



Meddygon Teulu yn y Pen Dwrn
GPs at the Deep End



Llywodraeth Cymru
Welsh Government

Deep End Cymru

Evaluation of the first phase



The Deep End Cymru Steering Group

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Index

	Page
1.Summary	3
2.Introduction	6
3.Background	6
4.What did Deep End Wales do?	7
5.Methods of evaluation	9
6.Results	11
7.Outputs	22
8.Conclusion	24
9.Appendices	25

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

Deep End Cymru is a grassroots movement developing mutual support between GP practices serving the most deprived communities and using this over time to generate change to improve healthcare services and health outcomes for people with the greatest health needs. People from poorer socioeconomic groups, or from vulnerable groups, die younger and develop multiple morbidities at a younger age. This poor health has a significant impact on workload for those GP practices serving them.

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. It was inspired by Dr Julian Tudor Hart, who coined the Inverse Care Law – that the availability of good medical care varies inversely with population need - back in 1971¹. It has taken until now to test out whether it could work in Wales.

Launch

We focused on the 100 GP practices that had the highest proportion of their patients living in the most deprived 20% of Lower Super Output Areas in Wales and invited engagement. The project launch was in November 2022 and 25 practices attended, comprising 22 GPs and 5 Practice Managers. 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.

The project was met with enthusiasm by participants with comments such as *“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”* and *“Deep End has given me recognition that I’m doing something worthwhile over and above being a GP”*.

After the launch a steering group was set up which meets monthly supported by two Clinical Leads, a full time Project Manager, a Public Health Lead and an Academic Lead.

Process

Four events have been held to discuss and outline direction, to network and swap ideas, and four workstreams initially emerged: Education and training; Funding and finance; Recruitment and retention and Workload. 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. 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

¹ [THE INVERSE CARE LAW - The Lancet](#)

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.

Evaluation

The network formulated a mixed method of evaluation to help inform whether a long-term Deep End programme is feasible in Wales, this comprised narrative, quantitative and qualitative elements.

Characteristics of Deep End practices were examined and compared with those outside the network. We were interested to note that the Deep End practices reach almost 60% of the 653,413 people living in the most deprived quintile. These were predominantly located in Southeast Wales, disproportionately distributed across health boards but scattered across Clusters with very few having a majority of Deep End practices.

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.

Deep End GPs have larger list sizes, 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.

We examined why many Deep End practices did not engage with the network, the main reasons given were insufficient time, conflicting meetings, difficulties with securing locums and uncertainty about how the network would benefit practice and patients. Support for backfill was felt to be the main enabler for engagement.

In addition to the workstream topics additional factors influencing delivery of services were identified: Patient literacy and advocacy; Mental health; Complaints and low morale; Elderly and co-morbidity; Patient engagement and Reducing waiting lists. Discussion around these topics allowed dissemination of views and some possible solutions to the wider network.

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.

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.

2. Introduction

This is an interim report on progress of the first phase of Deep End Wales. Deep End 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 from September 2022 to March 2023.

3. Background

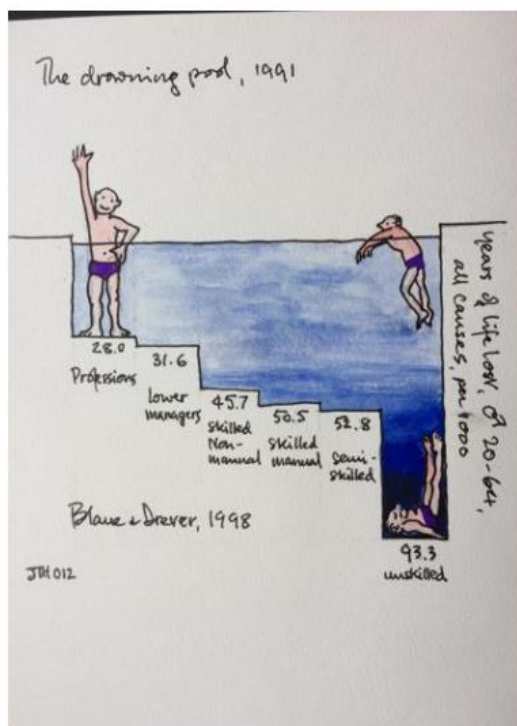
Why do we need Deep End?

Inverse Care Law

People from poorer socioeconomic groups, or from vulnerable groups, die younger and develop multiple morbidities at a younger age². 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 2009³, 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 Glyncoed 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 Wales do?

What Deep End is and what it is not

The Deep End Wales 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 2022⁵.

