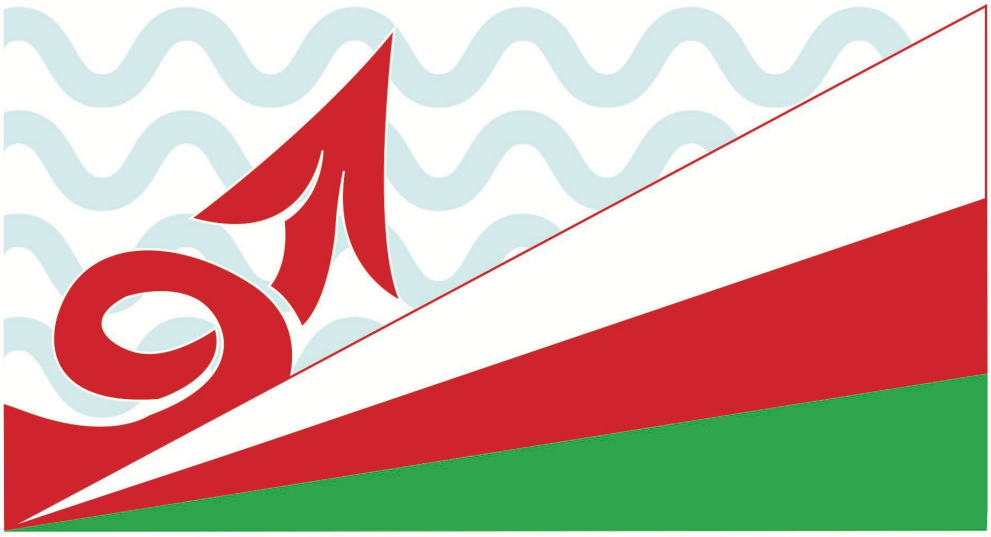
GENERAL PRACTITIONERS AT THE DEEP END
INTERNATIONAL BULLETIN NO 9
JULY 2023



INTRODUCTION

Welcome to the 9th Deep End International Bulletin, with over 50 pages of shared enthusiasm, activity and drive.

The Deep End Projects in Wales and Cheshire and Mersey were introduced in Bulletin No 8 and now have Deep End Logos to share. (Page).

On Page x, we welcome Deep End Bristol with its impressive new logo.

On page y, Mogens Westergaard and Nynee Bech Utoft explain a change to the colour scheme of the Deep End Denmark logo – less garish and less likely to frighten horses.

There are reports of the successful recent Deep End Conference in Dublin and an advance announcement for the Deep End Conference planned for Glasgow on 12-13 April 2024.

Rachel Steen describes the English Trailblazer Scheme (Page), while Ben Jackson and colleagues describe the FAIRSTEPS Project in Yorkshire Humber (Page).

And there are reports of prodigious activity in Yorkshire/Humber, East of England, North East and North Cumbria (NENC), and London.

Finally, a poem by the Late Tom Leonard, capturing the need for inclusiveness, which is a feature of the motivation behind all of the Deep End Projects.

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Being a Human Being

By Tom Leonard

for Mordechai Vanunu

not to be complicit
not to accept everyone else is silent it must be alright

not to keep one's mouth shut to hold onto one's job
not to accept public language as cover and decoy

not to put friends and family before the rest of the world
not to say I am wrong when you know the government is wrong

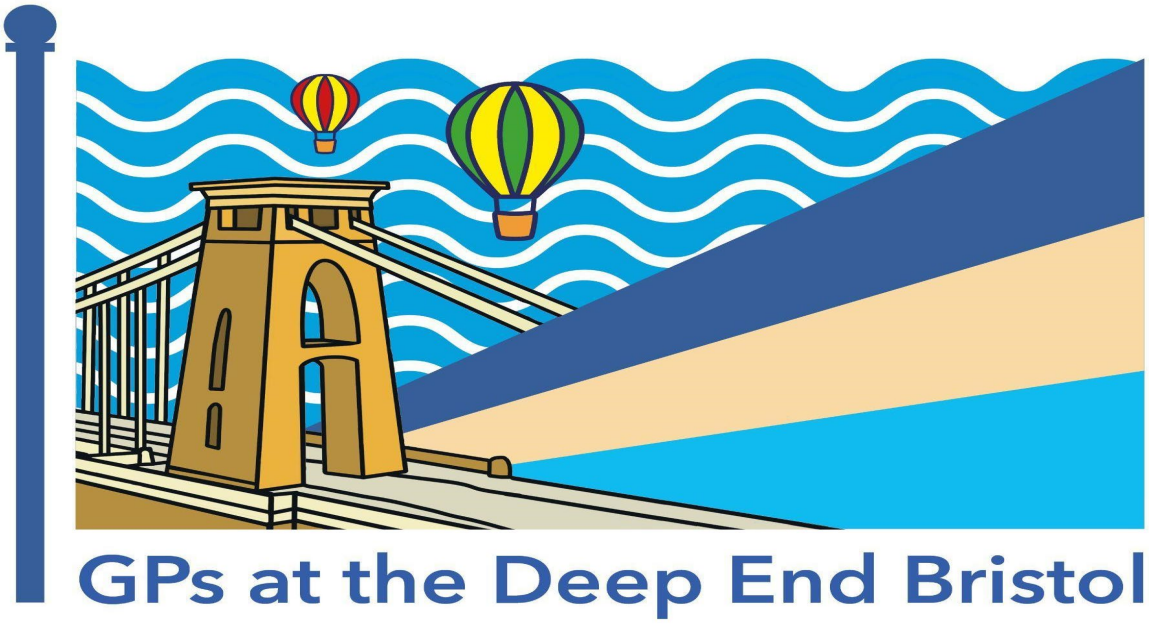
not to be just a bought behaviour pattern
to accept the moment and fact of choice

I am a human being
and I exist

a human being
and a citizen of the world

responsible to that world
— and responsible for that world

DEEP END BRISTOL LAUNCH



The Deep End network Bristol launched in May 2023.

