Meddygon Teulu yn y Pen Dwfn
GPs at the Deep End

Llywodraeth Cymru
Welsh Government

Deep End Cymru

Report of the first phase 2022-24

The Deep End Cymru vision is for NHS general practice to be at its best where it is needed most

The Deep End Cymru Steering Group

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Cover: word cloud of answers to “What have been the benefits of Deep End for you?”, Round Table September 2023

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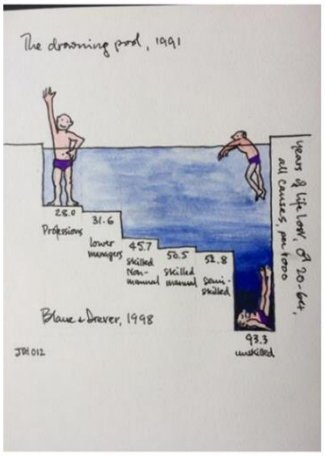
We would expect that the sickest and poorest patients in Wales would have the greatest provision of general practice. However, this does not seem to be the case and Deep End is an approach that aims to explore exactly what is going on and how it could be improved.

1. Summary

The Deep End approach was inspired by Dr Julian Tudor Hart, who coined the term “Inverse Care Law – that the availability of good medical care varies inversely with population need” - back in 1971[1]. It has taken until now to test out whether it could work in Wales.



‘Deep End’ describes the additional needs for populations living in the most deprived areas with the concomitant increase in workload and complexity for GP practices that support these communities.

Deep End Cymru is a grassroots movement developing mutual support and using this over time to generate change to improve healthcare services and health outcomes for people with the greatest health needs. It is a way to bring a stronger health equity lens to all business as usual, for example in Cluster plans and Social Prescribing programmes. It aims to add value for those communities who are often less able to access and benefit from existing services.

The Deep End approach has been shown to be effective in multiple locations in the UK and internationally since the first programme started in Scotland in 2009. The spread of the model comes from the conviction that mutual support and shared learning contributes to the morale, effectiveness and eventually the sustainability of practices that are at highest risk of drowning.

Deep End practices

Wales had 389 practices when we started. We invited the 100 GP practices that had the highest proportion of their patients living in the most deprived 20% of communities in Wales. The proportion of registered patients living in these areas ranged from 48% to 83% in the top 50 practices and was greater than 34% for all the Deep End practices. These were predominantly located in Southeast Wales, in four of the seven health boards. However, they are not concentrated in Clusters with very few Clusters having a majority of Deep End practices.

Deep End practices reach almost 60% of the 653,413 people living in the most derived quintile in Wales. Of the 100 practices invited, seven had already closed or merged. Of the remaining 93, 85% responded with 35% attending at least one Deep End event in person.

We found evidence of an Inverse Care Law in resources such as funding and workforce, and inequitable differences across all staff groups, which in turn describes significant unfairness for patients in terms of the time and energy available of the people caring for them in their GP surgery.

[1] THE INVERSE CARE LAW - The Lancet

Deep End findings

Participants were concerned that patients faced too many barriers to accessing the best quality care (such as not having English as a first language, being insecurely housed and having lower health literacy skills). Their ability to provide high quality was affected by excess workload, and a lack of adequate workforce.

Deep End practices are drowning faster than average

- **Deep End practices have a greater workload and a smaller workforce.**
- **GP partners in the Deep End have on average 764 (29.7%) more patients than those in the 100 least Deep End practices.**
- **Deep End practices are closing or merging at double the rate of other practices**

Five half day events were held over 18 months, including the launch in November 2022. Our common challenges were identified, and the prioritised, and we then did deep dives into these.

Different Patients

- (Don't use Challenging, Difficult , etc -!!!)
- Obesity/ smoking/ alcohol/ substance misuse
- Mental health/post trauma/ personality
- Infectious diseases
- Complexity and multi-morbidity
- Language barriers/ Low health literacy
- Cultural issues
- Non-responder for prevention.
- Chronic illness
- Homelessness
- Walk in patients
- Poor understanding of health care system
- Younger cohort, less funded

Impact

- Increased consultation time
- Frequent attendance for even minor ailments
- Disease prevalence difficult to manage with many patients having no medical history
- Safeguarding/ inquests
- Increased security costs
- Difficulty in recruitment and sourcing locums
- Practitioner stress/burnout and steep learning curve for new clinicians
- Difficulty reaching targets
- Need to offer higher sessional rate to deal with additional pressure
- Large amounts of DNA's which waste money despite DNA policy
- Lower income/ less alternative income
- Higher Number of Admin Staff and Reception

The top four priorities that we wished to work on emerged as:

1. Finance and funding
2. Workload
3. Recruitment and retention
4. Education and training

We moved quickly from describing problems to coming up with potential solutions. These were multiple, varied and innovative, with staff sharing what they were doing and learning from each other. Much of the focus was about non-medical solutions for patients, such as social prescribing, in particular support for income maximisation and housing, and for those with complex needs. Many felt that becoming a training practice was the best route to recruitment, but that current GP Training schemes did not take account of the value of Deep End experience, or match interested Registrars to Deep End practices. Many felt that losing their skilled and experienced staff was a constant threat and would be improved through measures to improve income and morale.

The project was met with enthusiasm by participants. Participants say they love to work in their practices, and expressed a strong wish to be able to do more and do better

Stakeholder views

We commissioned Beaufort Research to interview key stakeholders (2 internal and 4 external). Most believed that Deep End Wales could play an important role in tackling health inequalities, by advocating for health professionals working in Deep End practices and for patients living in the communities they served. Overall, the majority of stakeholders interviewed believed that Deep End Wales should continue. However, most emphasised the need for the movement to evolve and have clearer, more measurable objectives.

Solutions

The key message from the experience so far is:

1. **Capacity**. We develop at the speed of trust, and this takes time, energy and capacity to build.
2. **Protected time**: Deep End staff have a greater workload, so gaining some time and headspace for improvement work through Deep End will only happen if their time out is genuinely protected with full cover for their normal workload.
3. **Workforce**. Our participants say they love working in their practices, and many GPs in training are very keen to have placements with them but we believe that this is not promoted enough. We have begun work with stakeholders to promote multi-disciplinary training of health workers to work in more deprived areas and in health inclusion. We have influenced GP training, by facilitating four Vocational Training Schemes in South Wales to reserve one place each for specialising in deprivation medicine.
4. **Non-medical needs.** We considered how best to meet the non-medical needs of our patients, and how to connect them with community assets, so are now developing a proposal for community health workers
5. **Research.** We have engaged with the research community, here in Wales and through the UK Deep End Research Network. We have already built a strong relationship with the Division of Population Medicine at Cardiff University as our “academic home”. We want to answer the questions most relevant to our patients, and also to get more practices and patients engaged in research. We are about to publish our first research study.
6. **Education.** We are keen to share learning about what works, and have run a series of online “lunch and learn” sessions and a very successful Health Inequalities Study Day, planned to be an annual event

7. **Staff Well Being.** We are very aware of the stress that all General Practice is under and know that our teams are at the sharpest end of this. We know that the mutual support we already have is valued, and we want to formalise this to improve staff wellbeing.
8. **Resource allocation.** We have identified inequalities in workforce and funding that have not been identified elsewhere and are not being addressed. We know that Deep End practices are more likely to close, merge or be taken over by external companies. We have a role in advocacy for practices that have the least time to do this for themselves and are at greatest risk of folding, leaving their patients at an even greater disadvantage.

Conclusion

The purpose of the first phase of Deep End Wales, was to conclude whether a long-term Deep End programme is feasible, acceptable and likely to add value to patients and staff in Deep End practices serving the most deprived communities in Wales.

We believe that we have demonstrated this, and that Deep End is here to stay.

The Deep End Wales vision is for NHS general practice to be at its best where it is needed most.

2. Introduction

This is the final report on the first phase of Deep End Cymru, which ran for 18 months between September 2022 and March 2024. Deep End Cymru is hosted by the Royal College of General Practitioners (RCGP Wales), although it is independent with its own steering group (See Appendix 1) and the views therefore are not necessarily those of the RCGP.

We are very grateful to the Welsh government for funding to enable the first phase of Deep End Cymru.

3. Background

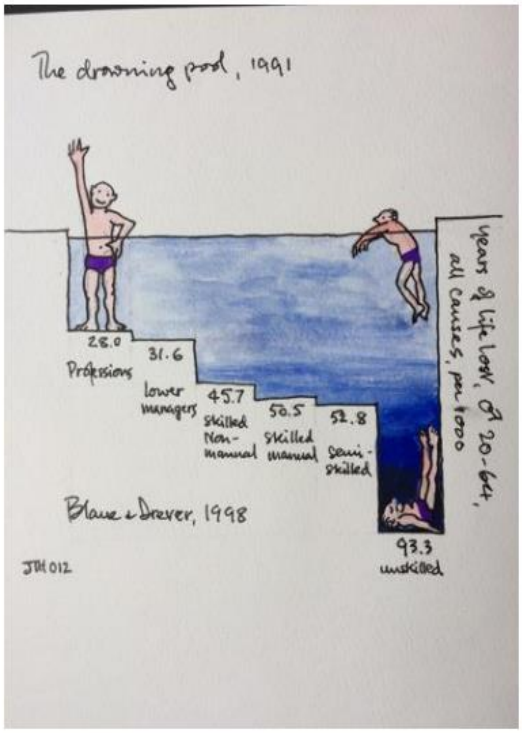
Why do we need Deep End?

Inverse Care Law

People from poorer socioeconomic groups, or from vulnerable groups, die younger and develop multiple morbidities at a younger age[2]. This poor health has an impact on workload for those GP practices serving them. So, we would expect that the sickest and poorest patients in Wales would have the greatest provision of general practice. However, this does not seem to be the case and Deep End is an approach that aims to explore exactly what is going on and how it could be improved.

Although Deep End was inspired by Dr Julian Tudor Hart, it has taken until now to test out whether it could work in Wales. The Deep End movement began in Scotland in 2009[3], and the ethos and approach has now extended to multiple Deep End programmes in the UK and internationally.

The original concept was inspired by Dr Julian Tudor Hart of Glyncorrwg in South Wales. He used a swimming pool as an analogy for those living in the most deprived areas, as well as the general practices that are trying to help them.