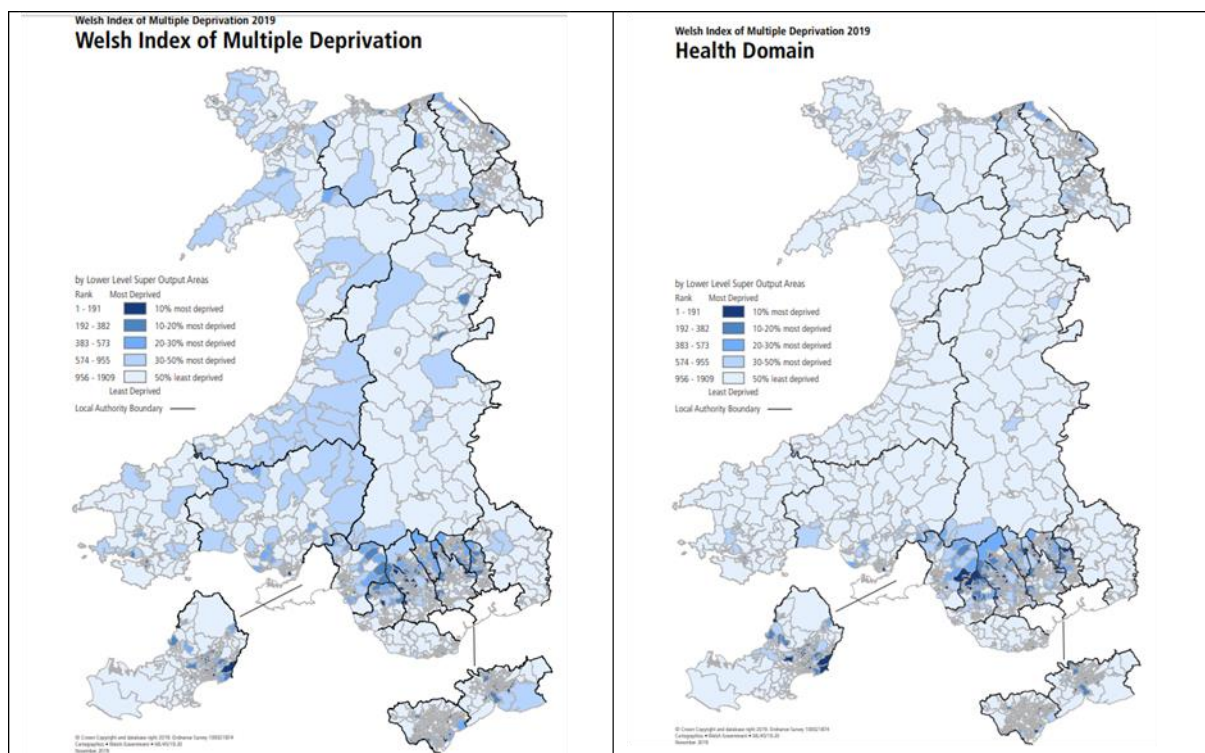
As can be seen from the map below, deprivation is not distributed evenly across Wales. Four of the seven Health Boards have a significantly higher proportion of their populations living in the most deprived 20% of LSOAs. Wales has 653,413 people living in the most deprived quintile. Of course, not every 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 \(gov.wales\)](https://gov.wales/wimd). 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 \(gov.wales\)](https://gov.wales/deprivation-at-gp-practice-level)

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. There has been engagement and mutual learning, although these primary care services and this will be included in the final report at the end of the project

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 and over the duration of the project, to inform them about Deep End Wales and to invite them to participate in any way they were able. Emails were sent to the generic practice manager account and practice websites were searched online for other contact emails such as Senior Partners, Practice Nurses, Business Managers and Deputy Practice Managers. Online search engines were used for practice websites, health board information and practice manager associations. Telephone enquiries were made to NHS Wales Shared Services Partnership Primary Care Services, but they were unable to help.

A list of Senior Partners and Practice Managers was compiled. This was problematic as no organisation holds an up-to-date list of practice contacts, mainly due to the constant change in practice staff. Therefore, word of mouth and online searches generated the list.

A project launch was felt to be a good way of bringing focus to the project and to start building a collaborative network. The Chair of RCGP Wales and other GPs who were aware of the project were asked

to spread the word to colleagues. Relevant cluster leads were also contacted to encourage their practices to attend.

Individual letters were sent to the Senior Partner and Practice Manager, inviting them to the project launch in November 2022 in Abergavenny. This location was chosen due to good links with public transport, particularly for those coming from North Wales. These were followed up by telephone calls to each practice explaining the nature of the call. This approach had limited success - there was often a lengthy call wait, information was given in English and Welsh and reception staff had not heard of the project and were unsure to whom to relay it. In addition, this approach rarely resulted in speaking to either the Practice Manager or GP. Emails were also sent to invite Senior Partners and Practice Managers (or a representative) to the event. These were followed up weekly until the launch.

How Deep End does its work.

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 Bulletin⁶ to share progress.

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 events have been held that are 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:

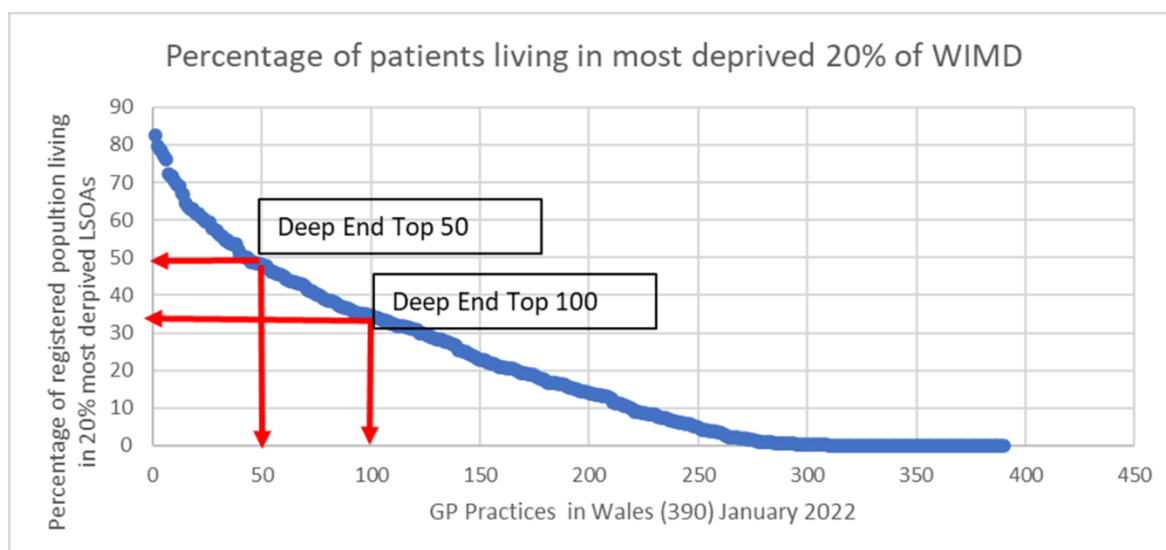
- a. Deprivation
- b. Geographical distribution
- c. Alignment with clusters
- d. List size
- e. Workforce
- f. Managed, merging and closing practices
- g. Training status

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%.