Within Bristol, North Somerset and South Gloucestershire (BNSSG) considerable health inequalities exist, with life expectancy reduced by nine years for those living in the most deprived areas compared to the most affluent. Over 15% of Bristol residents live in the most deprived areas in England. Burnout and clinician retention in these challenging, yet incredibly rewarding areas, are key issues. We want to help address this through GP fellowships, GP registrar training schemes, creating a supportive community and providing research opportunities to improve the representation of patients who are often excluded in a bid to address the key WEAR (Workforce, Education, Advocacy and Research) topics other successful Deep End networks have previously highlighted.

We are delighted to have received funding from the BNSSG training hub for six health inequalities GP fellows, who all work in Deep End practices, and have eight hours a week to work on a project that tackles local health inequalities to improve staff retention and participant recruitment. The diverse group of GPs are focusing on a variety of areas including: the greener practice movement, deprescribing pregabalin with opiate replacements and implementing trauma informed care. These GPs are also part of a steering group for the Bristol ‘GPs at the Deep End' network. Furthermore, three new Deep End affiliated GP registrar posts will launch in September in Health Equity Focused Training.

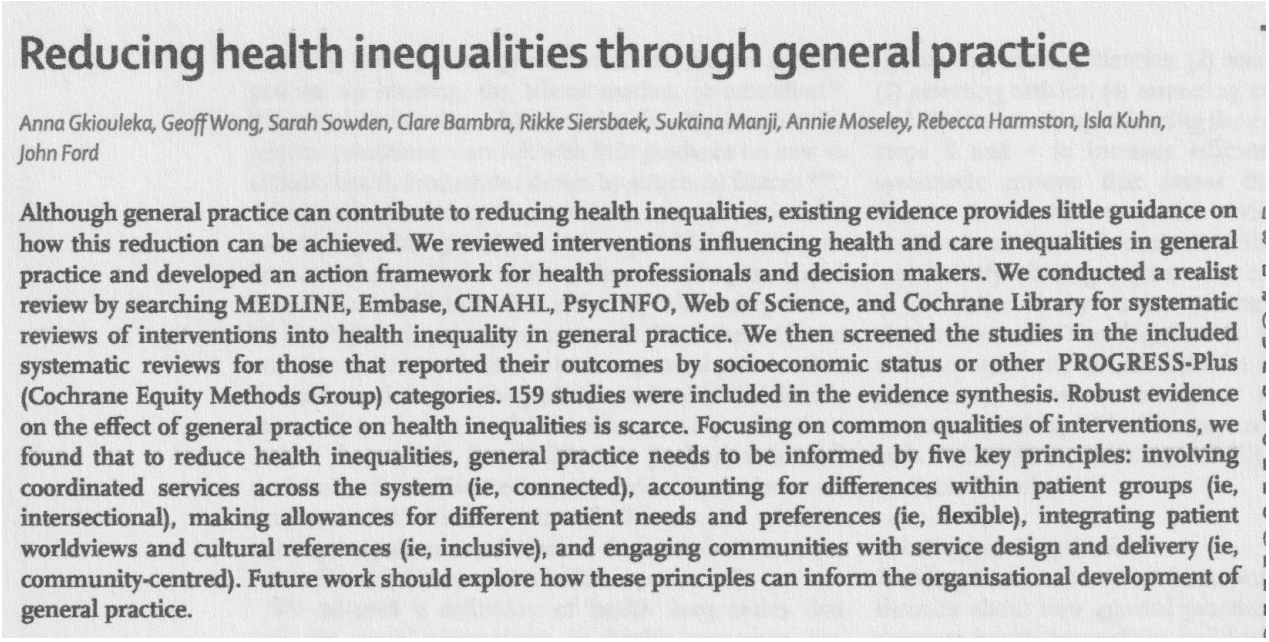
Additionally, we have received funding from the West of England CRN and BNSSG Integrated Care Board (ICB) to develop our network. This will be co-led by Dr Beth Winn (Deep End GP) and Dr Shoba Dawson (Primary Care researcher in EDI) along with administrative support from Zoe Wilkins, to provide central coordination and continuity to the project. We are also supported by several collaborators from the Centre of Academic Primary Care and Applied

Research Collaborative, West, including Dr Polly Duncan who had the original idea for the network. The funding will enable us to run two GPs at the Deep End engagement events.

Our launch engagement event will take place, face-to-face, on Friday, 14th July where we hope 30-40 GPs/other healthcare professionals will attend to make valuable contributions on how they want the network to look and work. There will be presentations, discussions, planning and an opportunity to shape our future network together. We have invited all GP surgeries with an IMD score >31 (ranging from 31 to 60), which includes 17 surgeries in total in Bristol and Weston-super-Mare.

Moving forward we have plans to increase the research activity of some of our already active practices, as well as support some of those not already involved to become research active. For next year, we have funding for a community research link worker and a research nurse to develop and support inclusivity in recruitment, particularly racial and ethnic minority groups. Bristol is made up of 20% of people from racial and ethnic minority groups and yet only 1% of research participants from a racial and minority ethnic background take part in studies run by Bristol Medical School. Furthermore, we hope to develop a diverse Patient and Public Involvement (PPI) group who will be involved in shaping this agenda to transform the landscape of this area.