'Deep End' describes the additional needs for populations living in the most deprived areas with the concomitant increase in workload and complexity for GP practices that support these communities. This means that:

1-Disease is more prevalent in younger cohorts
2-There are higher levels of physical and mental health co-morbidities at a much younger age
3-There is lower health literacy requiring additional support to benefit from healthcare
4-There is an increase in workload for GPs and greater complexity for primary care
5-GPs and their teams struggle to keep their heads above the water ('deep end')
6- There is evidence that Deep End practices are relatively underfunded.

[2] Making sense of the evidence: Multiple long-term conditions (multimorbidity) - NIHR Evidence
[3] University of Glasgow - Schools - School of Health & Wellbeing - Research - General Practice and Primary Care - The Scottish Deep End Project

4. What did Deep End Cymru do?

What Deep End is and what it is not

The Deep End Cymru vision is for NHS general practice to be at its best where it is needed most. The Deep End approach is a grassroots movement to share experience, ideas and action to help serve the communities that most need high quality primary care. At the moment, the eligibility to join Deep End is open to anyone who works in a GP practice that has the highest proportion of people living in the most deprived areas. However, this is the first phase and already there is interest in including health inclusion services, the wider primary care team members and other GP practices that serve similar populations, even if this is not a large proportion of their workload.

It is not a new structure or organisation; it is flexible and works with any and all stakeholders who have similar goals. It is a way to bring a stronger health equity lens to all business as usual, for example in Cluster plans and Social Prescribing programmes. It aims to add value for those communities who are often less able to access and benefit from existing services.

Selecting the GP Practices

The first step was to identify the GP practices that would meet the criteria for being invited to join Deep End Wales. We decided to use the same approach as that taken in Scotland and in most other Deep End programmes, that is to focus on "blanket deprivation" and therefore those practices that had the highest proportion of their patients living in the most deprived 20% of Lower Super Output Areas (LSOAs) in Wales. The Welsh Index of Multiple Deprivation (WIMD, 2019) [4] was selected as the criteria to identify practices to participate in Deep End Wales, using the latest available data from January 2022[5].

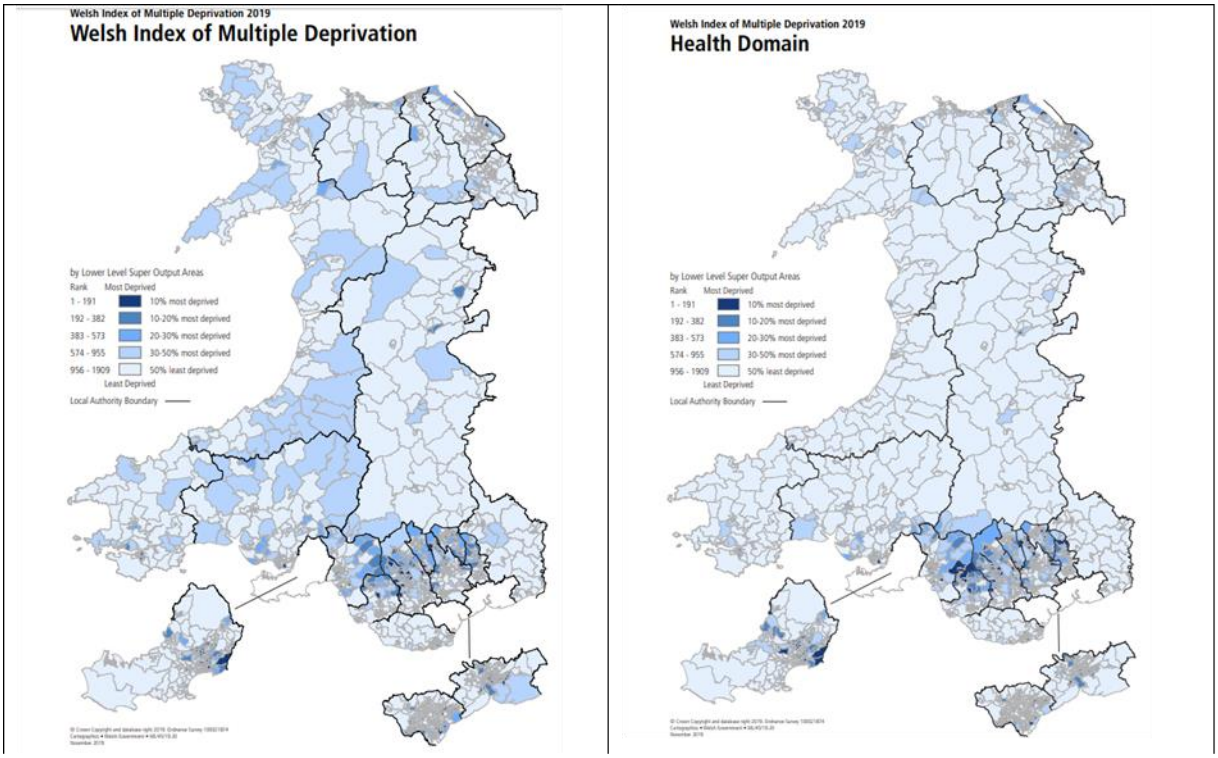
As can be seen from the map below, deprivation is not distributed evenly across Wales. Four of the seven Health Boards have a significantly higher proportion of their populations living in the most deprived 20% of LSOAs. Wales has 653,413 people living in the most deprived quintile. Of course, not every household in these areas is income deprived and/or in poorer health, and there would be many households in more affluent areas that are income deprived and/or in poorer health.

Initially, the plan had been to invite the 50 practices with the highest proportion of patients living in the most deprived 20% of LSOAs. This was extended to the top 100 GP practices before the launch as it became clear that this would reach a significantly greater proportion of patients and offer greater engagement and shared learning between GP practices.

[4] Welsh Index of Multiple Deprivation (gov.wales). WIMD is made up of eight separate domains (or types) of deprivation: Income; Employment; Health; Education; Access to Services; Community Safety; Physical Environment and Housing.

[5] Deprivation at GP practice level (gov.wales)

Figure 1: Map of deprivation in Wales, and the WIMD Health Domain



During the course of the programme, it also became clear that there were common concerns and synergies with health inclusion services across Wales. Health Inclusion Services are designed for the needs of multiply excluded groups, for example: people seeking asylum and refugees; people experiencing homelessness; people engaged in sex work; prison leavers; Roma, Gypsy and travelling people.

Many Deep End practices have a higher proportion of their patients from these groups. Some do not have any other health inclusion service locally, as Health Inclusion specialist services are provided very differently in each Health Board area. Deep End Cymru has engaged mainly with the Cardiff and Vale Health Inclusion Service (CAVHIS)

Engagement

All practices received an email in early October 2022, to the Practice Manager, and a written invitation to the Senior Partner and Practice Manager inviting them to engage with the project and confirm contact details. The project manager followed up the initial contact with a phone call. The invitation was rolled out to the top 100 practices via this process.

The launch was organised for November 2022 in Abergavenny.

The 100 GP practices were contacted by several means, including emails and phone calls, and repeatedly throughout the project. No organisation holds an up-to-date list of practice contacts, mainly due to the constant change in practice staff. A mailing list was laboriously developed, using online search engines for practice websites, health board information, practice manager associations, Cluster Leads and word of mouth.

What did we learn from other Deep End launches?

Deep End programmes have all followed a similar methodology of identifying their eligible GP practices and setting about exploring their common challenges and possible solutions using highly focussed protected time. All have established steering groups with membership from practices and often with strong academic engagement in leadership. Most have used the themes of Workforce, Education, Advocacy and Research (WEAR) to define their priorities, and these are reflected in our focus areas. This has generated much rich evidence, both qualitative and quantitative. Many have also gone on to develop and deliver specific programmes, funded with additional resources. The Scottish Deep End programme publishes an International Bulletin[6] to share progress.

We can only develop at the speed of trust, and this takes time, energy and capacity to build.

Governance

The RCGP is accountable for delivery of the Wales programme, and has appointed two Clinical Leads, a full time Project Manager, a Public Health Lead and an Academic Lead.

At the launch, a steering group was formed (see Appendix 1) that has continued to meet regularly every few weeks. The group agrees actions.

Four further events have been held that were open to anyone working in any of the eligible GP practices. Up to two staff could be reimbursed, but more were welcome. The format was one of maximum participation to enable deep dives into the common challenges and potential solutions.

As priorities emerged, four work streams were set up, each led by a steering group member. These were:

- Education and training
- Funding and finance
- Recruitment and retention
- Workload

[6] University of Glasgow - Schools - School of Health & Wellbeing - Research - General Practice and Primary Care - The Scottish Deep End Project - International Deep End

5. Methods of evaluation

The original small group agreed a theory of change (see Appendix 2). From this a practical approach was taken to evaluation of the very early first phase of setting up a Deep End programme. Feedback was gratefully received and incorporated from Dr Haroon Ahmed, Academic Lead for Deep End from Cardiff University Division of Population Medicine, from colleagues in the Primary Care Division of Public Health Wales and Professor Graham Watt, founder of Deep End Scotland.

The outcome after 18 months was to conclude whether a long-term Deep End programme is feasible, acceptable and likely to add value to patients and staff in Deep End practices serving the most deprived communities in Wales. (See Appendix 1 for Theory of Change diagram, and the full evaluation plan).

We developed a mixed methods process of evaluation, with the following components:

1. **Narrative report of emerging themes from steering group and round table meetings**
2. **Quantitative measures of engagement with the process, and baseline GP practice characteristics**
3. **Qualitative interviews of key informants (Deep End Practice members and stakeholders) – as research study with ethical approval, aiming for publication**

Data

Data was accessed for the dates thought to be most appropriate, using baseline date for September 2022 whenever possible, or the nearest available. Some key data was not available to us, for example funding and activity data, although some is collected by NHS Wales and the Welsh Government.