A large number of 109 practices (28%) had 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.

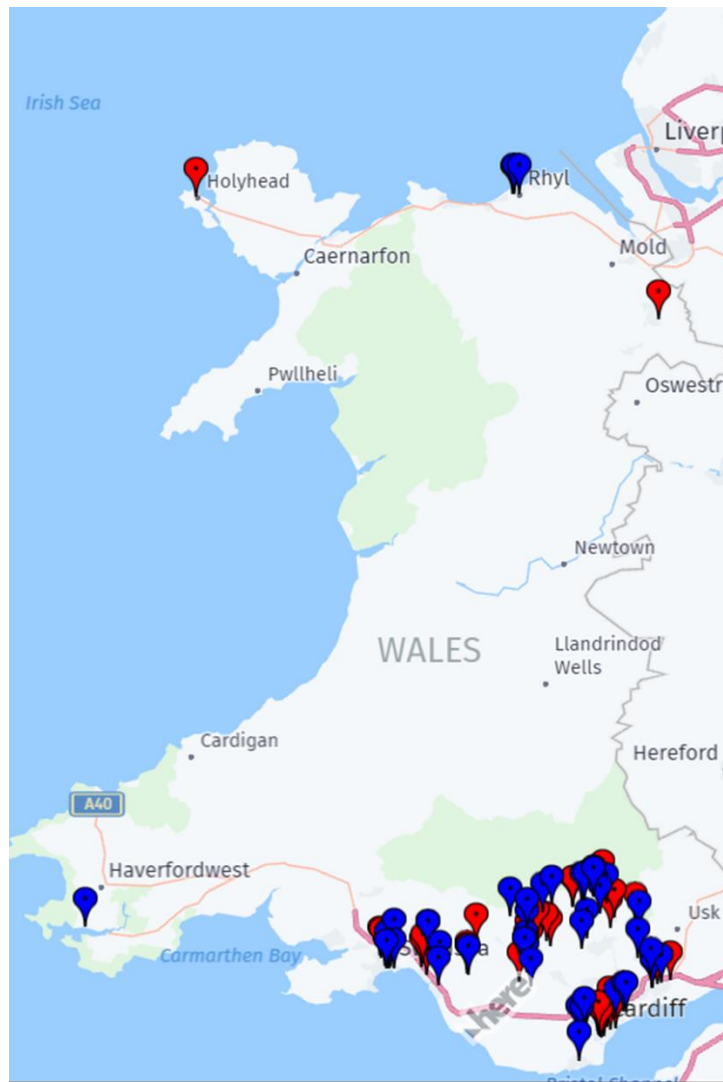
Table 1: Number of people in most deprived 20% reached by Deep End practices

	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 south east 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

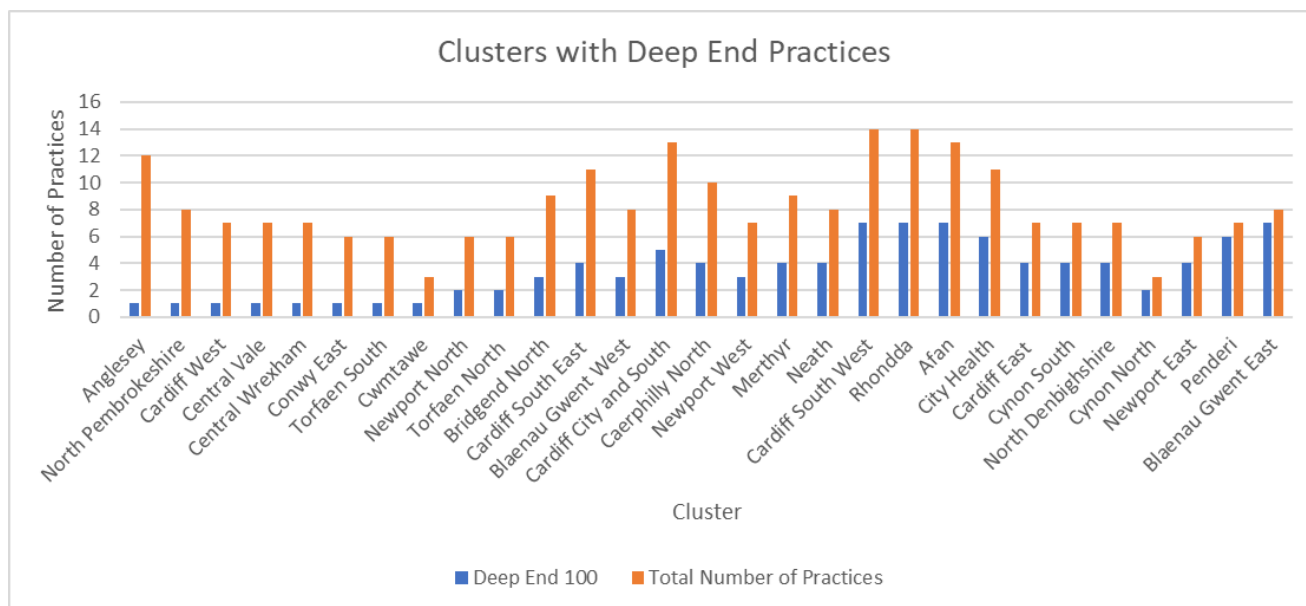
University Health Board	Number of Deep End GP Practices
Aneurin Bevan Health Board	26
Swansea Bay Health Board	24
Cardiff and Vale Health Board	21
Cwm Taf Morgannwg Health Board	20
Betsi Cadwaladr Health Board	6
Hywel Dda Health Board	1
Powys Health Board	0

Alignment with Clusters

GP practices are required to become engaged in cluster working⁷, 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 patients living in most deprived 20% of LSOAs	61%	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 patients living in most deprived 20% of LSOAs	61%	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.

