evolves. The advanced clinical training means the psychologists are able to act independently, helping to both improve care and reduce pressure on GPs.

Additionally, MINDED has led to improvements in the interface and relationships between primary and secondary care. We are working with the ICB's Mental Health and Learning Disability Workstream within their transformation programme to explore opportunities to mainstream this approach in communities with the greatest need.

TAPER2: Opioid and Gabapentinoid Deprescribing – we are concluding a second pilot comprising 11 practices (evaluation commencing) supporting patients waiting for surgery by successfully reducing their reliance on medication that can adversely impact post-surgical outcomes and recovery. The pilot has drawn interest from the National Pain Symposium which has requested a case study. Early findings indicate that 64% of identified patients were successfully recruited to the pilot, with 71% accepting deprescribing support and 53% accepting social prescribing support. We are due to expand the pilot into other locality areas across 31 further practices.

Education

TrainDEEP: increasing the number of training practices in the Deep End. To improve recruitment and retention, and ultimately to increase access to healthcare for those most in need, the NENC Deep End Network developed the TrainDEEP pilot intervention. This 12-month intervention supported the transition of Deep End practices to training practices. Two practices self-selected to participate through an open expression of interest call coordinated by the NENC Deep End Network. The intervention consisted of 2 phases:

- Phase 1 (months 0-6): An experienced GP trainer visited the DE practice twice weekly to upskill and support the transition into a Training Practice. They also provided clinical cover, giving the DE GP protected time to complete an intending trainer's course.
- Phase 2 (months 6-12): A GP registrar joined the practice, receiving joint supervision from the experienced and new trainer. The experienced GP trainer continued to deliver weekly clinical sessions.

On completion of the pilot, the DE practices became accredited training practices and are able to host registrars, supervised by the new GP trainer.

Continuous Professional Development – a series of education events for practice nurses, medical students and Foundation Year doctors were highlighted as important and

valuable in practice, including sessions on homelessness, managing chronic pain, and the menopause.

Fellowship Programme – in November 2024 we awarded four Fellowships to Deep End practice doctors to deliver a healthcare inequalities improvement project over a 12-month period. Projects comprise cervical screening, working with isolated groups, enhancing coding to improve patient outcomes, and strategies to improve engagement within chronic health management.

Advocacy and Patient Engagement

- System Advocacy: challenging traditional funding streams and advocating for Network funding (£1.6m in 2024/25 from NENC ICB)
- Network Events: bringing colleagues together to share and learn
- Deep End Practice Nurses' Network: supporting nurses working in the Deep End
- Patient Engagement: hearing and learning from our patients on their needs.

Our network's Patient Involvement and Community Engagement (PICE) Lead has led a team of researchers, members of the public and public involvement professionals to conduct a literature review and develop a model for evidence-based public involvement in applied health and social care research. This model gives organisations and individuals key areas to prioritise, identifies potential unintended negative consequences of involvement, and can be tailored to support public partnerships across a range of different contexts.

An evidence summary is now available to read here: Understanding meaningful public involvement in health and social care research - ARC

The full research paper is available here: https://onlinelibrary.wiley.com/doi/full/10.1111/hex.70160

This work is currently informing ongoing engagement and involvement work within Deep End communities. Further tailored guidance and information for member practices is in development.

NENC Deep End Research

Co-design and evaluation research underpins all NENC Deep End work programmes to ensure all our activity is:

- Informed by evidence – what works and why to help address health inequalities in primary care?
- Builds on existing evidence base in a way that involves Deep end practitioners, patients and communities.

Our NENC Deep End research team is based at Newcastle University, under the auspices of the National Institute for Health and Care Research (NIHR) North East and North Cumbria (NENC) Applied Research Collaboration.