ARTICLE TO NOTE



Reducing health inequalities through general practice

Anna Gkiouleka, Geoff Wong, Sarah Sowden, Clare Bambra, Rikke Siersbaek, Sukaina Manji, Annie Moseley, Rebecca Harmston, Isla Kuhn, John Ford

Although general practice can contribute to reducing health inequalities, existing evidence provides little guidance on how this reduction can be achieved. We reviewed interventions influencing health and care inequalities in general practice and developed an action framework for health professionals and decision makers. We conducted a realist review by searching MEDLINE, Embase, CINAHL, PsycINFO, Web of Science, and Cochrane Library for systematic reviews of interventions into health inequality in general practice. We then screened the studies in the included systematic reviews for those that reported their outcomes by socioeconomic status or other PROGRESS-Plus (Cochrane Equity Methods Group) categories. 159 studies were included in the evidence synthesis. Robust evidence on the effect of general practice on health inequalities is scarce. Focusing on common qualities of interventions, we found that to reduce health inequalities, general practice needs to be informed by five key principles: involving coordinated services across the system (ie, connected), accounting for differences within patient groups (ie, intersectional), making allowances for different patient needs and preferences (ie, flexible), integrating patient worldviews and cultural references (ie, inclusive), and engaging communities with service design and delivery (ie, community-centred). Future work should explore how these principles can inform the organisational development of general practice.

https://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(23)00093-2.pdf

Here is Austin O'Carroll, generating electricity as usual, at the end of one of the days at the recent Deep End Conference in Dublin. For his report of the conference, see the next page.

WELLNESS ON THE MARGINS – DEEP END CONFERENCE IN DUBLIN

Some things demand a celebration. The development of network of GP Educational programmes to train young GPs to work in areas of deprivation and with marginalized groups demands a celebration. The concept of training GPs to work in areas of deprivation and with marginalized groups only started in 2009. Since then there has been a burgeoning of GP training programmes and Fellowship programmes across the UK and Ireland that specifically focus on training GPs to work in areas affected by health inequities and with marginalized populations such as homeless people, people who use drugs, travellers, undocumented migrants etc. This movement is deeply aligned with the Deep End Movement.

There are those who argue against having schemes specializing in such training on the basis that this segregates training for social deprivation from the mainstream and lets all the other GP training schemes 'off the hook'. Whilst there is also strong argument that inclusion health needs to be more visible in all training curricula, these health-equity focused schemes firstly, equip GP trainees to work in such areas, secondly provide them with the vision and passion to tackle health inequities and ultimately, improve GP recruitment in such areas. Further, such schemes can act as foci of change within the wider health system by developing a cohort of younger GPs who will fight on behalf of deprived communities.

As well as requiring a celebration, the development of this network of Educational programmes also demands a coming together of all those programmes from England, Wales, Scotland, Ireland and Northern Ireland as a community. This was the idea behind the conference Wellness on the Margins conference which was held in Dublin in April 2023, a communal celebration. This celebration had been originally scheduled for March 2020 but due to the Covid Pandemic had to be deferred till 2023.

Wellness on the Margins was originally conceived to unite the disparate groups who were training GPs to work in the Deep End. These schemes are typified by having GP trainees and Fellows who are passionate in their ideals and energetic in their endeavours to address social and health injustices. This passion and energy needed harnessing. The title was chosen to take the focus off the negative aspects of health inequity and focus on what can we do. There were five subthemes Hope, Joy, Kindness, Inclusivity and Advocacy. The Friday afternoon of the conference spoke to the theme of Hope and Inclusivity. Half the conference attendees were divided into groups of 10 and visited social medicine placements in Dublin. These included four drop-in centres for homeless people; a Step-Up, Step-Down Intermediate Care Centre for homeless people; a prison medical centre; an addiction clinic and a Support centre for migrants. It also included both a tour of the North Inner city (an area steeped in poverty since the early twentieth century when Dublin was the second poorest city in the British Isles) and a play, performed by Anu theatre company, which explored the themes of marginalization. The play was performed on a mobile health unit which is used to deliver healthcare to rough sleepers at nighttime.

As these tours were taking place, there was a concurrent conference session exploring education for GPs working in the deep end. David Buck came from the US and outlined how they are delivering education to undergraduates on the provision of healthcare to people from deprived or marginalized communities. He outlined the development of an educational

curriculum for values based medical care for medical students. We then heard about the GP fellowship and GP training programmes educating doctors to work in areas of deprivation and with marginalized groups:

- The Scottish Pioneer programme. This programme operated between 2016 and 2020. Unfortunately, funding was discontinued for this programme in 2020, despite the evaluation demonstrating significant positive outcomes on recruitment and retention
- The UK Trailblazer scheme, now with 55 Trailblazers spread across 15 schemes rn England and Wales.
- The new Health Equity Focussed Training (HEFT) in London which has 150 GP trainees expanding to 226 in 2024.
- The Greater Manchester GPST training scheme, which focused on deprivation
- The North Dublin City GP Training Programme (2009) which has 85 GP trainees expanding to 120 in 2024 and has over 150 graduates.

Throughout these presentations evidence was quoted outlining how GPs graduating from these schemes were highly likely to work in areas of deprivation; to feel equipped with the knowledge and skills necessary to work in areas of deprivation and with marginalized groups; and felt supported in working with socio-economically deprived and marginalized populations. These presentations spoke to the theme of Hope as there is a sense of an expanding group of young GPs who are passionate about addressing health inequities and also had the knowledge and skills to advocate for action to address health inequities.

The organising team

Ben Jackson also presented results of his FAIRSTEPS Framework and Guidance whereby they had developed ‘an evidence informed tool for developing locally sensitive interventions targeted at addressing health inequity through primary care.’ The developed this tool through conducting a review of the literature. They outlined the various interventions that had been taken in primary care to address healthcare for those on the margins but also how those

interventions were delivered to outline the features of service delivery that improve access to quality healthcare.

They used their findings to develop a FAIRSTEPS guidance for those wishing to address health inequities in their own local communty. This involved firstly. identifying the problem; secondly, identifying which care processes contributed to the problem; thirdly, identifying which patient experiences needed to be improved; fourthly, identifying which staff training needed to be provided; and lastly, outlining which were the key ingredients that needed to be included in the local intervention. He looked at how this tool could be used in educational programmes seeking to train GPs to work in areas of deprivation.