Managed, merged and closing practices.

During the first 12 months of Deep End, 7 practices closed or merged. We do not have data to know whether this is a higher or lower rate than overall in Wales.

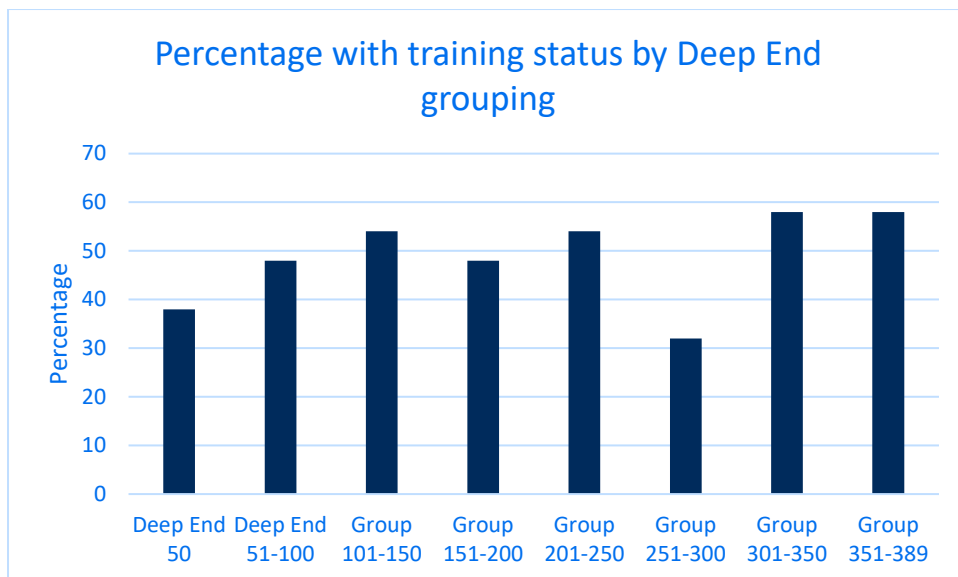
5 of the Deep End practices were under health board management at the beginning of the programme. However, there is no data in the public domain about how many managed practices there are in Wales, so no comparison was possible.

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.. 43% of Deep End practices have training status, while 58% of the least Deep End two groups have training status.

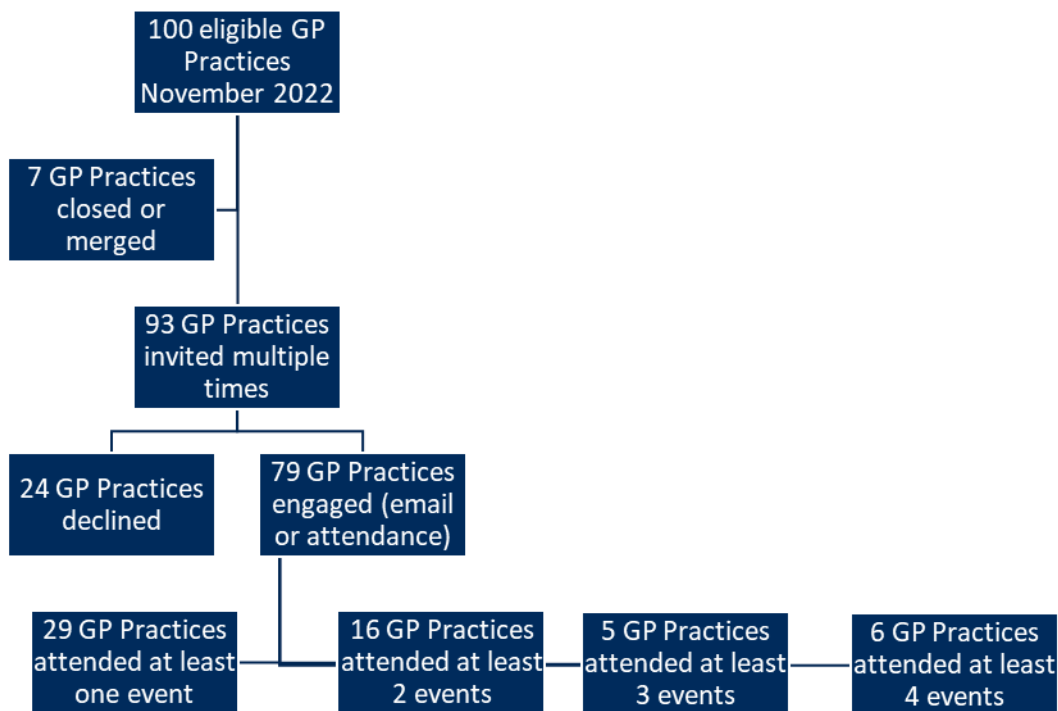
Figure 6: Training practice status by grouping



Deep End engagement

We understand from other Deep End programmes, that about 20-25% of GP practices eventually actively engage in time. There remains a proportion do not wish to engage, and many will dip in and out. In the first year of Deep End Wales, 85% of eligible practices responded positively. Of these, 31% attended at least one of the four events, some sending more than one member of staff.