- Find out more about our research activity: https://deependnenc.org/research
- Meet our research team: https://deependnenc.org/research/research-team/
- Learn about our public, patient and community research engagement activity: https://deependnenc.org/research/patient-and-public-involvement/
- Read and listen to our research outputs: https://deependnenc.org/research/research-outputs/

We have undertaken co-design research to understand and inform the focus and direction of our NENC Deep End network activity and funded pilots. More about this work here:

- Wildman, J.M., Sowden, S. and Norman, C. (2023) *"A change in the narrative, a change in consensus": the role of Deep End networks in supporting primary care practitioners serving areas of blanket socioeconomic deprivation*. Critical Public Health, DOI: 10.1080/09581596.2023.2205569
- Norman C, Wildman JM, Sowden S. COVID-19 at the Deep End: A Qualitative Interview Study of Primary Care Staff Working in the Most Deprived Areas of England during the COVID-19 Pandemic. International Journal of Environmental Research and Public Health 2021, 18(16), 8689. https://doi.org/10.3390/ijerph18168689
- Jeffries J, Wearn A, Hassan S, Fryer K, Mitchell C, Sowden S. *In at the Deep End: Innovative Approaches to engaging underserved communities in Northern England*, European Journal of Public Health 2024; 34: Supplnet_3, https://doi.org/10.1093/eurpub/ckae144.956

The research team has supported the co-design and evaluation of the NENC ICB funded NENC Deep End work programme, as well as developing wider research linked to NENC Deep End communities. This work includes the following projects.

TrainDEEP - transforming Deep End general practices in to training practices

- Armstrong M, Wildman J, Sowden S. *Addressing the inverse care law: how can we increase GP recruitment in areas of socioeconomic deprivation? A qualitative study of GP trainee views and experiences in the UK, 2023.* https://doi.org/10.3399/BJGPO.2023.0201
- Gupta A, Armstrong M, Vance G, Sowden S. *TRAINDEEP (Training Assistance Initiative in Deep End Practices) pilot evaluation: transforming GP practices into training practices in deprived areas of the North East and North Cumbria region of England.* 4E.1, SAPC, Bristol, July 2024. https://sapc.ac.uk/doi/10.37361/asm.2024.1.1

Mental health IN the Deep EnD – MINDED

- Jeffries J, Wearn A, Hassan S, et al OP25 *Qualitative evaluation of a complex mental health intervention in general practices serving socioeconomically disadvantaged communities in northern England* J Epidemiol Community Health 2023;77:A13. https://doi.org/10.1136/jech-2023-SSMabstracts.25
- https://arc-nenc.nihr.ac.uk/arc-impacts/

- https://arc-nenc.nihr.ac.uk/projects/mental-health-in-the-deep-end-minded-pilot-evaluation/

TAPER- Supporting opioid and gabapentinoid deprescribing

- Parbery-Clark C, Portice J S, Sowden S. *Realities of opioid and gabapentinoid deprescribing in socioeconomically disadvantaged communities: qualitative evaluation* BJGP Open DOI: https://doi.org/10.3399/BJGPO.2024.0160
- *CareDEEP – addressing the wider determinants of health and wellbeing*
- Abstract accepted for presentation at Society for Social Medicine and Population Health Annual Scientific Meeting, Bradford, September 2025

Lipid management in Deep End primary care

- Research explores how health care providers could improve cholesterol management and cardiovascular health in deprived communities - ARC
- Fu Y, Price C, Sowden S, Newton J. *Lipid management in primary care for socioeconomically disadvantaged populations in Northern England UK: a qualitative study,* Journal of Primary Care and Community Health, 2024. https://doi.org/10.1177/21501319241272026

Immunisation catch-up pilot

- NENC Applied Research Collaboration Doctoral thesis*: "Unequal Vaccines? A Mixed Methods Study Exploring Socioeconomic Inequalities in Routine Vaccination Uptake in a Post-COVID-19 Era".* Part of this PhD involved qualitative research around the NENC Deep End Immunisation pilot implementation, the work is currently being written up for publication (https://deependnenc.org/research/research-projects/)

Supporting mental health in families and children in the Deep End

PhD student in NIHR Newcastle Patient Safety Research Collaboration and an Occupational Therapist, is doing a part of her PhD within the Deep End. Her PhD is about mental health and wellbeing in families with child and / or adult multiple long-term mental health conditions. She presented her PhD plan at the Future of Evaluation in Health and Social Care symposium at Northumbria University, 14th - 16th January 2025.