6. Results

Baseline characteristics of eligible GP practices

We looked at the following characteristics, compared to non-Deep End practices where possible:

a. Deprivation
b. Geographical distribution
c. Alignment with clusters
d. List size
e. Workforce
f. Managed, merging and closing practices
g. Training status

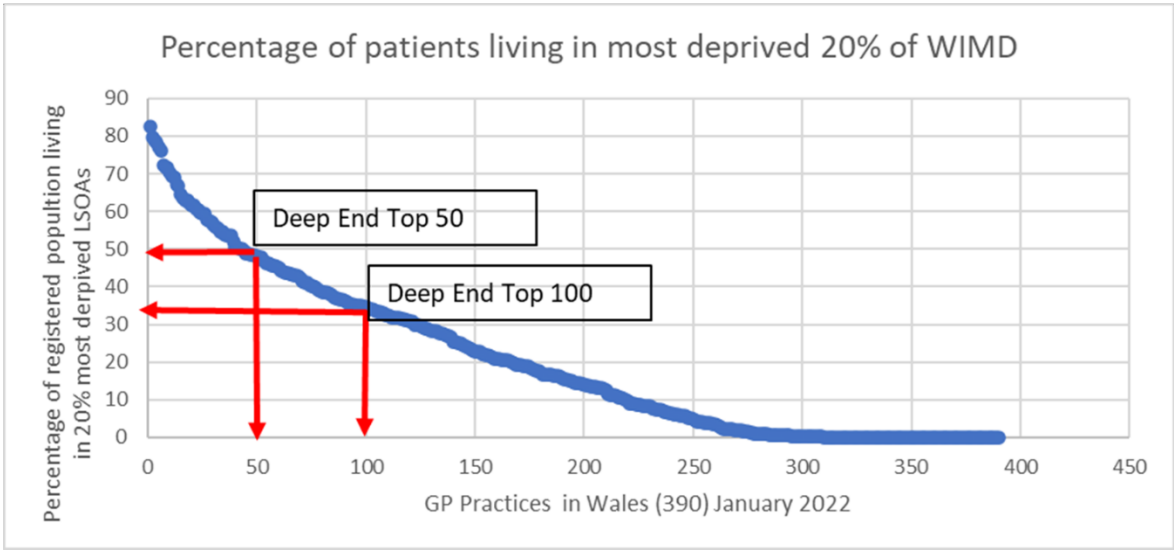
Deprivation

In November 2022, when baseline data was collected, there were 389 GP practices in Wales. We ranked them all by the proportion of their registered population that lived in the most deprived 20% of LSOAs. This proportion varied from 0% to 82.5%.

The proportion of registered patients living in the most deprived areas ranged from 48% to 83% in the top 50 practices, and was greater than 34% for all the Deep End practices

A large number of 109 practices (28%) have fewer than 100 patients (< 1%) living in deprived areas.

Figure 2: GP Practices by deprivation, ranked 1 to 389.



So, although a large number of people living in more deprived areas are registered with GP practices not included in Deep End, they would be a relatively smaller proportion of the registered practice population for those practices, and hence have less impact on the practice workload.

However, between them, the 100 Deep End practices would reach 58.5% of the population living in the most deprived areas.

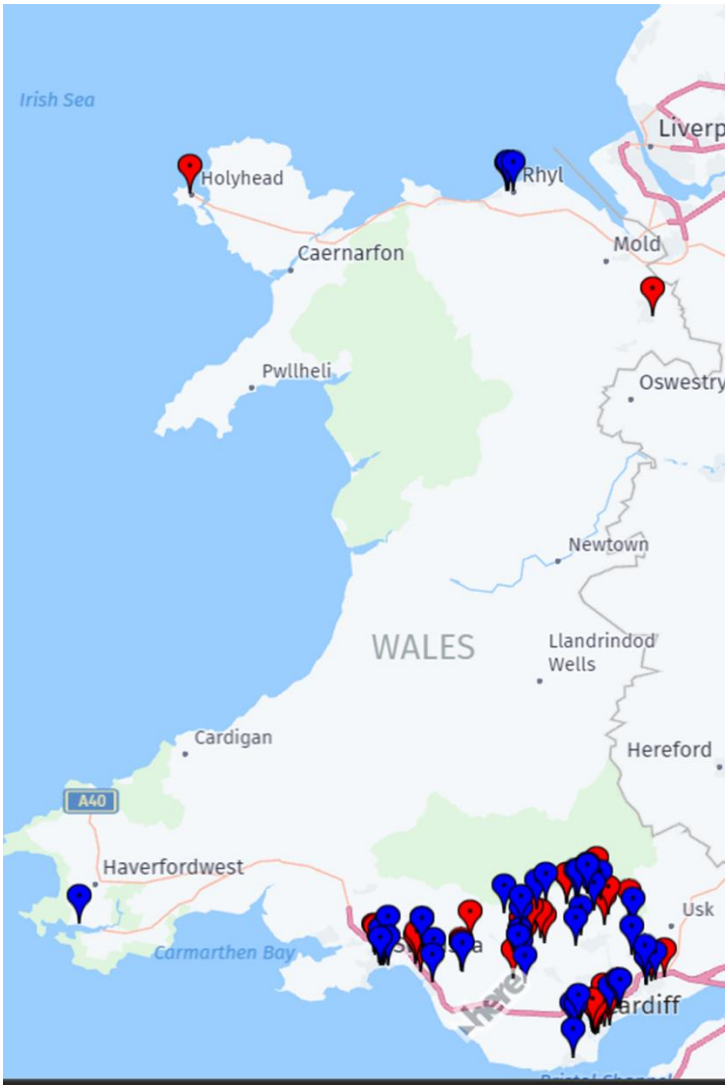
Table 1: Number of people in most deprived 20% reached by Deep End practices

	Deep End Top 50 practices	Deep End Top 100 practices	All Wales
Total number of those living in most deprived 20%	218,490	382,450	653,413
Proportion of those living in most deprived 20%	33.4%	58.5%	100%

Geographical distribution

It is not surprising that the Deep End practices are mostly in the southeast of Wales, and unevenly distributed between health boards.

Figure 3 Map of Deep End practices (more detailed maps in Appendix 3)



Red = top 50 for percentage of patients in most deprived 20%, Blue = top 51-100 for percentage of patients in most deprived 20%

Table 2: Deep End practices distribution among Health Boards and Clusters

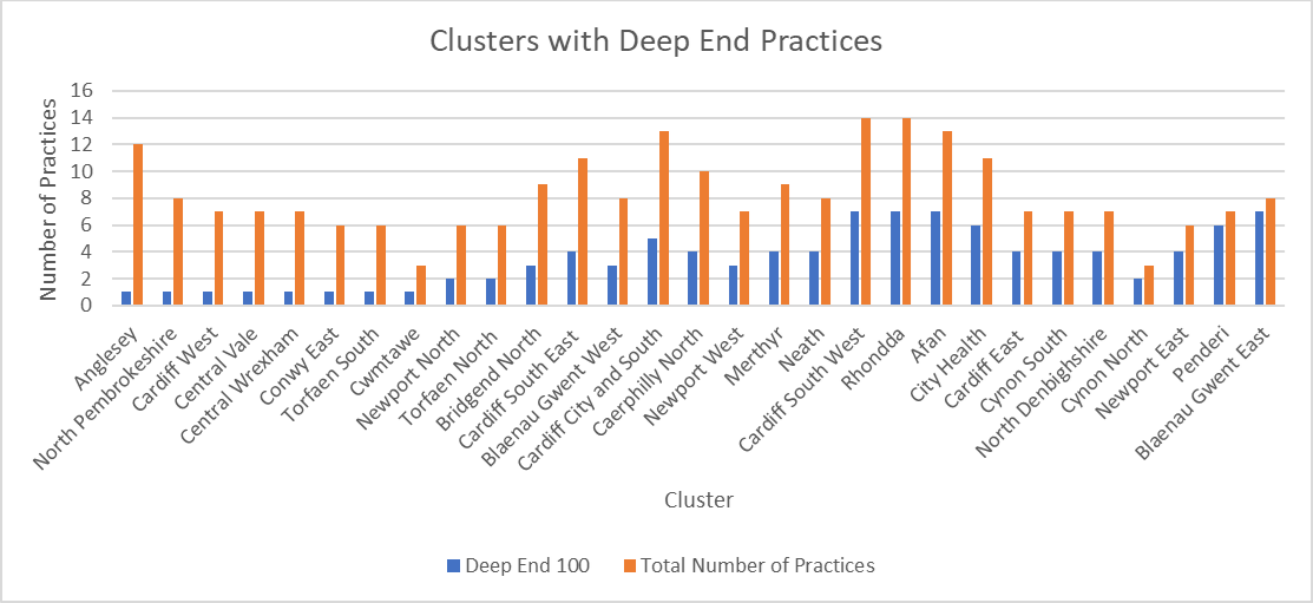
University Health Board	Number of Deep End GP Practices
Aneurin Bevan Health Board	26
Swansea Bay Health Board	24
Cardiff and Vale Health Board	21
Cwm Taf Morgannwg Health Board	20
Betsi Cadwaladr Health Board	6
Hywel Dda Health Board	1
Powys Health Board	0

Alignment with Clusters

GP practices are required to become engaged in cluster working[7], and now Pan Cluster Planning Groups, and Professional Collaboratives. The principle of cluster working is that clusters identify unmet local needs and highlight these within cluster plans and IMTPs.

There are 64 clusters in Wales, of whom only a small number have a majority of GP practices that are Deep End. Many Deep End practices are in clusters where they are a minority. Some of the feedback from our round table meetings is that Deep End practices find it more challenging to find time to engage with clusters and feel that the perspective of their patients in the more deprived neighbourhoods can therefore be lost. They felt that there was not much evidence of recognition of health inequalities in Cluster plans.

Figure 4: Deep End practice distribution across Clusters in Wales



List size

The Deep End practices tended to be smaller than the Welsh average, although there is a wide range, from 1,975 to 20,379 patients.