Figure 7: flow diagram of engagement with eligible GP Practices



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

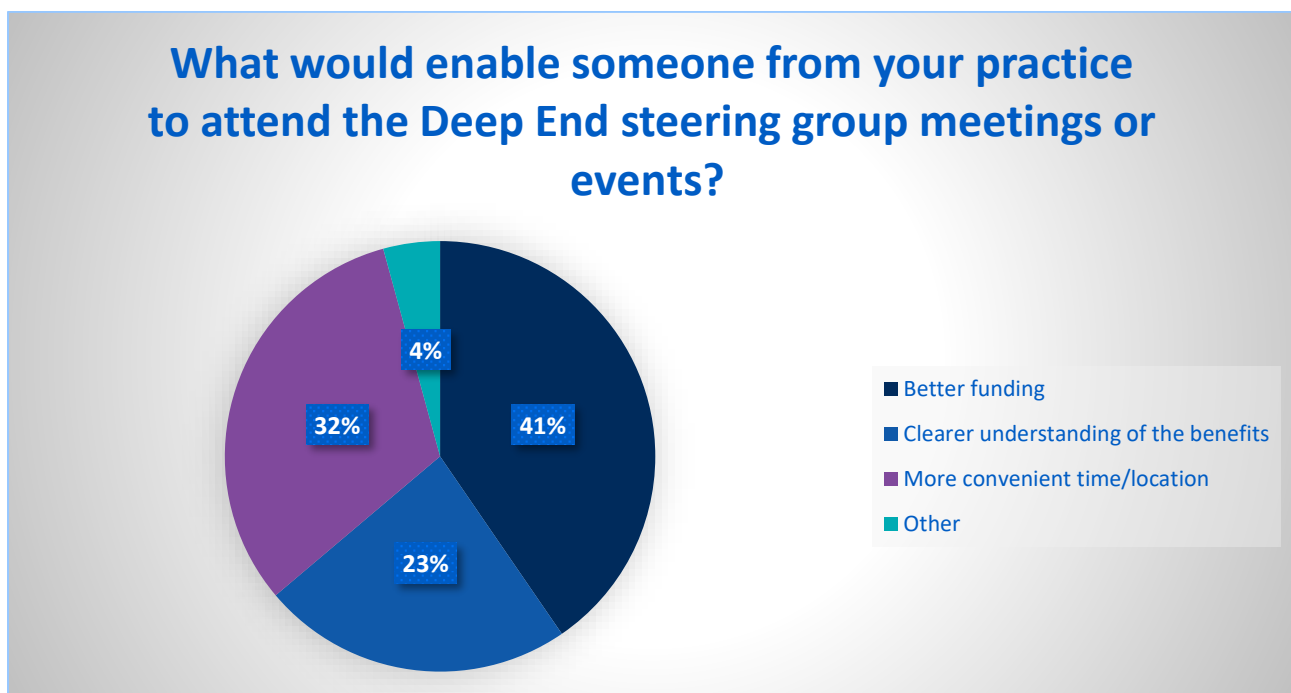
- Being short staffed (holidays, sickness, unable to recruit)
- Single handed practice

- Having conflicting commitments (e.g., CPET on the day of the event)
- 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 WG for recognition (preferably financial) for those practices in the most deprived areas
- Participation and involvement in a clear project with measurable outcomes/ goals

Narrative report of emerging themes from steering group and round table meetings

Launch event in November 2022

27 practice staff attended the project launch, comprising 22 GPs and 5 Practice Managers, representing 25 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.

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

Participants then broke out into smaller groups to discuss their chosen issue and look at how these could be addressed by support from the Deep End.

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.

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.

Round Table March 2023

The second Round Table event was held in March in Cardiff 2023. 15 practice staff attended, of whom 13 had also attended the launch. Again, participants were asked to identify key issues. In addition to the seven existing key themes, three more were added:

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

An outcome of this event was the establishment of several workstreams, led by a steering group member:

- Education and training
- Finance and funding
- Recruitment and retention
- Workload

The groups held additional meetings to take pertinent issues forward.

Round Table July 2023

The third round table event was held in Swansea in July 2023. 15 practice staff attended with 4 new practices engaging. This was a smaller venue and with many staff on holiday the event was surprisingly well attended.

Participants addressed the remaining three issues in small groups:

- elderly and co-morbidity,
- patient and population advocacy and
- mental health.

Whilst addressing all 10 themes are currently beyond the project's capacity, establishing an understanding is useful, should additional funding be secured.

Round Table September 2023

The fourth round table event was held in Cardiff in September 2023. 23 practice staff attended with 1 new practice engaging and 4 GP trainees. The format of this event differed from the others. Dr Ayla Cosh, Clinical Director of the Cardiff and Vale Health Inclusion Service gave an overview of the Health Inclusion Service. Participants then discussed the development of a Health Inequalities Study Day for practice staff and others such as trainee GPs and medical students. The rest of the day was spent discussing the way forward for Deep End. Ideas of what Deep End would look like in three years' time included:

- National conference and Health Inequity study day(s)
- Complex needs workers
- Fully funded Deep End hub - under RCGP
- education Provider, admin support, lobbying.
- Lobbying for more trainees in Deep End practices
- Agreement of fairer targets in Deep End practices
- Links to academia
- Area for research, more Academic Clinical Fellows (ACFs)
- More recognition, protected groups
- Better access to mental health for clinicians

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

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 fourth round table, 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.

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.

Emerging themes

10 key themes emerged from round table discussions (see previous). However, the project did not have capacity to address all 10, and so 4 areas of priority were taken forward:

- Education and training
- Finance and funding
- Recruitment and retention
- Workload

Each working group had a GP lead who worked in a Deep End practice. The most established group was for funding and finance. The group met virtually and developed a letter outlining pertinent issues of the new GMS contract and its implications for Deep End practices. This was sent to the Minister for Health and Social Services.

6. Outputs

Communications

We have our own Deep End channel on Teams for internal communication and shared files. This gives the Steering Group protected space for meetings and documents.

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.