Developing Deep End Dentistry and Pharmacy

- We have been undertaking research around developing the concept of Deep End Dentistry and Deep End pharmacy:

- Beeson M, Vernazza C, Sowden S. *At the Deep End of dental inequality* (in press: British Dental Journal)
- https://sphr.nihr.ac.uk/research/preventing-chronic-disease-with-community-pharmacies-at-the-deep-end/

NOTTINGHAMSHIRE

Over the past year, Deep End Nottinghamshire has continued to hold monthly meetings, which we aim to keep short and focused. We often invite guest speakers we're interested in hearing from, and this format has helped make the meetings a valuable and enjoyable.

Increasingly, we've received requests from other parties who wish to support health equity. This has recently led to a pilot project in partnership with local hospitals, aimed at supporting patients on urgent cancer pathways who may face challenges engaging with healthcare services for any reason.

On March 19th 2025, we proudly launched the inaugural meeting of the Nottinghamshire Deep End Research Cluster. Backed by funding, we're now set to grow and strengthen the collaboration across our 9 Deep End Group member practices. Our mission is to increase underserved populations involvement in research by boosting practice capability and direct engagement with our communities.

Dr Julia White
The Fairfields Practice
Mary Potter Centre

Deep End International Bulletins 1-12 can be accessed at https://www.gla.ac.uk/schools/healthwellbeing/research/generalpractice/deepend/international/

PLYMOUTH

Logo of Plymouth Deep End including a lighthouse

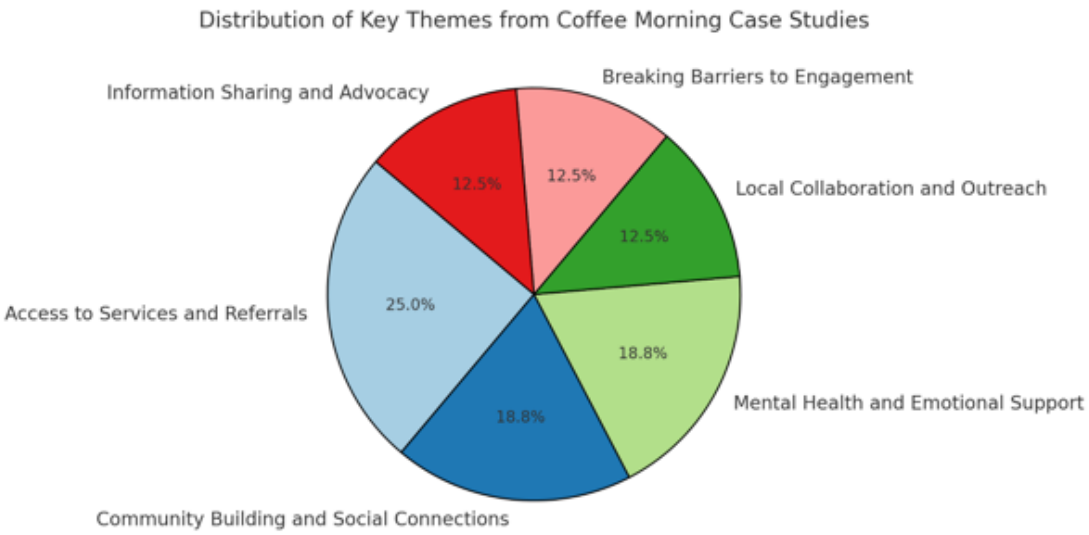
We started the Plymouth Deep End group in 2019, including practices working in the 3% highest deprivation neighbourhoods by IMD score. Our key aims were summarised using the acronym “WEAR”.

Workforce; to recruit GPs to work in Deep End practices,
Education; to educate GPs, students and practice teams on Deep End issues,
Advocacy; to advocate in every way possible for our patients and communities and
Research; to do and participate in research addressing Deep End issues.

We have had a busy and productive year, starting or continuing several projects to address our aims. These are:

1. Employing **Community Health & Wellbeing Workers** in Stonehouse; the only area in the SW with an LSOA in the 1% most deprived in the country. This is based on a model working successfully in Brazil in the 1990s and brought to Northwest London (Imperial College demonstrating proof of concept) and then Cornwall in 2022.

Our CHWWs each have a defined “patch” where they visit regularly, but they also hold community events like coffee mornings. Here are some topics discussed!