[7] 6. Transformation and the Vision for Clusters - Primary Care One (nhs.wales)

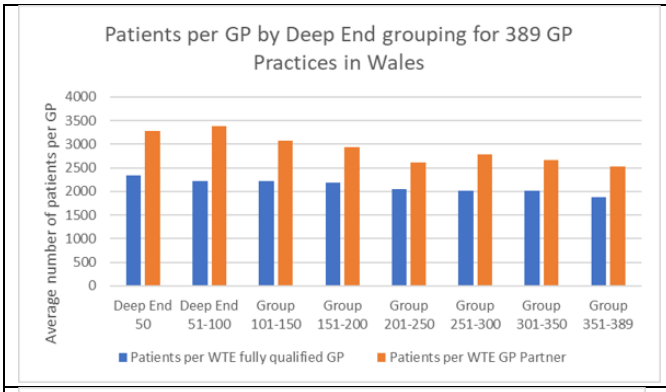
Table 3: GP Practice list sizes

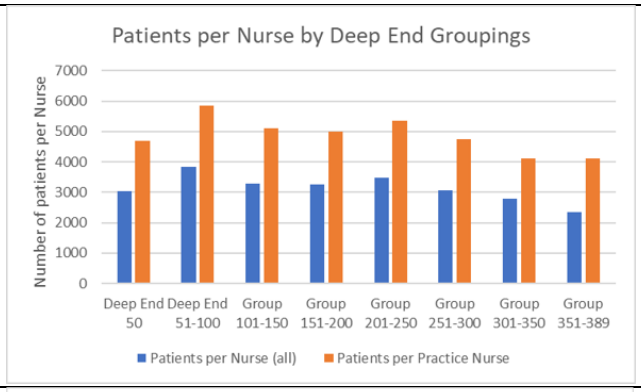
	Deep End Top 50 practices	Deep End Top 100 practices	All practices in Wales
Average list size	7335	7744	8,284

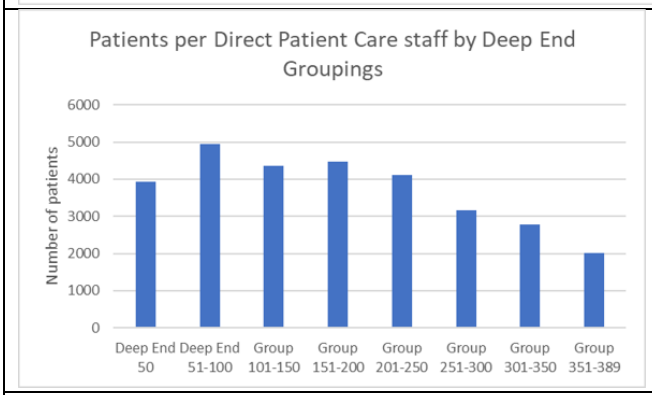
Workforce

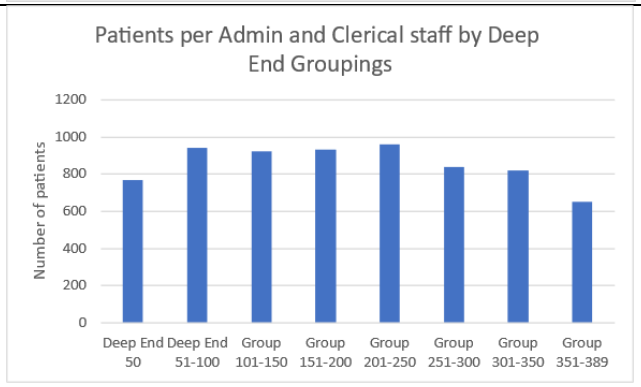
Workforce data for all general practices in Wales was extracted and Full Time Equivalent staff were compared with the deprivation ranking of each practice. There were 389 practices included at the baseline (November 2022). The practices were divided into groups of 50, to enable comparisons with the Deep End 50 and the Deep End 100 with all Welsh practices. This gave seven groups of 50 practices in each, and one group of 38 practices, so the analysis was done pro rata. The sum of the staffing numbers in each of the groups of practices was calculated and a mean taken for each group.

Figure 5: General Practice workforce by grouping









Sources: Workforce data was taken from the Wales National Workforce Reporting System for November 2022, which was taken as the baseline when Deep End Cymru was launched. Deprivation data was taken from the latest available on Welsh Stats website, which was January 2022. (Deprivation at GP practice level (gov.wales))

We compared workforce in the Deep End 100 Practices and the 100 Practices with the lowest proportion of patients living in the most deprived 20% of LSOAs (the “Shallow End” of the swimming pool)

Table 4: Patients per fully qualified GP (excludes locums and registrars) and per GP Partner

	Deep End 100	Shallow End 100	Absolute difference	Percentage difference
Average proportion of registered patients living in most deprived 20% of LSOAs	**49%**	**0%**		
Patients per WTE fully qualified GP	**2272.31**	**2006.74**	**266**	**13.2%**
Patients per WTE GP Partner	**3335.68**	**2572.05**	**764**	**29.7%**

Table 5: Patients per Direct Patient Care Staff (DPC) and Administrative and Clerical Staff (ANC)

	Deep End 100	Shallow End 100	Absolute difference	Percentage difference
Average proportion of registered patients living in most deprived 20% of LSOAs	**49%**	**0%**		
Patients per DPC staff	**4404.99**	**2478.30**	**1927**	**77.7%**
Patients per ANC staff	**852.45**	**741.72**	**111**	**14.9%**

- There are inequitable differences across all staff groups, which in turn imply significant unfairness for patients in terms of the time and energy available from the people caring for them in their GP surgery.
- Deep End GPs have more patients overall, compared to the 100 Practices with the least proportion of patients in the most deprived areas. They have 266 (13.2%) more patients per fully qualified GP. This is more marked for partners, with GP partners in the Deep End having on average 764 (29.7%) more patients.
- For direct patient care staff, the difference is even more stark; staff in Deep End practices are serving an average of 1927 (77.7%) more patients.

Practice Sustainability.

Welsh Stats [8]started providing data on GP Practices and Clusters ranked by deprivation in early 2022. Comparing the first list in January 2022 with the latest update in April 2023:

- 389 practices reduced to 382
- 8 GP practices have disappeared, although it is clear whether these are mergers or closures
- Of these, 50% of these are in the highest ranking 100, so Deep End practices are disproportionately losing/ merging in deprived communities

Between our baseline of January 2022 to the end of March 2024, we are aware of at least 7 Deep End practices which had closed or merged.

[8] General practice population (gov.wales)

5 of the Deep End practices were under health board management at the beginning of the programme. However, there is no data in the public domain about how many managed practices there are in Wales, so no comparison was possible.

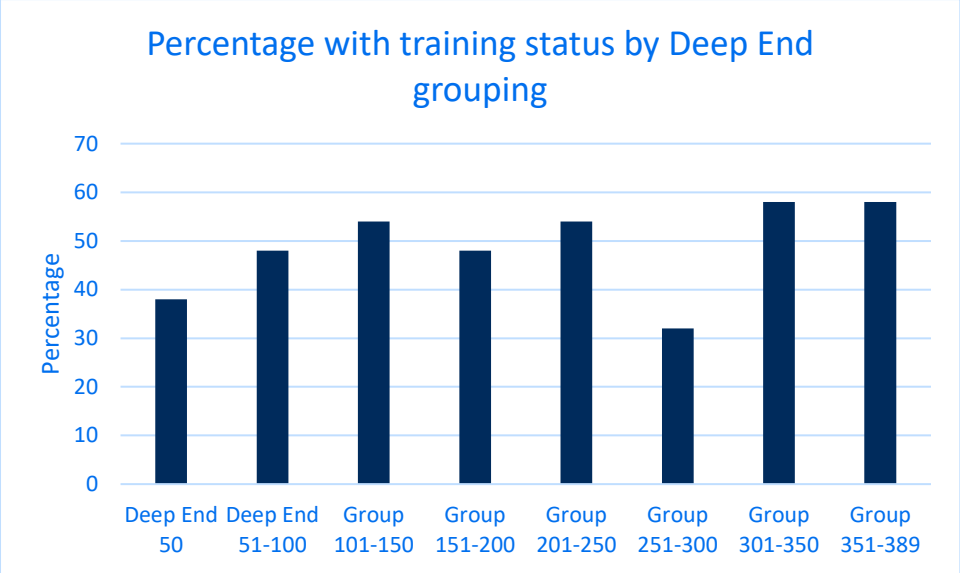
Pulse Magazine produced a map of all GP practice closures across the UK which left a gap in provision between 2013 and 2021. They report that "They were in postcodes that were in more deprived areas than other average surgeries. 69% of practices that closed for good in England received lower funding per patient the last full financial year before they closed than the average funding for that financial year; Practices in deprived areas were more likely to close, and told Pulse their workload is higher, their patient population is less prone to self-care but they also miss out on funding that practices in more affluent areas receive"

Training status

Of the 389 practices in Wales, 202 are recognised as having training status by Health Education and Improvement Wales (HEIW). We were not able to find data on how many registrars are currently in these practices.

There is a mixed picture across the Deep End groupings. We found that 43% of Deep End practices have training status, while 58% of the least Deep End two groups have training status.

Figure 6: Training practice status by grouping

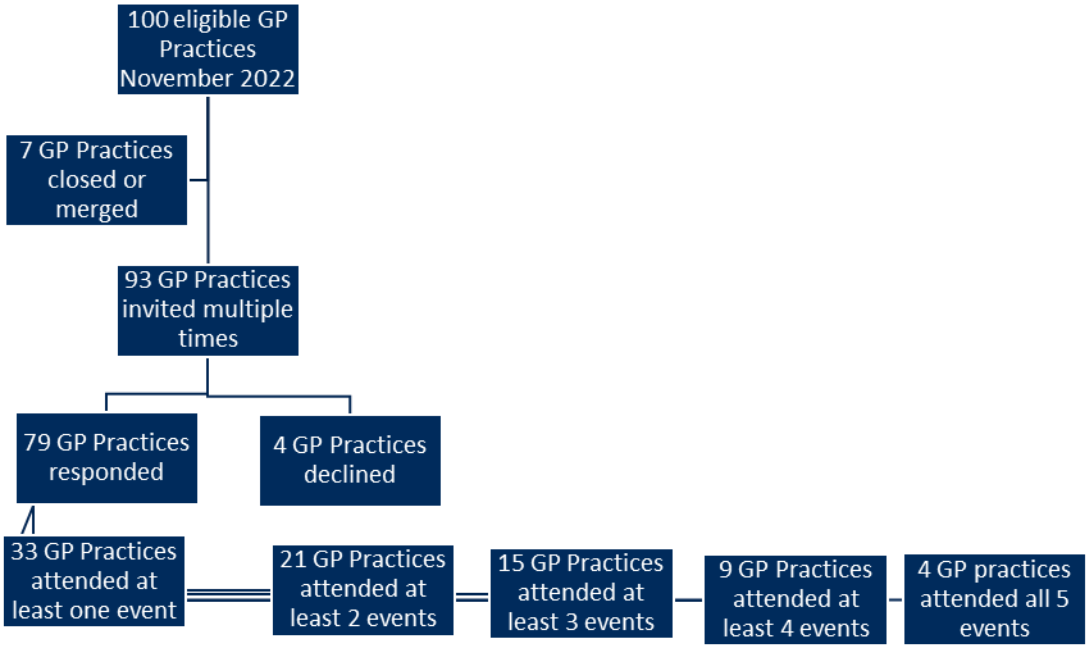


Deep End engagement

No one knew whether there would be an appetite for a Deep End network in Wales. We understand from other Deep End programmes, that about 20-25% of GP practices eventually actively engage in time. There remains a proportion that do not wish to engage, and many will dip in and out.