Advocacy

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 20 th 1 – 2pm	Gillian Orrow GP	'Growing Health Together: working with communities to improve population health and health equity'
Thursday October 26 th 1 - 2pm	Gareth Thomas PM West Quay Surgery	'Practice Finances'
Tuesday November 28 th 1 - 2pm	Rowena Christmas GP Monmouth	'Safeguarding in the Deep End'
Thursday December 14 th 1 - 2pm	Laura Nielson GP Shared Health Foundation (SHF) Lead Manchester	'Deep End Manchester – challenges and opportunities'

Wednesday January 17 th 1 - 2pm	Debra Morgan Nicola Baxter	'Cwmtawe Pathway Service: Developing Person Centred Care for Patients with Complex Needs'
Thursday February 22 nd 1 -2pm	Dr Sara Thomas	'Understanding your population'
Wednesday March 20 th 1 - 2pm	Looking for speakers/topics	

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 begun 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 and any barriers they perceive to establishing it. This will be led by Dr Louise Thompson, Academic Clinical Fellow, supervised by Professor Fiona Wood. The study will be seeking to do 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. 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.

7. 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.

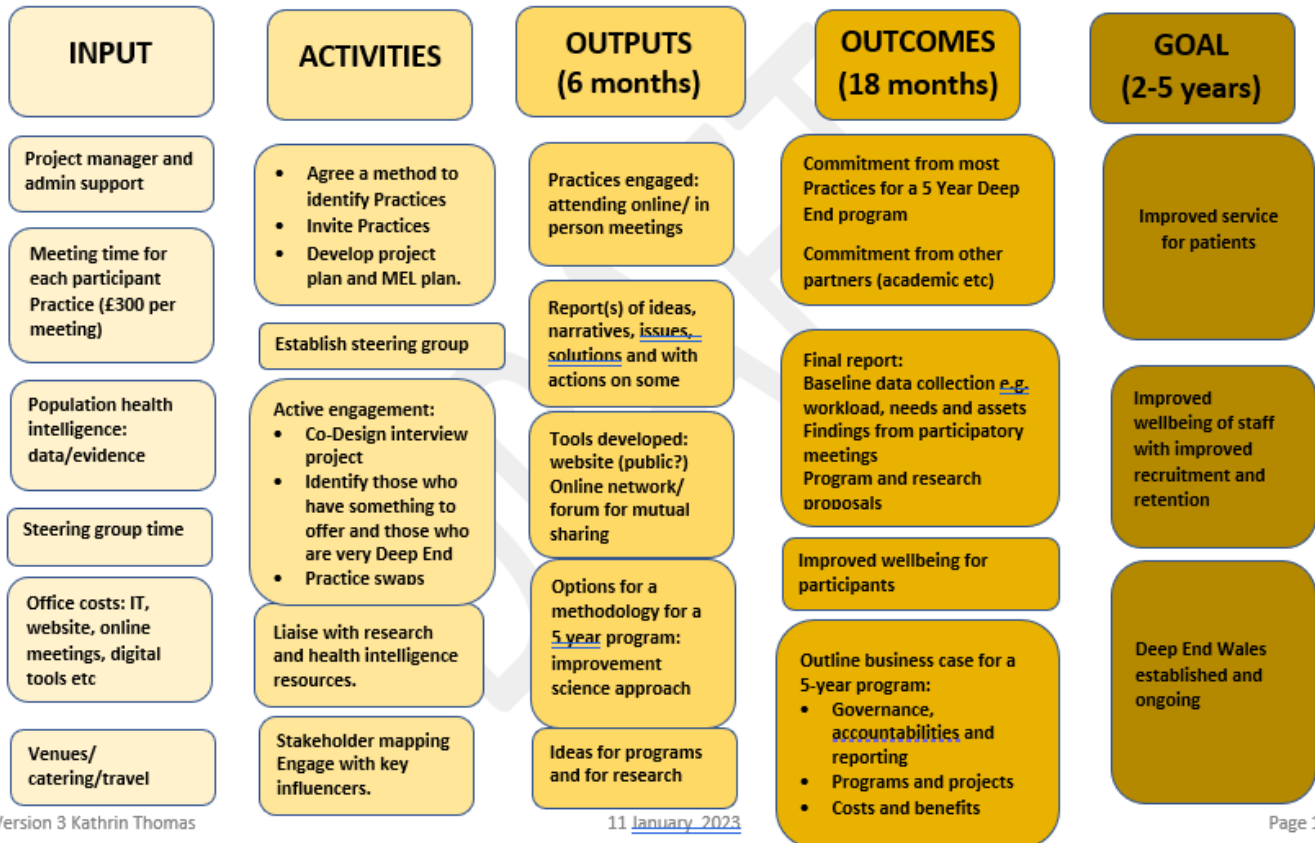
Looking to the future

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

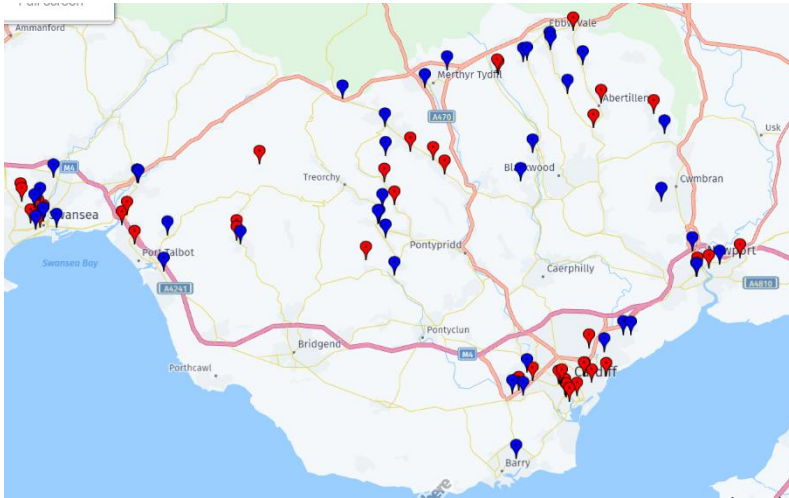
APPENDIX 3 Maps

Maps of Deep End GP Practices

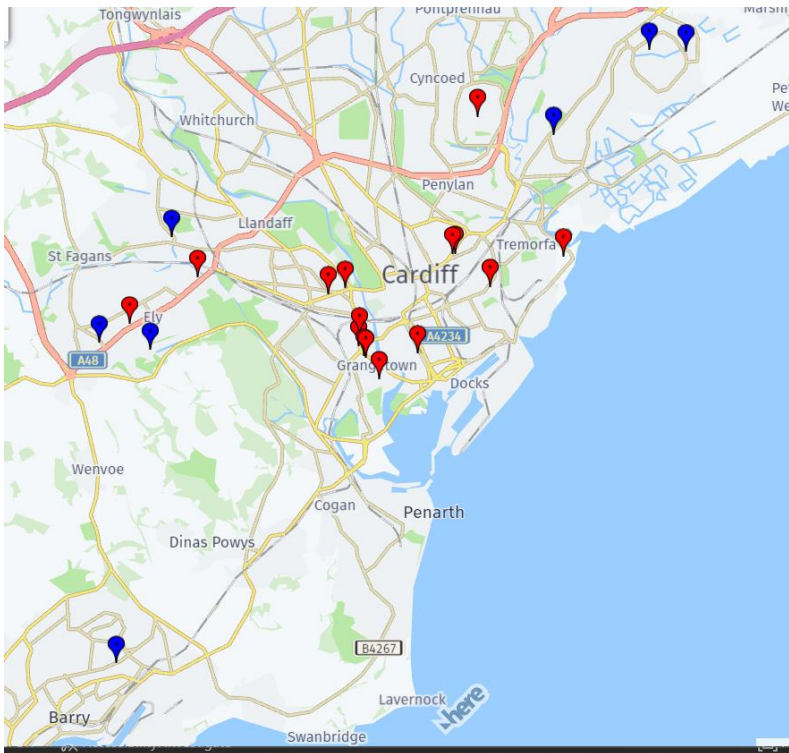
Red = top 50 for percentage of patients in most deprived 20%