2. **"Feel good Friday":** Health & Social inclusion, engagement and education events in our local communities.

   These are outreach events bringing up to 25 different organisations together with general practice into the community. Our first event in Stonehouse attracted over 350 local people.

   We run these events in collaboration with a huge variety of community and voluntary organisations. As an example, here is the list of participating organisations at our last event in April 2025

   1 Citizens advice
   2 Safe families
   3 Social Prescribing
   4 Food is Fun
   5 Macmillan Plymouth Cancer Champions Project
   6 Improving Lives
   7 Community Builders
   8 Plymouth Community Homes and Livewell Southwest Partnership
   9 The Chestnut Appeal for Men's Health
   10 DWP
   11 Plymotion
   12 The Children's Society Service Manager Plymouth Substance Misuse
   13 Research Nurse
   14 IPS Grow Employment
   15 Argyle Community Trust
   16 Chronic Pain
   17 Screening Breast Care Nurse
   18 The Chestnut Appeal for Men's Health

19 Community Pharmacy NHS First Blood Pressure Checks
20 NHS APP
21 Plymouth Wellbeing Hubs Programme Lead
22 UHP Raspatory Team
23 Marbles Lost and Found PM Only
24 Elder Tree
25 UHP Research Team
26 One You Ply Wellbeing Team LWSW
27 Van Liver Scanning UH

3. **Trauma Informed education sessions in Deep End practices**. Working with complex patients with multi-morbidity, mental health and addiction issues, we know that adverse childhood experiences and trauma underlie much of what presents to us. Trauma-informed care has emerged as a transformative methodology. We have developed an educational package for practices which one of our GPs with expertise in this area is taking out to Deep End and other practices.

4. **Trauma-informed sessions with patients** who have combined physical and mental health presentations. Some of our most complex patients present frequently and haphazardly to both primary and secondary care. We have started special clinics where an expert doctor has time to understand and address underlying issues – and, where appropriate, to support change in consulting behaviour.

These projects have all been shown to be highly acceptable in our community (based on quantitative attendance and engagement data), and based on qualitative case studies are likely to have an impact on population health. To adequately measure health service impact outcomes, they need to be continued into 2025-6 and beyond.

Beyond these current projects we are working to:

- Collaborate and create positive change for our practices, patients and communities in deprived areas of Plymouth

- Engage with those practices which look after blanket populations in the bottom decile, whilst recognising that the additional demands of working with this population mean that they often do not have the time and resource to develop different ways of working.

- Advocate for our patients to have the right services when they may lack the resources to advocate for themselves.

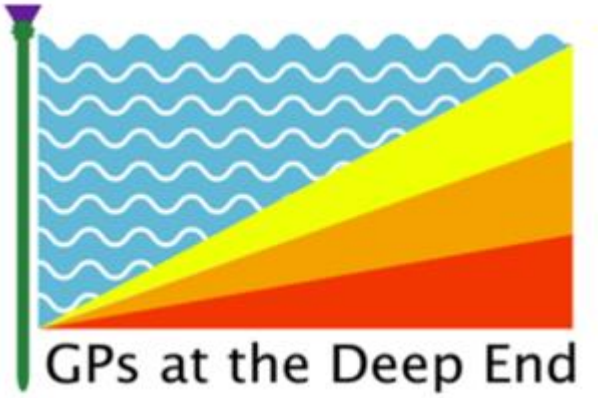
- Develop new ways of working to address need - utilising innovative projects, expanded social prescribing and moving care as far as possible into primary care and away from expensive and often inappropriate hospital settings.

- Disseminate the learning to all primary care

- Embed research and evaluation into these projects and instigate our own research into Deep End issues

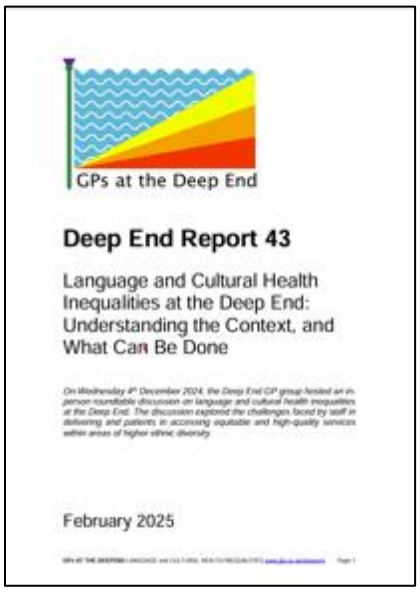
Dr Richard Ayres. Lead, Plymouth Deep End GP