However, the launch event in November 2022 was very well attended and had a huge buzz in the room.

Figure 7: flow diagram of engagement with eligible GP Practices



In the first months, 85% of eligible practices responded, of whom 4.3% declined to take part although many practices neither confirmed nor declined participation. Of these, 35% attended at least one of the five events, some sending more than one member of staff. The majority (66%) of those attending came from the 50 most Deep End practices.

Of the 18 practices in Wales that are the most "Deep End" (each has over 60% of their patients living in the most deprived 20%), eleven (61%) attended the launch.

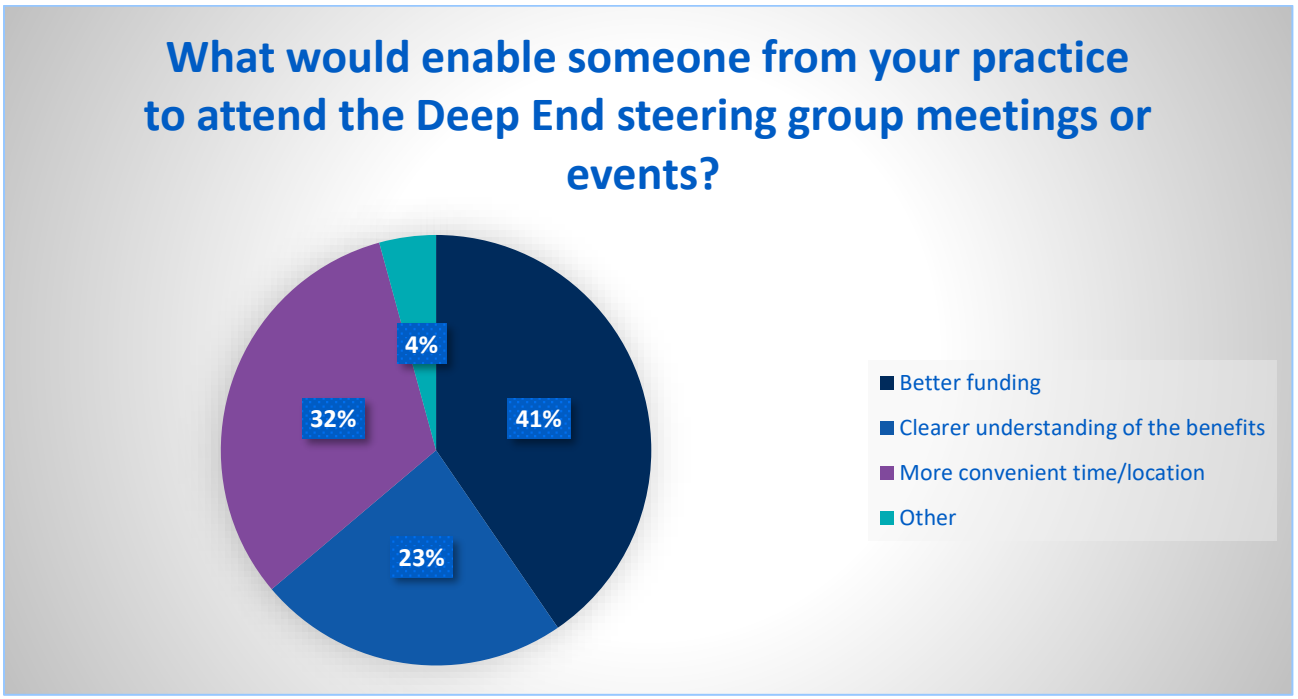
For those practices that did respond positively to initial contacts, their reasons for not engaging further included:

- Being short staffed (holidays, sickness, unable to recruit)
- Single handed practice
- Having conflicting commitments (e.g. Health Board Protected Learning Time event at the same time)
- Unable to afford a locum to cover GP time away.

An e-survey asking practice staff about the Deep End programme and their engagement, was emailed to the 100 practices in March 2023. Weekly reminders were emailed out until 30 September 2023 and it was also noted in the June newsletter. Twenty five percent (*n*=25) of participants completed the survey. All were aware of the Deep End Wales programme. The most notable reason for being unable to attend a Deep End Wales steering group meeting or event, was insufficient time. Other reasons included meetings clashing with other commitments; difficulty arranging locums and associated costs, and not enough information received to understand how the practice and patients would benefit.

Better funding (for example, covering locum costs) was the main suggestion to encourage attendance. Other responses included backfill funding and travel time.

Figure 8: enablers for non-engaging practices to send participants to Deep End events.



Participants were also asked what outcomes they would like to see as a result of the Deep End Wales programme. Responses included:

- Better funding and more support for Deep End practices
- More resources of people and services, not more pay
- Practical grass roots solutions for the current demand within primary care
- Better funding for deprived practices to access equipment eg better language line equipment, more translation services, more GPs, meaning more time to offer patients
- Negotiating power with Welsh Government for recognition (preferably financial) for those practices in the most deprived areas
- Participation and involvement in a clear project with measurable outcomes/ goals

Narrative of emerging themes from steering group and round table meetings

Launch event in November 2022

The format was a series of speakers both virtually and in person, outlining the outcomes of deprivation in communities and how similar projects have worked. Participants were then asked to identify 5 key issues which were affecting their practices. These were then collated into seven common themes for later discussion:

1. Patient literacy and advocacy
2. Recruitment and retention
3. Workload
4. Mental health
5. Complaints and low morale
6. Elderly and co-morbidity
7. Education and training

At later events, the following were added:

8. Funding and finance
9. Engagement
10. Reducing waiting lists

Round Tables
We held a further 4 half day events between February 2023 and February 2024. The formats were based on those used by other Deep End movements. Rotating locations for the events provided equity for practices travelling and hopefully encouraged more practices to attend. Practices were invited by email and reminded weekly.

We took deep dives into the following themes across the 4 events:

1. Priority setting for themes: 4 priorities identified
    a. Finance and funding
    b. Workload
    c. Recruitment and retention
    d. Education and training
2. Elderly and co-morbidity, patient and population advocacy and mental health.
3. Health Inclusion Groups, the way forward for Deep End
4. Connecting people with community assets

Participants broke out into smaller groups to discuss each issue in detail. After a break, the discussion moved on to potential practical solutions and how these could be taken forward together.
After each event, a report was sent to all eligible practices and participants, outlining the issues discussed and their potential solutions. An evaluation form was also completed asking participants about their experiences and thoughts on the day.

What did we learn from participation?

Active engagement from staff working in Deep End practices was higher than expected, and of those who did participate, the feedback was very positive. They valued the networking and mutual support.

The challenges identified at the first event remained consistent in the further deep dives. The narrative became more detailed, and some were identified by consensus as priorities.

> There was agreement in the steering group and the round tables, that inequitable funding was the most important issue and would affect the ability to tackle any other priority.

There was consistent discussion of the greater needs and greater complexity of the patients that practices were serving, and their strong wish to be able to do more and do better. Staff were concerned that patients faced too many barriers to accessing the best quality care (such as not having English as a first language, being insecurely housed and having lower health literacy skills). Their ability to provide high quality was affected by excess workload, and a lack of adequate workforce.

> Solutions were multiple, varied and innovative, with staff sharing what they were doing and learning from each other.

This was informal and impossible to capture in detail. Much of the discussion was about non-medical solutions for patients, such as social prescribing, in particular support for income maximisation and housing. Additional support for people with complex needs was another constant theme.

Improving recruitment of doctors and all staff to Deep End practices was a consistent theme. Many felt that becoming a training practice was the best route to recruitment, but that current GP Training schemes did not take account of the value of Deep End experience, or match interested Registrars to Deep End practices.

Results from participant feedback from Round Tables

Participants were asked to complete an evaluation form to provide feedback to improve subsequent meetings. The form had 11 scored statements (1 – strongly agree to 5 – strongly disagree), later increased to 16 questions, which were a mixture of closed and open-ended questions, ranked questions and a space for further comments.
Statements included:

- The event met my expectations
- I felt motivated by the event
- The event was an appropriate length
- The speakers were relevant for the event
- I had an opportunity to network
- I felt supported by other colleagues
- This project will benefit my practice and patients
- I will engage with this project

For all events, the majority of answers were positive, either strongly agree or agree. For example, at the first-round table, 74% percent felt that the event met their expectations, 88% felt motivated by it, and 8 of the 11 statements were scored positively above 80%.

With regards to improving further events, suggestions included:

- More discussion time in smaller groups
- Opportunity to discuss more than one key issue
- Face to face meetings would be much more beneficial
- Organise more frequent meetings
- Longer day
- More structure - wasn't sure what to expect

At the second and third round tables, participants rated the event as excellent or good and all would attend another event.

Comments from the events included:

I have rarely been in a meeting of GPs that had so much buzz and energy, which is especially amazing in the current times

Hopefully this will work and encourage more GPs to take partnerships in deprived areas

Good focus on advocacy and encouragement to look at "within" for resources already available

In all my years as a GP, this is the first time I've been asked what I think the issues are, I've always been told

Deep End has given me recognition that I'm doing something worthwhile over and above being a GP

Networking, engagement, reduced my symptoms of burnout, stopped me leaving the practice

In summary, participants said that the Deep End initiative was most likely to help with support, improving patient care and accessing resources.

Steering Group

During the launch in November 2022, participants were invited to engage further with the project and join the steering group. Criteria for entry were being a primary care practice member (e.g. GP, PM, nurse, pharmacist, etc), working within one of the top 100 practices or with a particular interest in health inequalities and capacity to attend monthly meetings. This invitation was followed up by weekly email reminders.

A total of 18 staff volunteered to be members of the steering group - 16 GPs and 2 PMs. This represented 11 clusters and 3 health boards. One member dropped out before attending any meetings. Following discussions, Terms of Reference were developed. On average 4 steering group members attended each meeting.