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

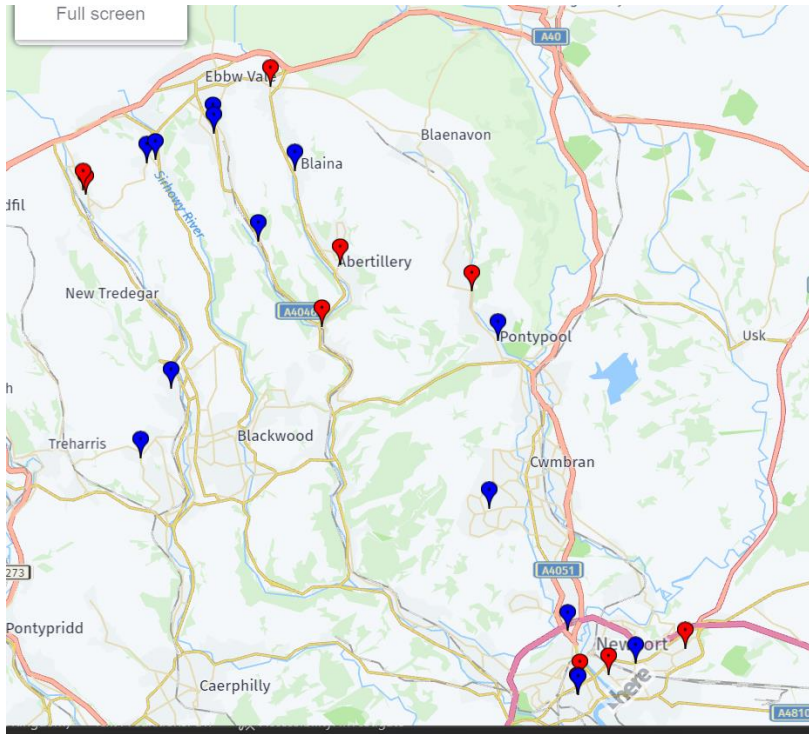
South Wales



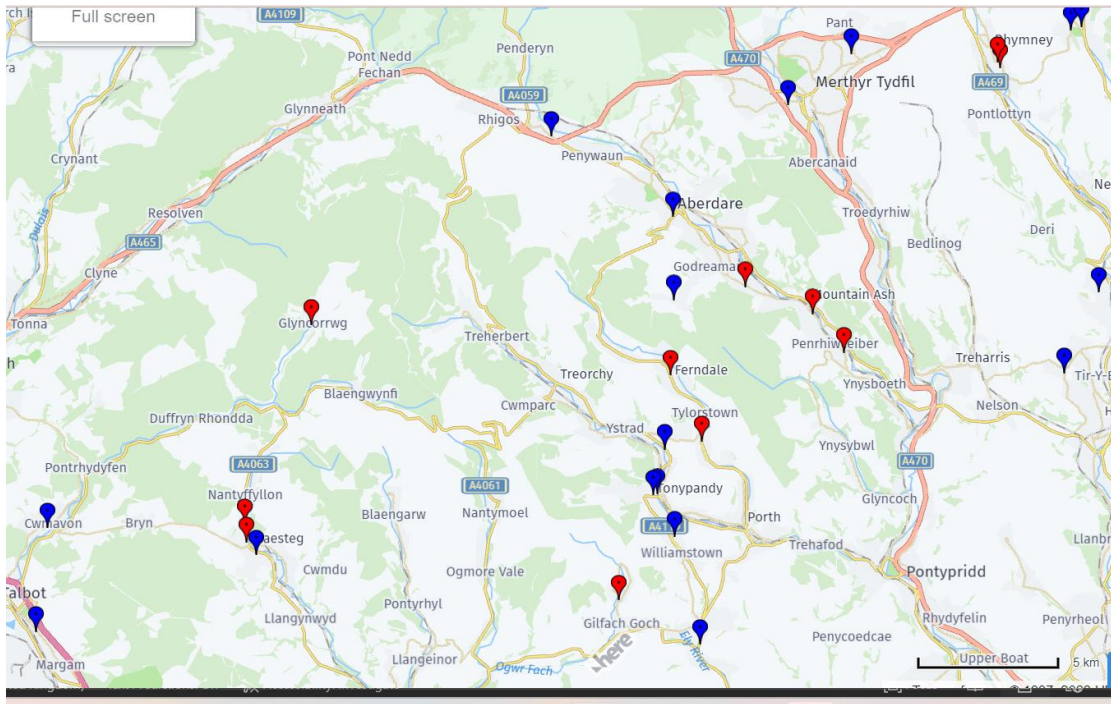
Cardiff and Vale



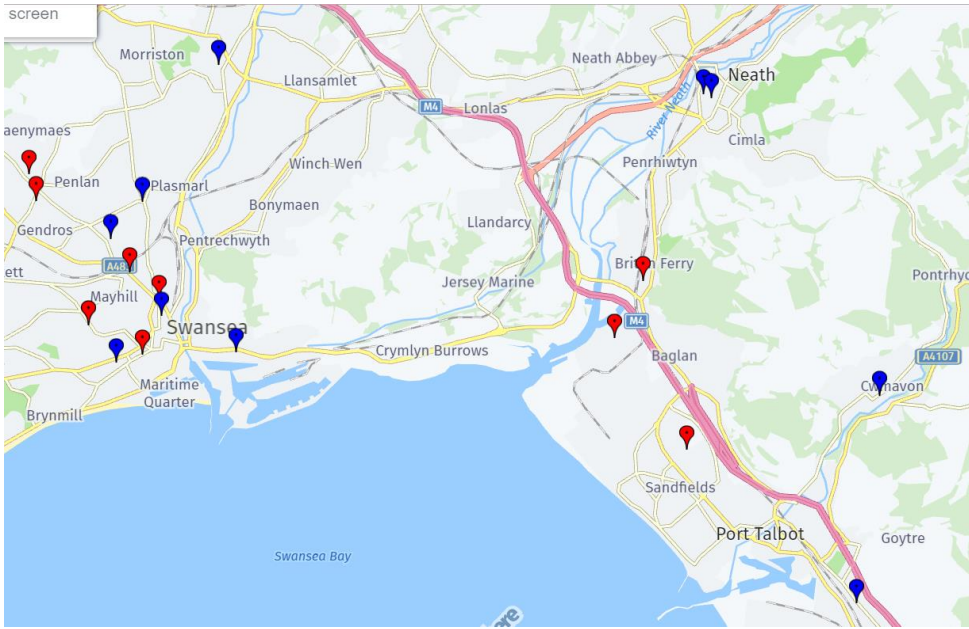