SCOTLAND



Cultural and Language Health Inequalities at the Deep End

In the last International Bulletin, we referenced the evaluation of the Inclusion Health Action in general practice pilot project in Scotland, an initiative to provide additional resource to practices serving the most socio-economically disadvantaged communities in Glasgow, to specifically address health inequalities. One of the recurring themes that emerged from this work – familiar to colleagues working in the Deep End – is the challenge of providing high quality, equitable healthcare in areas of higher ethnic diversity.



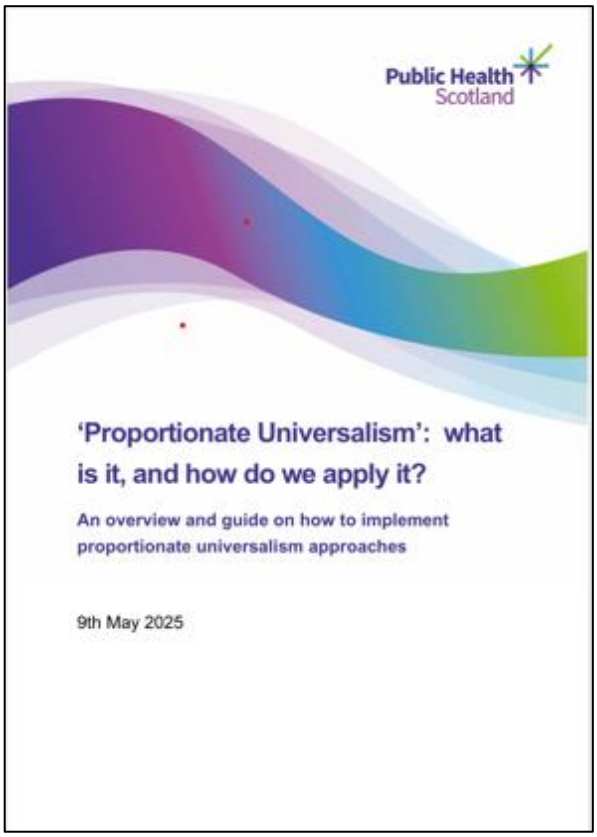
We decided to host an in-person roundtable to explore this further. We invited clinicians and key stakeholders, including colleagues from the third and charitable sector, NHS Education for Scotland, Scottish Government, Public Health Scotland, a community link worker and a person with lived experience of the asylum system (and of interpreting work). Our discussions explored themes around workforce training, workforce capacity, interpreting service quality, data quality and system barriers, and makes a series of recommendations. We've shared it widely, and invited follow-up conversations, in the hope that it will help to drive the change that we need to see. The full report is on our website here.

RCGP Health Inequalities Exhibition in London

We were delighted to be able to contribute to the new RCGP exhibition in London on the role of general practice in addressing and mitigating health inequalities, now launched and open to the public over the next year. It offers a fascinating historical context on how we have come to better understand the links between poverty and ill-health, the relatively recent concept of health inequalities, and the role that healthcare (and especially general practice) can play. It includes a dedicated section on the role of Deep End general practice and also some video patient stories from the "missingness" research. It has been hugely encouraging to see how much impact this research is having on challenging stigma, and informing policymaking within Scottish Government.

A display at the RCGP Health Inequalities Exhibition

New Proportionate Universalism guidance



A few of us were involved in writing new guidance on the practical application of proportionate universalism. We're delighted this has now been published on the Public Health Scotland website and can be accessed at: 'Proportionate Universalism': what is it, and how do we apply it?