The session was closed off by Dr Austin O Carroll talking about health is political. He described how the increasing negative influence of the neoliberal agenda on the delivery of healthcare. Neoliberalism seeks to not only create huge inequities between the rich and the poor resulting in hugely negative health impacts on those in deprivation, but we also blame people for being poor and we blame people for the consequences of poverty. Drug addiction is caused by poverty and we blame people who use drugs. Homelessness is caused by poverty and we blame those who are homeless. Migrants emigrate due to poverty and we blame migrants.

Dr Carey Lunan talked about how the original ideals of the NHS have gradually been eroded by the political forces at play in the UK. There is an increasingly obvious two tier system emerging in the UK. Carey asked how are doctors complicit in the development of this two tier

system. She referenced the second part of the inverse care law i.e. 'this inverse care law operates more completely where medical care is most exposed to market forces". She then went on to outline the challenges faced by both those living in and those working in the deep end. Those living in these areas have poorer health and less access to the services and less control over the factors that determine their health. Those working in these areas have less control over the factors that determine their patient care and have poorer working conditions and experience more stress than those working in more affluent areas. She discussed the patients who miss appointments who often are the people who most need access to healthcare. She laid the blame for the increasing two-tier system with some politicians whom she suggested had most to benefit from the decline of the NHS. She ended up with a note of hope outlining how we can advocate and influence the delivery of healthcare.

The Saturday morning was noted by several attendees to have been the most inspiring session they had ever attended. It was opened by a pre recorded presentation from Sir Michael Marmot outlining the wealth of evidence that people who are born into deprivation die younger and spend more of their shorter lives in poor health than those in wealthy areas. He further strongly refuted the arguments that people who are in poverty are at fault for being poor and for being unhealthy.

Adam Burley then presented on the importance of relationships between healthcare providers and clients. The relationship has both the potential to cause trauma for the patient or to offer healing to the patient. Relationships, he said, are the psychological equivalent of breathing – conversely,negative relationships are the equivalent of choking. The relational injuries caused by unhealthy and damaging relationships are not as easy to 'spot' as the physical injuries that cause visible bruising or broken bones. He discussed how people who experience trauma have to learn to survive that trauma, and that the behaviours that help them survive the effects of trauma may also be the ones that can cause damage to their future relationships with people who want to help them or offer them care. He discussed the centrality of trust to effective relationships, and that for many patients who have suffered adversity, trust may only ever be 'a second language'. . He referred to the concept of 'relational navigation' – how we learn to navigate the series of relationships we encounter in our daily lives. Those who are traumatised navigate using behaviours that helped them survive. He discussed how we tend to blame those whom we exclude due to the behaviours arising from their relational injuries. He called for healthcare professionals to develop patient relationships that will enable their patients to learn how to 'breathe' again.

Dr Cliona Nic Cheallaigh talked about Kindness. She spoke movingly about how stigma prevents doctors feeling able to be kind, in particular to patients who most need their care. She described kindness as a feeling that at work she can truly be herself and that it is an unguarded, openhearted feeling where she can demonstrate unconditional positive regard. She emphasised the importance of understanding the effects of childhood trauma. She distinguished between the patients' behaviours and their essence. She always felt she could see the good in patients and sought to help them see the good in themselves as well. She spoke of the role of doctor in nurturing patients who have been damaged and disenfranchised. She developed the concept of Inclusion Health which she believes is based on demonstrating kindness to those least likely to experience kindness. Everybody needs kindness but patients on the margins need it more. She expressed how she had a clear understanding on what her

role as a doctor which was not necessarily to save their lives but to treat them with kindness and help them using her skills as a doctor.

Dr Laura Nielsen spoke of Hope. She spoke of how 'perseverance produces character, and character produces hope'. She spoke of Hope as something that we need to work on. She spoke of how hope does not put us to shame. She noted how sometimes hope was perceived as naïve in our increasing cynical world. Hope can createe vulnerability, as people who hope actually believe things can change, and that belief creates vulnerability. She talked of how hope helped forge the career she followed which resulted in the development of a range of practices and initiatives to address health inequities. In reality, hope pervades medicine. Every consultation is an expression of hope, as why would a patient come in the first place? If one works in areas of deprivation and deals with the many horrific stories patients bring to doctors, one has to have hope.

Laura described the Focussed Care Worker model they developed to help patients who did not engage in healthcare due to their social circumstances and how the work of Focussed Care is rooted in giving these patients a sense of hope. She described how she had found that 10% of children who had died unexpectedly in the UK had been homeless when they died. She cried when she realised the implications of her findings. She is seeking to address this issue so they can reduce such deaths. This demands hope. She finished by declaring that we should not forget hope is everywhere and we just need to find it and recognise it.

The Saturday afternoon was a series of workshops. There was a diversity of sessions many of which were presented using the Arts as an educational tool. The workshops included:

- Advocacy Workshop (Dr Carey Lunan; Dr Patrick O Donnell)
- Balint Workshop (Patsy Brady)
- Intellectual Disabilities Theatre Workshop (Nicola Kealy)
- Mindfulness Workshop (Dr Ming Rawat; Paddy Gowan)
- Peer/Experts by Experience (Chris O Donnell; Bernard West)
- Poetry Workshop (Dr Rahhiel Rashiat)
- Theatre of the Oppressed Workshop. (Dr Austin O Carroll)
- Undergraduate Training for doctors to work in areas of deprivation (Dr David Buck).

There was very positive feedback on these workshops. Participants enjoyed the variety and the interactive and arts based educational methods used.

Overall the feedback on the conference was very positive with many commenting it was the best conference they had attended. They noted feeling a sense of having been inspired and re-motivated to work with patients facing the hardships caused by deprivation and marginalization. There was a commitment to ensure this conference became a regular annual event and that the varying schemes maintained contact in order to share knowledge, skills and to mutually support each other to address inequities in the Deep End.