Aneurin Bevan



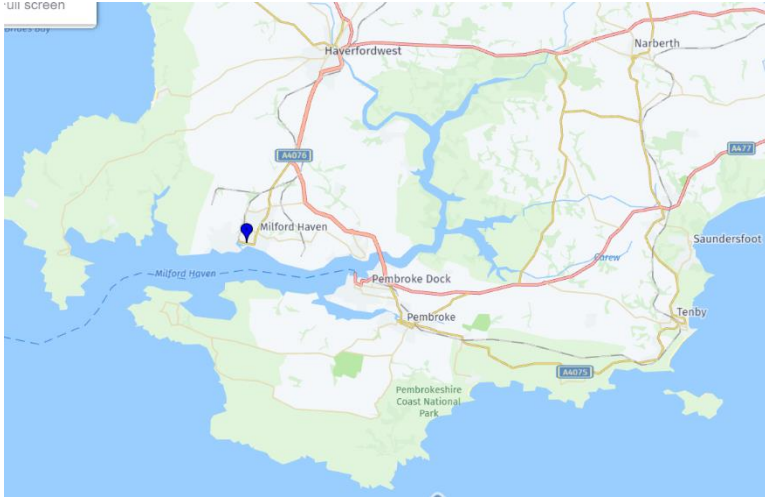
Cwm Taf Morgannwg



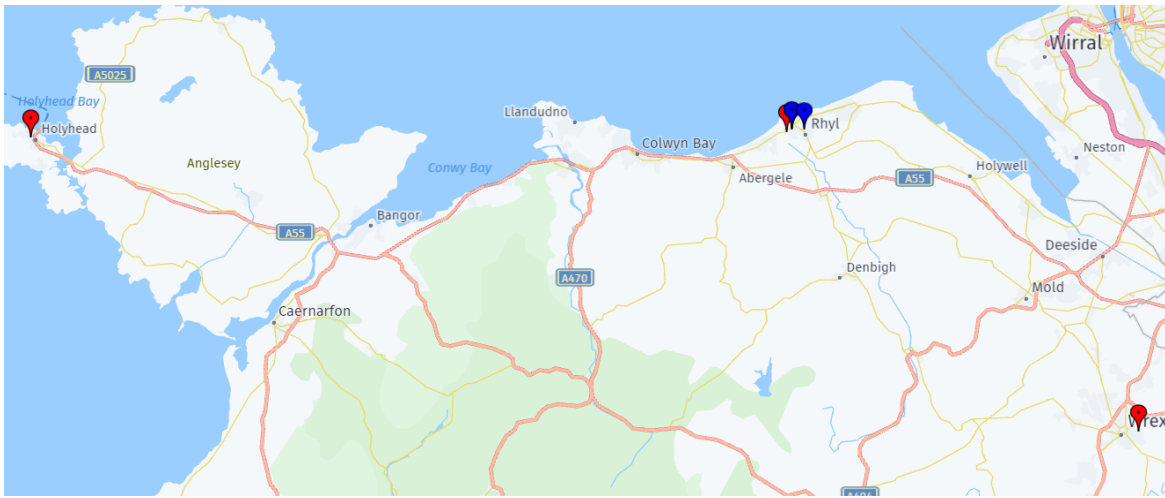
Swansea Bay



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