Stakeholder views

We commissioned Beaufort Research to conduct in depth interviews with 2 internal and 4 external stakeholders in May 2024. The full report is available here (*add link when available*) Key findings were:

- According to both internal and external stakeholders, the greatest added value of Deep End Wales to date had been the establishment of a community for practices to share ideas and experiences.
- Nevertheless, external stakeholders expressed some doubt about whether the movement was engaging and collaborating effectively with organisations such as Health Boards, Regional Partnership Boards and Public Service Boards to align their work or to support work already underway in the field of health inequalities.
- Most stakeholders believed Deep End Wales could play an important role in tackling health inequalities, by advocating for health professionals working in Deep End practices and for patients living in the communities they served. In addition, Deep End Wales could develop and share good practice amongst its network of practitioners to improve and ensure consistency in patient care.
- All stakeholders interviewed believed there was an opportunity for Deep End Wales to work more closely with Health Boards, Regional Partnership Boards and Clusters. They believed collaboration at this level would enable health professionals and patients to benefit from Deep End Wales's work.
- Lack of funding was seen as one of the main challenges facing Deep End Wales and the one most likely to impact negatively and limit the movement's future growth and development.
- External stakeholders believed it would be beneficial for Deep End Wales to focus on issues around recruitment and retention in Deep End practices, as well as exploring different workforce models and how best to capitalise on new technological developments to free up staff capacity.
- Confidence in Deep End Wales was mixed amongst stakeholders. They felt it was key for Deep End Wales to develop an evidence base so it could strengthen its message and demonstrate its impact clearly in the future.

We are listening to some of the "critical friend" feedback, for example:

"I think the aim is admirable, I think there's no evidence that it's effective… there's no clear evidence what they're actually doing is adding value to patients". (External stakeholder)

"If it did nothing else, it said people are feeling a little bit more confident about the future. But I think that would be lost if there is no follow through with this. If it just goes into the long grass, goes into the weeds, people are patted on the head, doesn't get some sort of proactive movement, then I think it'll just be it was interesting to do". (External stakeholder)

"I feel like it's cutting across some of the other more established pieces of work around health inclusion and just going off on doing its own thing without actually tapping in or supporting some of the pieces of work that actually exist". (External stakeholder)

- Overall, the majority of stakeholders interviewed believed that Deep End Wales should continue. However, most emphasised the need for the movement to evolve and have clearer, more measurable objectives.

Advocacy

We have aimed to raise awareness of Deep End with practices themselves and with external stakeholders and allies. We have regularly engaged with as many external stakeholders as we could, within the limited capacity of the steering group members. Among others, we have engaged with:

- Regular liaison with the Primary Care Division of Public Health Wales, who have provided excellent support with networking, events organisation and evidence.
- Health Inclusion Services, with eventual representation on our steering group
- Welsh Government officials and Medical Advisors, and the NHS Health Inequalities Group
- Academics from Cardiff and Bangor Universities and the University of South Wales
- Associate Medical Directors and Heads of Primary Care from all Health Boards
- Directors of Public Health from all Health Boards
- Several Members of the Senedd from all parties
- The Strategic Program for Primary Care
- The HEIW Primary Care Workforce Strategy leads
- The Inverse Care Law program in Betsi Cadwalader University Health Board
- Third Sector organisations, for example Adfeiriad, the Citizens Advice Bureau, and Cardiff Refugee project

We now have our own Deep End Wales webpage and Twitter account: @DeepEndWales.

Practices reported early on that they struggled to find patient information leaflets that were simple and in multiple languages. We sourced these and distributed them to all practices.

Nicola Mogford, one of our steering group members was interviewed on the ITV Wales at Six programme. Nicola talked about the issues for those living in Deep End communities. Nicola will be applying for Health Care Research Wales funding to set up a Healthy Start course for young parents in deprived communities.

We have engaged with the British Medical Association General Practitioners Committee for Wales (GPC Wales) and the Health Minister and Welsh Government officials, to highlight that Deep End practices are struggling even more than general practice as a whole. There is a lack of transparency and emerging evidence that primary care funding is not equitably distributed to practices and to Clusters. This is especially through the Carr Hill formula used to decide the main income for practices through the General Medical Services contract.

We have raised our concerns with the public via press statements regarding the GP contract negotiations failing in October 2023.

Education

Lunch and Learn online sessions.

A series of informal lunchtime online sessions started in September, in response to practice suggestions. The format will be approximately 30 minutes on the chosen topic followed by 15 minutes for questions. They are an opportunity to network and share ideas and mutual support.

Date	Speaker	Title
Wednesday September 20th 1 – 2pm	Gillian Orrow GP	'Growing Health Together: working with communities to improve population health and health equity'
Thursday October 26th 1 - 2pm	Gareth Thomas PM West Quay Surgery	'Practice Finances'
Tuesday November 28th 1 - 2pm	Rowena Christmas GP Monmouth	'Safeguarding in the Deep End'
Thursday December 14th 1 - 2pm	Laura Nielson GP Shared Health Foundation (SHF) Lead Manchester	'Deep End Manchester – challenges and opportunities'
Wednesday January 17th 1 - 2pm	Debra Morgan Nicola Baxter	'Cwmtawe Pathway Service: Developing Person Centred Care for Patients with Complex Needs'
Thursday February 22nd 1 -2pm	Dr Sara Thomas, Cwm Taf Morgannwg Public Health Team	'Understanding your population'
Wednesday March 20th 1 - 2pm	Dr Harry Ahmed, Division of Population Medicine, Cardiff University	Academic Clinical Fellow scheme, Cardiff University
Wednesday May 15th 1-2pm	Dr Jonathan Tomlinson, GP, Hackney	Trauma-informed primary care

Research

Cardiff University Division of Population Medicine kindly offered Deep End an academic home. Through Dr Harry Ahmed's leadership, they have supported Deep End with academic input to the steering group, for example planning the evaluation and planning research studies.

We have almost completed a qualitative research study with Cardiff University colleagues to explore experiences of frontline clinicians who are working in the GP Practices serving the most deprived GP communities in Wales and to understand what primary care staff want and need from a Deep End network including any barriers they perceive to establishing it. This is based on the methodology used by North East and North Cumbria Deep End led by Dr Sarah Sowden of Newcastle University.

The study carried out in-depth interviews with about 20 people working in Deep End Practices, from a mix of professional backgrounds and ages. The study received ethical approval in July 2023 and is now being written up for publication. Dr Louise Thompson, one of the Academic Clinical Fellows, is leading this with the supervision of Professor Fiona Wood, Professor of Medical Sociology.

On the advice of Cardiff University partners, we have three main strands for fruitful research collaborations proposed by academic colleagues:

1. Evaluation of delivery of the Deep End Programme
2. Building capacity and infrastructure across Deep End Practices for research delivery.
3. Generating and conducting new research of relevance to Deep End populations.

6. Conclusion

The purpose of the first phase of Deep End Wales, was to conclude whether a long-term Deep End programme is feasible, acceptable and likely to add value to patients and staff in Deep End practices serving the most deprived communities in Wales. This has been demonstrated by the level of engagement from eligible GP practices and other stakeholders. The evidence from the quantitative and qualitative data shows that the needs of Deep End practices and patients are not being met as well as they should be, and that this approach is welcomed. GP practices perceive it to be of value and it is already generating innovative ideas for solutions to common challenges.

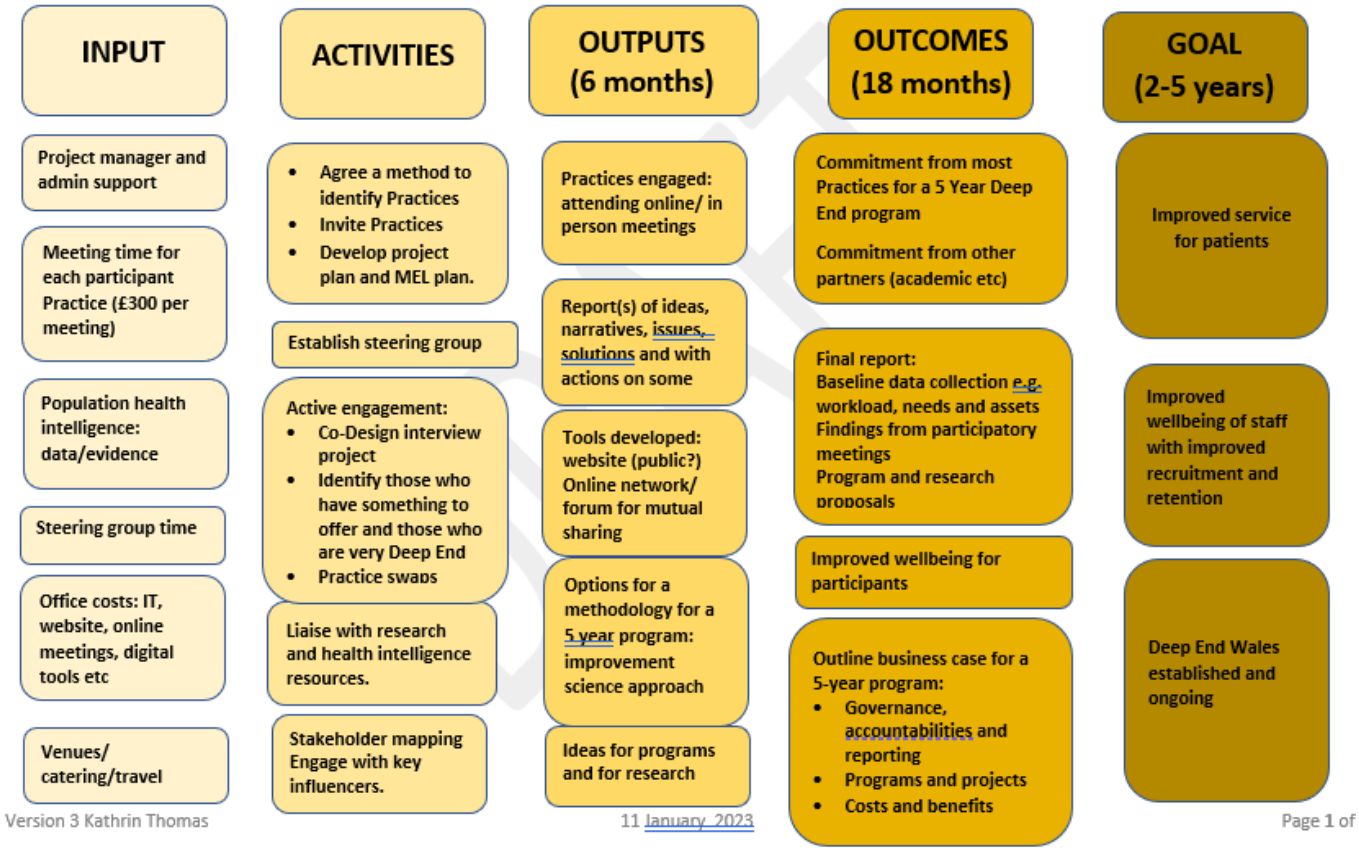
Looking to the future

The Deep End approach has been shown to be effective in multiple locations in the UK and internationally since the first programme started in Scotland in 2009. The spread of the model comes from the conviction that mutual support and shared learning contributes to the morale, effectiveness and eventually the sustainability of practices that are at highest risk of drowning.