WELLNESS ON THE MARGINS – ANOTHER VIEW

The Wellness On the Margins conference took place over two days, finishing up on April 1st, in the Catherine McCauley Centre in Dublin - a medical research centre close to the inner city where much work with marginalised communities takes place. The conference was, by all accounts, both a celebration of the beauty - and struggle - of people who live on the margins. Aimed at both education and dissemination, it was designed to teach tomorrow's doctors and trailblazers about working with those who need healthcare the most.

Throughout the two days of the conference there was a wonderful exchange between disciplines, both in and out of the talks and workshops. Myself, a peer support worker in homelessness, it was great to see the lively atmosphere as discussions were taking place, where people were listening to new projects being run in other areas. A strong international presence was felt, with speakers from as close as England, to as far as the US. Indeed, the conference was co-created by Dublin's Dr Austin O'Carroll, and Scotland's Dr Carey Lunan.

During the conference there were tours to areas of deprivation in the city. There was a site visit to a homeless residential service, a GP practice in an area deeply affected by poverty, one of Dublin's prisons, amongst other spots. One great site we visited was Dublin Simon's '*Step Up Step down.*' Daire Kinsella, the supervisor, explained that their service was a residential service for homeless people pre and post hospital discharge. To put it in more simple terms: when people are too ill to be homeless (as homelessness is, according to research, an 'Unhealthy State'), but also not ill enough to be kept in hospital, they can stay for several weeks in a respite that caters to their needs. Daire explained that the residents were asked to provide information - poetry, lyrics, insights, to the services internal newsletter.

In the North East Inner City, whose residents have been socially excluded on a massive scale, our tour approached a GP practice. Outside of the practice, was a mobile health unit. We were welcomed to the staging of a 17 minute performance '*Nannie's Night out'*, based upon a play by Sean O'Casey. It was only performed once, in the Abbey in Dublin, in 1924. The play is based on real events and memories of the young O'Casey, himself living in the tenement conditions in Dublin during those years. One day, he witnessed the visceral howl from a woman, Nannie, who had screamed at people on the street in a trauma response. Afterwards, she sat beside him and spoke with him gently and the young boy never forgot it.

Street Theatre

In the North East Inner City on March 31st, Anu's production of the play literally erupted from the mobile health unit, with Nannie, the heroine, storming out on to the street. It was seventeen minutes of witnessing high paced, adrenaline pumping pain, trauma, and the humanity - not behind it, but in it. It showcased how inept our healthcare system is in Ireland for dealing with those who need the care the most. I have a colleague who calls them 'the Forgotten People.' They are more often pathologised and simply referred to as 'chaotic', or 'unmanageable.' 'Nannie's last night' confronted that trope and we got to see a sweet, hurt, deeply traumatised woman who was not at peace. I came away feeling as though I had just witnessed something very profound.

Another stand-out piece of work was the social medicine placements which Dr. Fiona O'Reilly manages as part of the North Dublin City GP Training Programme. In the placements, students in their final year donate one day of their working week to go out and serve in places where people would be on the extreme end of marginalisation (homeless, migrant, prison, drug dependency).

It would naturally have the effect of opening doctors up to types of settings, circumstances and lives which would be very far from the norm in a standard GP practice. However, the social placements' potential goes beyond simple exposure and learning. There are assignments throughout with a view to breaking down stigma, to show GPs that they are not difficult patients, they have had difficult lives (as quoted from a graduate of the programme).

At the end of the placements, the GPRs sit and carry out a qualitative project, speaking to a patient in the service but not one they had treated. They speak to them about their lives, their hopes and dreams growing up, and what were the circumstances that led them to where they are today. It is a unanimously rewarding experience, One of the GPRs who had completed the

social medicine placement read an extraordinarily touching story of a woman - Ann - who had been in and out of the prison system and seismically let down by the State.

These were just some of the highlights of the conference. There were multiple talks, workshops, and a wonderful atmosphere in the Catherine McCauley Centre as people from across borders eagerly spoke about projects they are working on or planning on working together. Practically everybody I spoke to agreed this was one of the best, if not the best conference they had been to (and I don't employ hyperbole). Indeed, there was a very strong sense of working together overseas in future - we can learn so much from each other, while we can get also get stuck in our silos and lose sight of the bigger picture.

Chris O'Donnell

DEEP END INTERNATIONAL CONFERENCE, GLASGOW 2024

Exciting discussions have begun around plans for the next Deep End conference, three years since the online conference marking 50 years of the inverse care law. The conference will be held in Glasgow and will run over the afternoon of Friday 12th April into Saturday 13th April to enable as many people to travel and attend as possible. We want to build on the momentum and positivity of the 2023 Dublin conference on "Wellness on the Margins", casting the net even wider to include colleagues from all career stages – from aspiring medical students, to those who have retired but remain part of our Deep End community. The mixture of youth and energy with wisdom and experience is a potent one, that sustains and supports us all. 2024 is a special year for the Scottish Deep End project: our 15 year anniversary since inception, and 5 years since we were last able to host an in-person conference (The Exceptional Potential of General Practice), also in Glasgow, the city where it all started.

We would like to retain our focus on the values-driven themes of Joy, Kindness, Hope, Inclusivity and Advocacy, with an emphasis on practical take-home ideas and approaches. We are planning 'walk-abouts' into local communities, with our community link walker colleagues, who are now so integral to the way we deliver modern general practice in deprived areas, and are seeking to find a way to include our patients' voices, perhaps through the Glasgow walking tours, run by people with lived experience of homelessness.

The conference will comprise a variety of formats: inspiring keynote speakers, workshops, and story slams. Woven throughout, our Deep End colleagues from across the world will be sharing their stories in short video or audio diaries, reflecting on the story behind their flag, their key successes and challenges, and hopes for the future. There are plans to collate these on an interactive world map. Our ideas are still in evolution, and we'd love to hear from you if you have some to share – or would like to get involved in the organisation of the event.

We want it to be energising, thought-provoking and fun. We want to capture the story-telling that is so much a part of our professional lives, and our culture, and bring in music whenever possible! Which brings me to the Friday night social… there have been several requests for a ceilidh. We didn't need much persuading. There is no shortage of fantastic ceilidh bands in

Glasgow, and some will even do a disco too. Dancing shoes will definitely need to be packed alongside thinking caps.