The 5th Deep End Student Conference

Building on feedback from our previous student conferences, this year the conference organisers (led by Scott Craig, Glasgow University GP Society President) experimented with a few changes, including the conference being held in a circus training ground in a socioeconomically disadvantaged community (Ferguslie Park, Paisley), rather than on campus, which enabled co-creation with the local community. There were contributions from Deep End GPs and academics, students, community development professionals and members of the local community. The feedback was powerful, with one local community member commenting: *"It's the first time I've had a chance to talk to a GP without having to be sick."* and another reflecting that *"It feels like the start of something really exciting."*

The circus school venue for the 5th Glasgow student Deep End Conference

As ever, we are grateful to the Deep End steering group, without whom, none of this would be possible.

Carey Lunan and David Blane

The secret of change is to focus all your energy not in fighting the old,
but on building the new.

Socrates

YORKSHIRE AND HUMBER

What is the Deep End Research Alliance (DERA)?

The Deep End Research Alliance (DERA) is a growing, UK-wide, grassroots movement that develops and delivers research with and by underserved communities and the primary care practitioners who serve them. Originating in Glasgow, the Deep End movement now spans all four UK nations and has international reach. It is composed of locally-led clusters of general practices working in areas of highest deprivation, as measured by the Index of Multiple Deprivation (IMD).

These practices serve marginalised populations, including people experiencing homelessness, people who use drugs, sex workers, and communities with multiple barriers to healthcare access. Deep End clusters are united by a commitment to addressing the "Inverse Care Law," which highlights how those with the greatest health needs often receive the least care.

The Deep End community of practice is commonly guided by the WEAR framework—Workforce, Education, Advocacy, and Research—initially developed in Glasgow and later refined through a stakeholder consensus process in Yorkshire and Humber. This framework supports multidisciplinary collaboration, practitioner wellbeing, and equitable access to education, training, and resources. It underpins efforts to improve health equity in the context of complex clinical and social needs (1).

A key concern is the "Inverse Research Law": the systematic under-representation of underserved populations in clinical research. This leads to treatments that are less effective and less accessible for those at highest risk. Deep End-led research directly addresses this gap by involving patients, communities, and frontline practitioners in generating evidence that informs more relevant and equitable clinical care and policy.

DERA began in 2016 with a small team, including NIHR Clinical Lecturer Liz Walton, supported by Caroline Mitchell and Ben Jackson and a group of equity-focused early-career researchers, students, and practitioners at the University of Sheffield. Together, they successfully secured NIHR funding for the first Deep End Patient and Public Involvement (PPI) group and the first NIHR Deep End Clinical Research Network (now part of the NIHR Research Delivery Network, RDN).

From the outset, the vision has been a tripartite partnership between patients/communities, frontline practitioners, and academic researchers. DERA has evolved into a highly successful research group specialising in inclusive participatory research approaches for underserved populations, inextricably linked to practices , patients and communities: https://sites.google.com/sheffield.ac.uk/dera/home.

In the past five years, Deep End clusters have expanded rapidly. These include small networks (e.g. Leeds, Nottingham), medium-sized groups (e.g. North East & North Cumbria, Bristol, Yorkshire & Humber, Wales), and large networks like Glasgow (100 practices) and Northern Ireland (44 practices). Many clusters have been supported by local NIHR infrastructure (RDNs, ARCs), NHS England Integrated Care Boards, and COVID-19 research funding. However, long-term funding remains uncertain.

In March 2025, the NIHR supported a national webinar that brought together 198 participants; Deep End clinicians, public contributors, academics, and research delivery staff, to discuss inclusive research. Presentations covered topics such as:

- NIHR Inclusion strategy and RDN activity
- The WEAR framework
- Community-based primary care research including a novel Community Link Worker programme
- Research delivery perspectives (e.g. Senior nurse leadership, ICBs)
- Deep End pharmacy-led research

A full report is in preparation. Research-active Deep End clusters are invited to contact Caroline Mitchell (current NIHR-linked Deep End co-lead) to share updated contact details. Ongoing coordination and support are being discussed, pending NIHR decisions.

Professor Caroline Mitchell GP Sheffield and Professor of General Practice Research at Keele University c.mitchell@keele.ac.uk

1) Walton L, Ratcliffe T, Jackson BE, Patterson D. Mining for Deep End GPs: a group forged with steel in Yorkshire and Humber. Br J Gen Pract. 2017 Jan;67(654):36-37. doi: 10.3399/bjgp17X688765.