At the most recent round table ambitions for the network were outlined. These included: having a funded Deep End core group; facilitating opportunities for learners including trainees in Deep End practices; aiming for fairer targets in Deep End practices; holding Health Inequities study days; working to develop complex needs workers deepening links to academia; developing research with more Academic Clinical Fellows (ACFs); gaining more recognition, protected groups; and better access to mental health for clinicians.

The Deep End Wales vision is for NHS general practice to be at its best where it is needed most.

Appendix 1: Theory of Change



The questions agreed to guide evaluation of Deep End Wales 18-month programme were:

1. Is a Deep End Wales Network feasible?
    a. What are the barriers and enablers?
    b. How does 'Deep End' link to Clusters and ACD?
    c. What attracts GPs to the 'Deep End' Cymru project?
    d. What does good and effective engagement with Deep End Practices/stakeholders/patients look like?
    e. What are the critical factors for success?

2. What could the outcomes of Deep End Wales be?
    a. What key outcomes would stakeholders, GPs, and patients consider most important to demonstrate the impact of Deep End Wales in a future longer-term evaluation?
    b. What are the key priorities for 'Deep End'?
    c. How does 'Deep End' Cymru develop over time?
    d. What works, for whom, in what respects, to what extent, in what contexts, and how for the 'Deep End' project?

Evaluation Plan

Quantitative		**Qualitative**	
At 6 months	**At 18 months**	**At 6 months**	**At 18 months**
Number/ proportion of 100 GP Practices responded in any way. Breakdown by geography and deprivation percentage and training status	Number/ proportion of 100 GP Practices responded in any way. Breakdown by geography and deprivation percentage and training status		Summary of views from GP Practices that strongly committed on why they have engaged Survey response of sample of non-engagers on why they chose not to engage
	Steering group meetings and round tables arranged and delivered: number attending each by geography and deprivation and training status	Evaluation forms from each event, with free text comment	Evaluation forms from each event, with free text comment
			moothstudy based on NENC methodology: interviews with a sample of Deep End Practice staff, and learning from Establishing a Deep End GP group: a scoping review - PubMed (nih.gov)
Wider stakeholders mapped and contacted.	Number of stakeholders responded in any way	Focus group and/or interviews	Report on how stakeholders engaged/ missing stakeholders etc
	Connect with a number of other Deep End networks		Contribution to the International Bulletin, co-ordinated by Graham Watt.
	Which tools developed and use of these (e.g. website. CoP, chat forum)		Evaluation forms from participants
Plan for actions: in each GP Practice/ Cluster/ across Deep End	Identify a small number of projects that show potential, or identify issues, or challenges and/or solutions	Report of insights and ideas from all meetings	Report of insights and ideas from all meetings Narrative of a small number of in-depth case studies.
	Proportion of original GP Practices/ Clusters committed to continuing to 5 years programme		Impact evaluation e.g. participant and stakeholder response to “what was the most significant change?”
			Business case agreed for a 5 year programme, ready to submit to potential funders

APPENDIX 2: Steering Group membership

Co-Chairs and Clinical Leads

Dr Mair Hopkin and Professor Peter Saul

Deep End practice members

	Health Board	Cluster	Practice	Deprivation Ranking
Dr Modupe Obilanade	ABHB	Newport West	St. Paul's Clinic	2
Sophie Jones (PM) until Sept 2023)	ABHB	Newport West	St. Paul's Clinic	2
Dr Sayma Ahmed	CandV	Cardiff South East	Cloughmore Medical Centre	9
Dr Emily Watkin	CandV	Cardiff South West	Ely Bridge Surgery	11
Dr Jonny Currie	ABHB	Newport East	Ringland Medical Practice	14
Dr Neil James	ABHB	Caerphilly North	Cwm Rhymni Practice	16
Dr Ceri Walby	CandV	Cardiff South East	Clifton Surgery	22
Joanna Watts-Jane (PM)	ABHB	Newport East	The Rugby Surgery	27
Dr Roger Morris	CandV	Cardiff East	Llan Healthcare	30
Dr Sophia Hough	CandV	Cardiff City and South	Grange Medical Practice	39
Dr Jo Rudling	ABHB	Blaenau Gwent East	Abertillery Group Practice	41
Dr Nicola Mogford	Cwm Taf Morgannwg	Cynon South	Meddygfa Glan Cynon Surgery	45
Dr Natalie Tebb	Cwm Taf Morgannwg	Bridgend North	Bron y Garn Surgery	60
Dr Isolde Shore-Nye	ABHB	Blaenau Gwent East	Cwm Calon practice	84

Academic Lead – Dr Harry Ahmed, Cardiff University

Public Health Lead – Dr Kathrin Thomas, Consultant in Public Health (sessional)

RCGP Cymru Project team

- Project Manager - Melanie Peters
- Head of RCGP Wales & ROI - Nicola Edmunds
- Professor Kamila Hawthorne - Chair RCGP UK
- Dr Rowena Christmas - Chair RCGP Wales

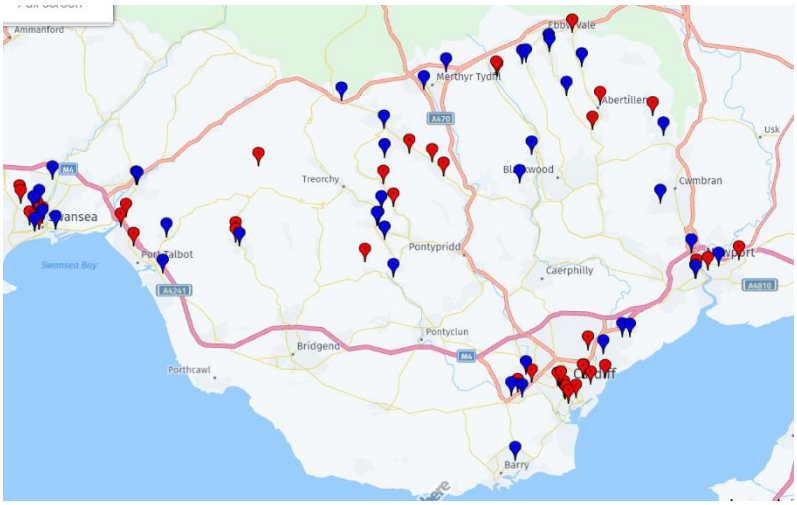
APPENDIX 3 Maps

Maps of Deep End GP Practices

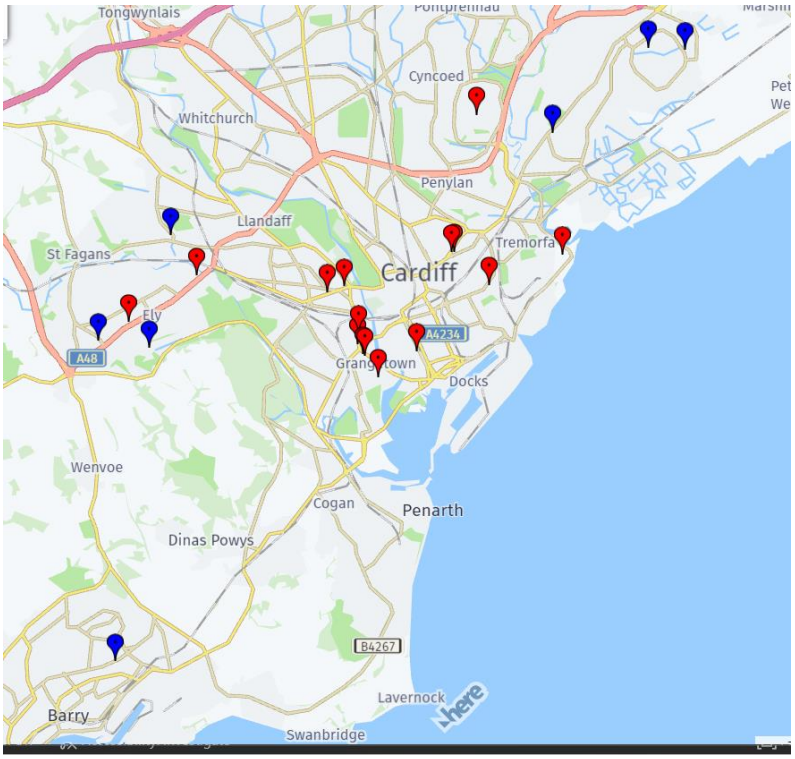
Red = top 50 for percentage of patients in most deprived 20%