We will keep you updated as plans progress, and when booking becomes available.

Looking forward to seeing you there!

Carey Lunan, Chair, Scottish Deep End Project Steering Group
David Blane, Scottish Deep End Project Academic Coordinator

Plenary venue for Glasgow Deep End Conference 2024

ARTICLE TO NOTE

ABSTRACT

RESEARCH ARTICLE

Implementing social interventions in primary care in Canada: A qualitative exploration of lessons learned from leaders in the field

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Purpose

Primary health care providers and practices are increasingly instituting direct interventions into social determinants of health and health inequities, but experiences of the leaders in these initiatives remain largely unexamined.

Methods

Sixteen semi-structured interviews with Canadian primary care leaders in developing and implementing social interventions were conducted to assess barriers, keys to success, and lessons learned from their work.

Results

Participants focused on practical approaches to establishing and maintaining social
intervention programs and our analysis pointed to six major themes. A deep understanding of community needs, through data and client stories, forms a foundation for program development. Improving access to care is essential to ensuring programs
reach those most marginalized. Client care spaces must be made safe as a first step to
engagement. Intervention programs are strengthened by the involvement of patients,
community members, health team staff, and partner agencies in their design.

THE GP POST CCT TRAILBLAZER SCHEME

Dr Rachel Steen, Dr Sasha Darwazeh and Dr Nneka Anaegbu

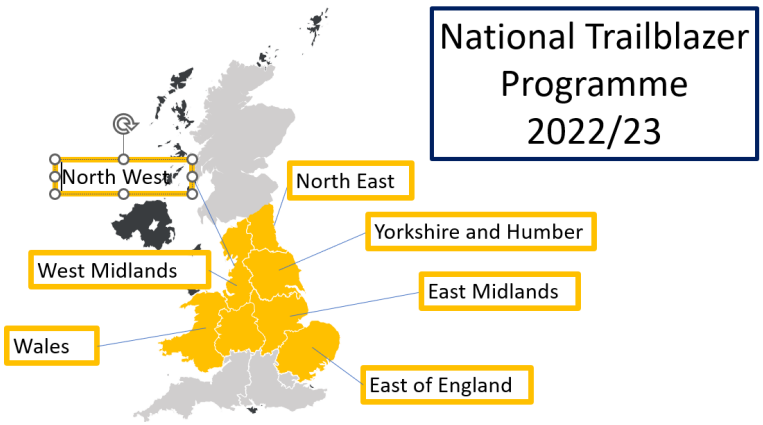
The Trailblazer Post CCT GP scheme started in England in Yorkshire and Humber in 2018 following on success of similar schemes in Glasgow and Ireland. The idea of the scheme is to give early career post CCT GPs the knowledge and skills to not just survive, but also to thrive working in areas of deprivation. The scheme is funded (in the most part) through Health Education England for paid release time from practice for two sessions of personal and professional development per week to supplement clinical sessions working in an area of deprivation.

> *"The Trailblazer fellowship gave me an in-depth understanding of inequalities in healthcare. It also gave me an opportunity to play a part in bridging the gap between my projects and those of other trailblazer team members so that together they impact the lives of our communities"*
>
> **Dr Nneka Anaegbu, Trailblazer GP Lincolnshire 2021/22**

Due to the success of the scheme locally in Yorkshire and Humber, the scheme is now in its fifth year in Yorkshire and Humber and third year in other areas of England and Wales. We bring together GP post CCT Trailblazers from across the country for education (held virtually online) once per month on a national education programme.

This exciting programme features nationally renowned speakers covering a vast array of topics on deprivation focussed medicine e.g. Trauma informed care. These sessions are a fantastic opportunity for GPs to learn together and share ideas and experiences outside of their local areas.

At the moment we have GPs joining the national educational programme from across Yorkshire and the Humber, East and West Midlands, Derbyshire, Wales, Leicester, the North West, and East of England. We currently have 55 GP fellows on the national programme. We are currently looking into supporting GPs joining the programme from Fairhealth fellowships in Scotland too. The national education programme can be accessed online via the fairhealth website.



To supplement the national programme, fellows join from a locally arranged fellowship programme. The makeup of this programme differs slightly area to area, but we encourage peer support, leadership and personal/professional development as part of the local programme. This gives the opportunity for fellows to connect, learn and support each other as part of a smaller group of other GPs in their local area face to face. We also encourage fellows to do a local project and also spend time developing their connections within the context and communities that they are working.

Trailblazer GPs Yorkshire and Humber 2021/22
Visit to Project 6 (an alcohol support service), Bradford, August 2022

We bring our current and alumni Trailblazer together for a yearly national conference in September each year…

Save the date… National Trailblazer GP conference 2023 – Friday 29th September 2023 – 10am – 3pm- online via ZOOM

This is an opportunity for current and previous GPs on the scheme to share their work but we also have plans for some amazing key note speakers too.
Please contact Rachel.steen@nhs.net or mathew.duke1@nhs.net if you are interested in attending.

It is a total privilege running the programme and to be able to hear about all the incredible projects that the fellows do during their year, share ideas and learning, but also see the increased confidence and enthusiasm for working as a GP in areas of deprivation. We feel that the scheme supports GPs to actively seek out and enjoy working in these challenging environments. The aim is to help with recruitment and retention in these hard to recruit areas, but also long term set up GPs working in these areas to have the knowledge and skills for a career having a positive impact on the patients they are working with.