Blue = top 51-100 for percentage of patients in most deprived 20%

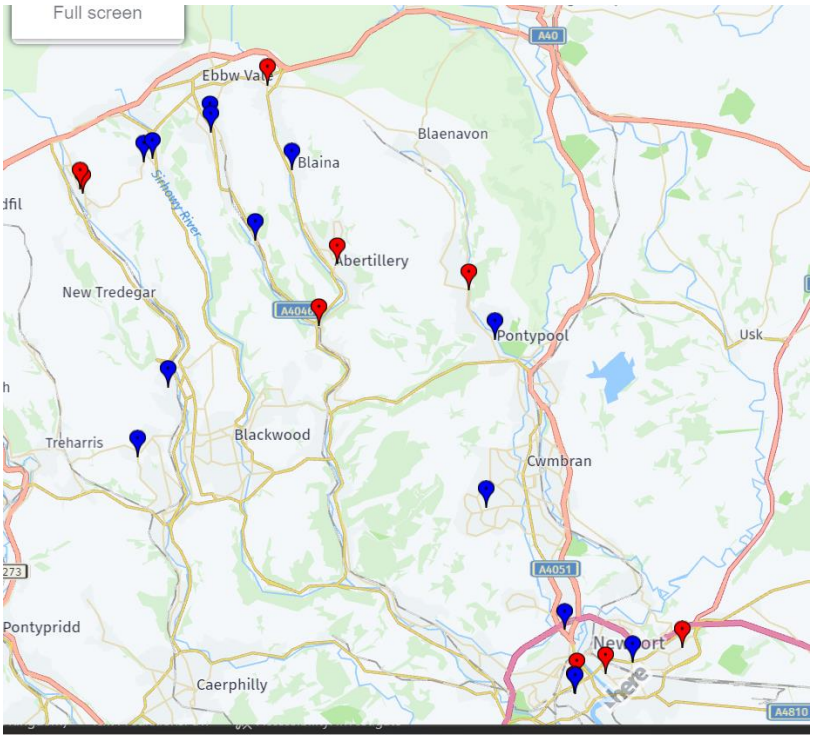
South Wales



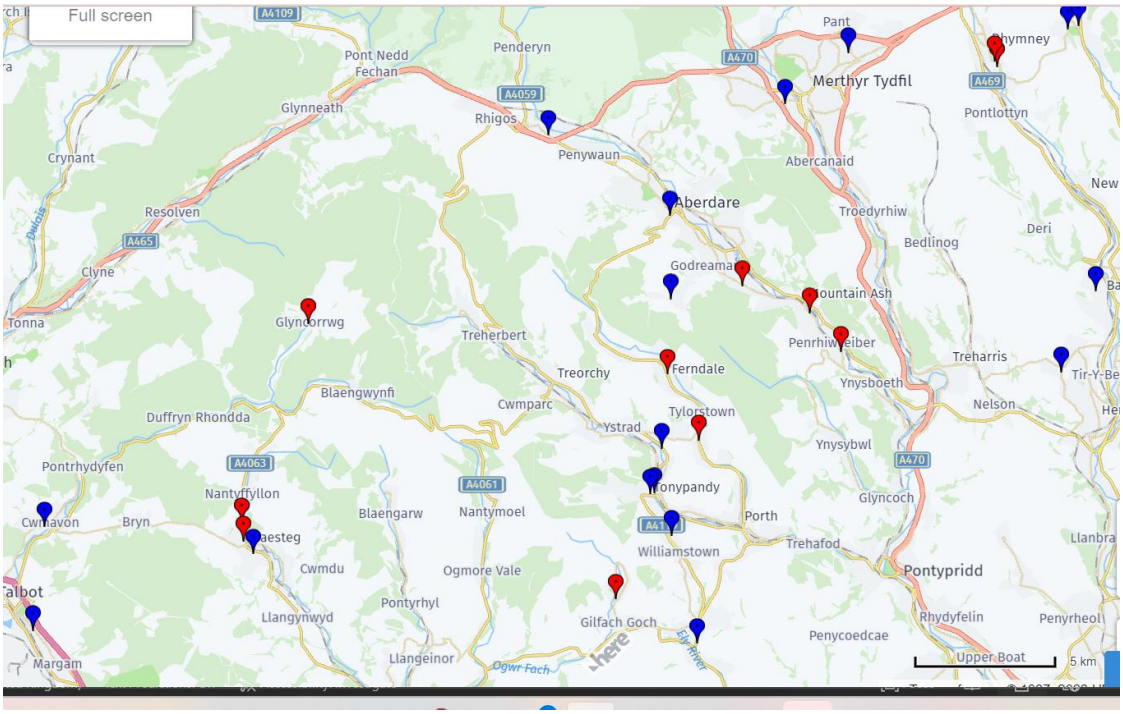
Cardiff and Vale



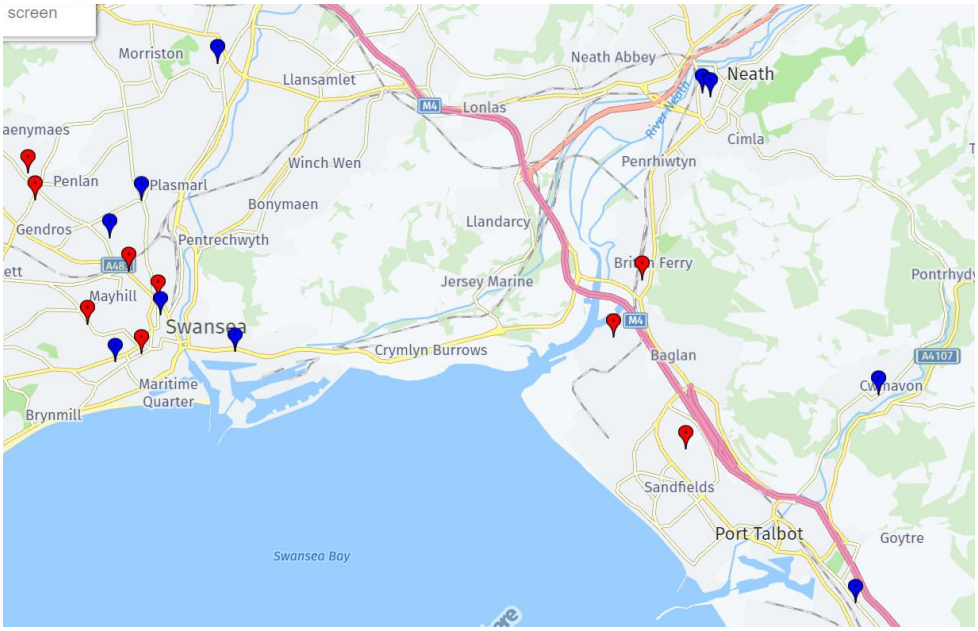
Aneurin Bevan



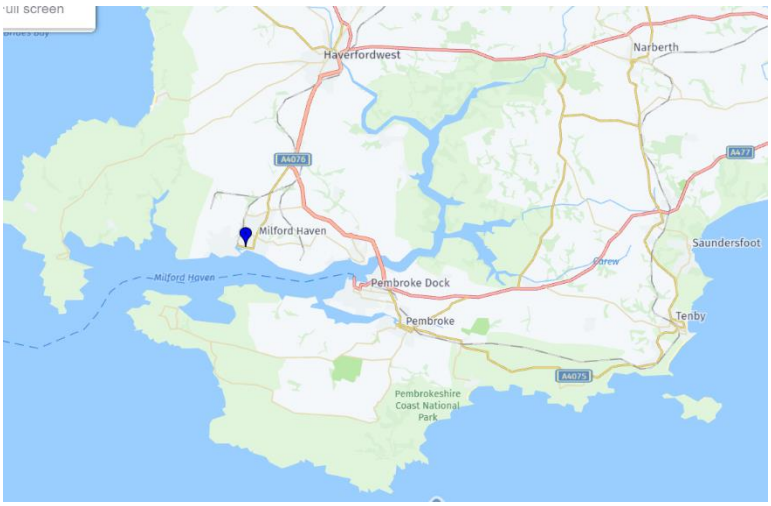
Cwm Taf Morgannwg



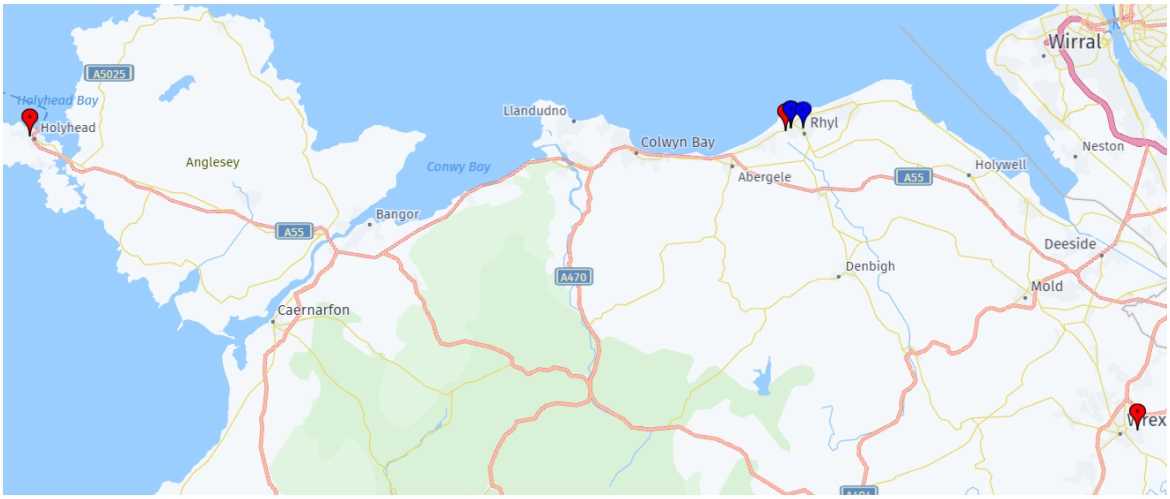
Swansea Bay



Hywel Dda



Betsi Cadwaladr



Appendix 4: Health Board and Cluster distribution

University Health Board	Number of Deep End GP Practices	Cluster	Number of Deep End GP Practices
Aneurin Bevan Health Board	26	Blaenau Gwent East	7
		Blaenau Gwent West	3
		Caerphilly North	4
		Newport East	4
		Newport North	2
		Newport West	3
		Torfaen North	2
		Torfaen South	1
Betsi Cadwaladr Health Board	6	Anglesey	1
		Central Wrexham	1
		North Denbighshire	4
Cardiff and Vale Health Board	21	Cardiff City and South	5
		Cardiff East	4
		Cardiff South East	4
		Cardiff South West	7
		Cardiff West	1
		Central Vale	1
Cwm Taf Morgannwg Health Board	20	Bridgend North	3
		Cynon North	2
		Cynon South	4
		Merthyr	4
		Rhondda	8
Hywel Dda Health Board	1	North Pembrokeshire	1
Swansea Bay Health Board	24	Afan	7
		City Health	6
		Cwmtawe	1
		Neath	4
		Penderi	6
Powys Health Board	0		0