Dr Rachel Steen, GP, Sheffield and National Trailblazer Scheme Programme Lead

See below an example of one Trailblazer's experiences as part of the scheme last year, contributed by Dr Sasha Darwazeh, GP Trailblazer Coventry and Warwickshire 2021/22

EXPERIENCE OF THE TRAILBLAZER SCHEME

My involvement in the Trailblazer program has significantly enhanced my abilities as a GP. Through active participation in various projects and engagement with local community groups, I have undergone personal and professional growth that has positively impacted my practice. It has deepened my understanding of the unique challenges faced by individuals in my community. One such group is asylum seekers and refugees who are able to register at the Meridien practice, who can meet the immediate health needs of asylum seekers and then, if refugee status is awarded, they support their transition into mainstream practice. I have gained valuable insights into the specific healthcare needs that asylum seekers and refugees have, and the barriers that they face. This heightened awareness enables me to provide more tailored and effective care to these vulnerable populations and I am able to signpost patients directly, and educate other GPs within my locality, to such services.

Thanks to the programme, I was awarded the rule to collaborate with organisations such as:

- Our local food bank,
- Highlife at Wava Hall; who work within their community to inspire young people to achieve their potential,
- Coventry City Mission; who support people at various points of crisis, be it economic, emotional, social, educational, or spiritual,
- Emmaus; a homeless charity with a community ethos.

By being aware of these services, my knowledge of available community resources has vastly expanded. I am now better equipped to signpost patients to these support networks, ensuring they receive comprehensive care beyond the confines of general practice.
Recognising the importance of a multidisciplinary approach, I actively collaborate with social prescribers, enabling me to provide holistic care that addresses both medical and social determinants of health and am more knowledgeable about services that are available.

Participating in the Coventry and Warwickshire VTS teaching sessions on health inequalities has allowed me to share my experiences and insights with aspiring GPs. By discussing the realities of working in deprived areas and dispelling misconceptions, I aim to inspire future doctors to embrace these challenging roles with enthusiasm. I am committed to fostering a positive mindset among ST3s, assuring them that working in areas of deprivation can be immensely rewarding and allows for significant positive impact on patients' lives.

Additionally, organising the Health and Wellbeing Event in Coventry and presenting at the Midlands wide health inequalities conference have further developed my leadership and communication skills. These experiences have honed my ability to effectively engage with diverse audiences and advocate for the importance of addressing health inequalities. By sharing my expertise and insights, I aim to inspire fellow healthcare professionals to join the movement towards more inclusive and equitable healthcare practices.

Overall, my participation in the Trailblazer program has transformed me into a more compassionate, resourceful, and patient-centred GP. It has broadened my perspective,

instilled a deep commitment to tackling health inequalities, and equipped me with the knowledge and skills necessary to provide comprehensive care to marginalised populations. Through continued dedication and advocacy, I am determined to contribute towards creating a more equitable healthcare system that truly addresses the needs of all individuals, regardless of their background or circumstances.

The patients whom I used to dread consulting with have now become my most cherished encounters. Witnessing the impact we can have on these patients, armed with knowledge, confidence, and access to suitable services, is truly invaluable.

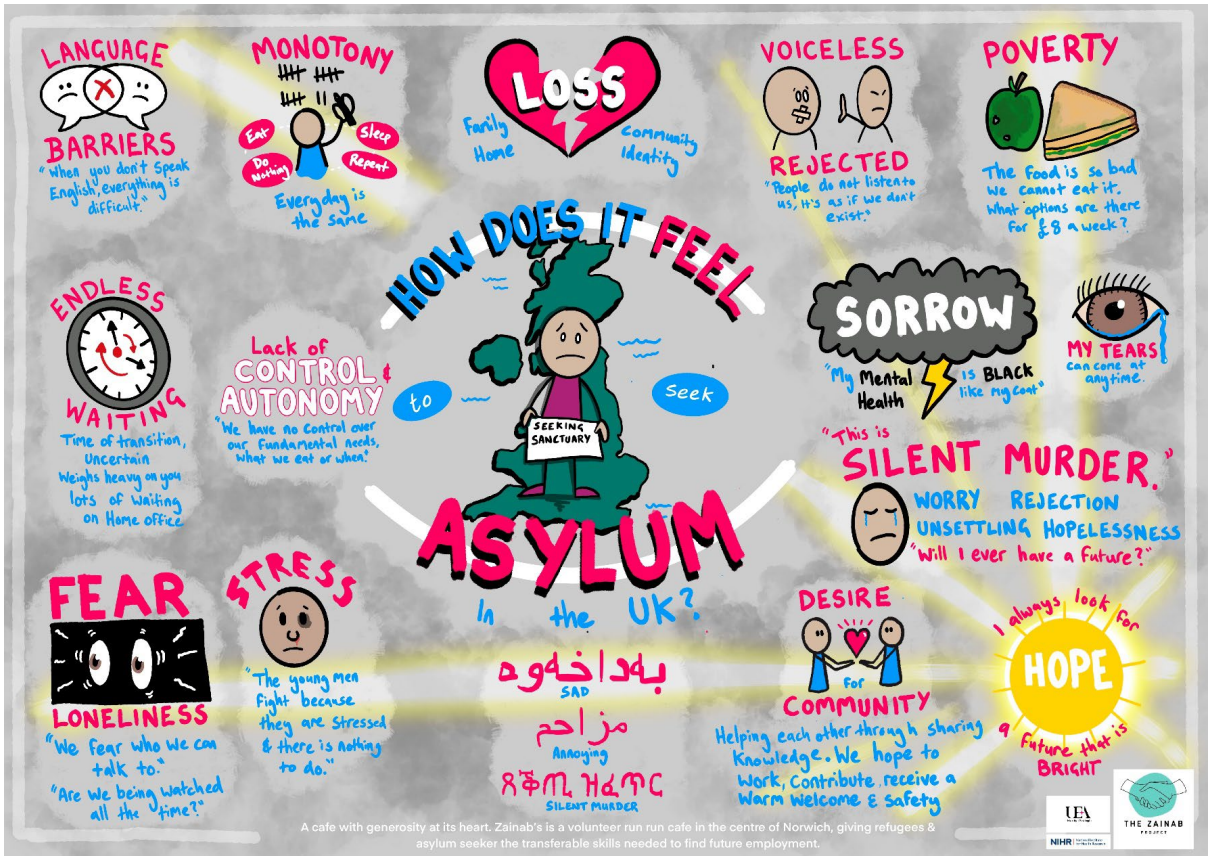
Dr Sasha Darwazeh, GP Trailblazer Coventry and Warwickshire 2021/22.

EAST OF ENGLAND DEEP END REPORT

1. PPIE (Patient and Public Involvement and Engagement)

Researchers from the University of East Anglia (School of Health Sciences and Norwich Medical school) have recently engaged with the asylum seeker and refugee community in Norwich in research engagement events. Dr Emily Clark (GP in Norwich, Research Lead for Deep End East of England and NIHR In-practice fellow) led the initiative with funding from NIHR CRN (clinical research network) and worked with The Zainab project to run the events. The Zainab project is a community volunteer run café in the centre of Norwich, giving refugees and asylum seekers the transferable skills needed to find femployment.

Over 70 asylum seekers and refugees attended from 14 different countries showing that these people arenot "hard to reach," we just need to go to them! Visual summaries of the events are shown above and below.



2. NIHR Clinical Research Network funding has gone to research active practices to analyse the demographics of their research participants as compared to their practice demographic (deprivation score by postcode, ethnicity, language needs, Learning disability, age etc) and establish a plan on how to make research participation more inclusive.

3. REND – yje Research Engagement Network Development Programme trained 38 VCSE (voluntary, community and social enterprise) trusted communicators during Research Ready Communities training sessions in Great Yarmouth and Waveney to increase awareness and diversity of research participation

Jessica Randall Carrick
Gilly Ennals

FAIRSTEPS AND THE POWER OF DEEP END NETWORKS

The Deep End General Practice movement is a variably connected network of practitioners and others with the shared purpose of making the provision of healthcare more equitable through transforming the way primary care is funded, commissioned and delivered. Since we set up Deep End GP Yorkshire and Humber, our regional Deep End network in Yorkshire has grown organically, reforming itself through developing new branches in response to changes in landscape, availability and opportunity. Its membership is hard to define, its activity and connectivity has varied as circumstances have changed.

The Oxford dictionary defines a network as an 'interconnected group of people… which may be exploited to gain preferment, information etc.' This suggests that in additional to sharing information or 'best practice', the purpose of a network is to gain strength or advantage. For a movement which seeks to change deeply embedded structural norms this is important.

Over the past two years, the University of Sheffield's FAIRSTEPS study had the good fortune to gain such advantage from international, regional and local Deep End networks. FAIRSTEPS integrates an extensive international review of primary care interventions addressing health inequity with a Delphi study on the usefulness and feasibility (with appropriate funding) of such interventions in UK general practice. A collaborative dialogue with the lived experience of members of the public informs the study design, analysis and dissemination.

The international Deep End network helped FAIRSTEPS gather grey literature from its members across the world, which significantly enriched the review. Deep End networks across the United Kingdom supported the recruitment of a diverse group of frontline practitioners from across the United Kingdom for Delphi study. Our local Deep End network enabled the lived experience of our patients to shape both its design and findings.

Networks are now shaping the impact of the study. Through developed connections with other academics concerned with health equity, a joint dissemination project with the University of Cambridge EQUALISE study has begun. Each study complements the other and a powerful toolkit for developing interventions to address health equity has been created which combines theory, practice and experience.

The FAIRSTEPS study, along with some concentrated local networking supporting our local workforce and developing research capacity have re-galvanised Deep End Yorkshire and the Humber activity right across our original quartet of Workforce, Education, Advocacy and Research.

Inequity leads have been appointed in our regional workforce hub and regular informal funded meetings are available to support GPs. Students are supporting third sector organisations through special Deep End GP placements and our Deep End Research Alliance (DERA) leads the national debate in collaborative research (see below).

Deep End Yorkshire and the Humber has found some new roots at the Academic Unit of Primary Care at the University of Sheffield.

The Deep End Research Alliance Yorkshire Humber (DERA-YH) empowers ethnic minority communities to co-produce research.

DERA addresses the role of health and academic institutions and processes in perpetuating inequality in health research. Our group were catalysts in a national movement to tackle the 'Inverse Research Law' -whereby those populations with the highest risk of long-term conditions and worst outcomes are least likely to be represented in research studies. The DERA-YH is a tripartite collaboration of patients/communities (DE PPI group); frontline practitioners (DE CRN) and our Primary Care Health Equity Research group at the University of Sheffield (UoS).

Since 2016 we have been awarded a series of grants including NIHR funding for our 'Deep End Sheffield Clinical Research Network (DE-CRN) of 9 practices serving 68,000 patients and have evolved and grown our multidisciplinary research group and Deep End Patient and Public Involvement group (DE PPIG). DERA-YH co-designs and delivers useful, inclusive research which is relevant and close to practise at the Deep End.

Initially we met constant challenges in engaging people from culturally diverse participants, socially disadvantaged and other underserved groups to research in the DE CRN. All the external studies offered to the DE CRN were culturally incompetent and/or had recruitment materials inaccessible to people with low health literacy or non-proficient English. However over 7 years, through a series of research studies, co-designed and delivered locally, we have built trust and strong networks with Deep End communities.

Our ‘Deep End‘ research group, co-led by Caroline Mitchell and Kate Fryer, includes three NIHR Academic Clinical Lecturers (Jayasooriya, Mawson, Huang), two NIHR Academic Clinical Fellows (Reynolds, Linton) , supervision of two doctoral students to recent completion (a pharmacist, a GP) , a GP ‘Innovative training post-ITP’, and a research associate. Our early career researchers specialise in inclusive participatory research methodologies. Two ACFS (Reynolds, Linton) have been awarded RCGP grants for innovative research studies working with community research link workers to co-produce interventions to address health disparities in ‘Dementia’ and ‘Contraception’ healthcare.

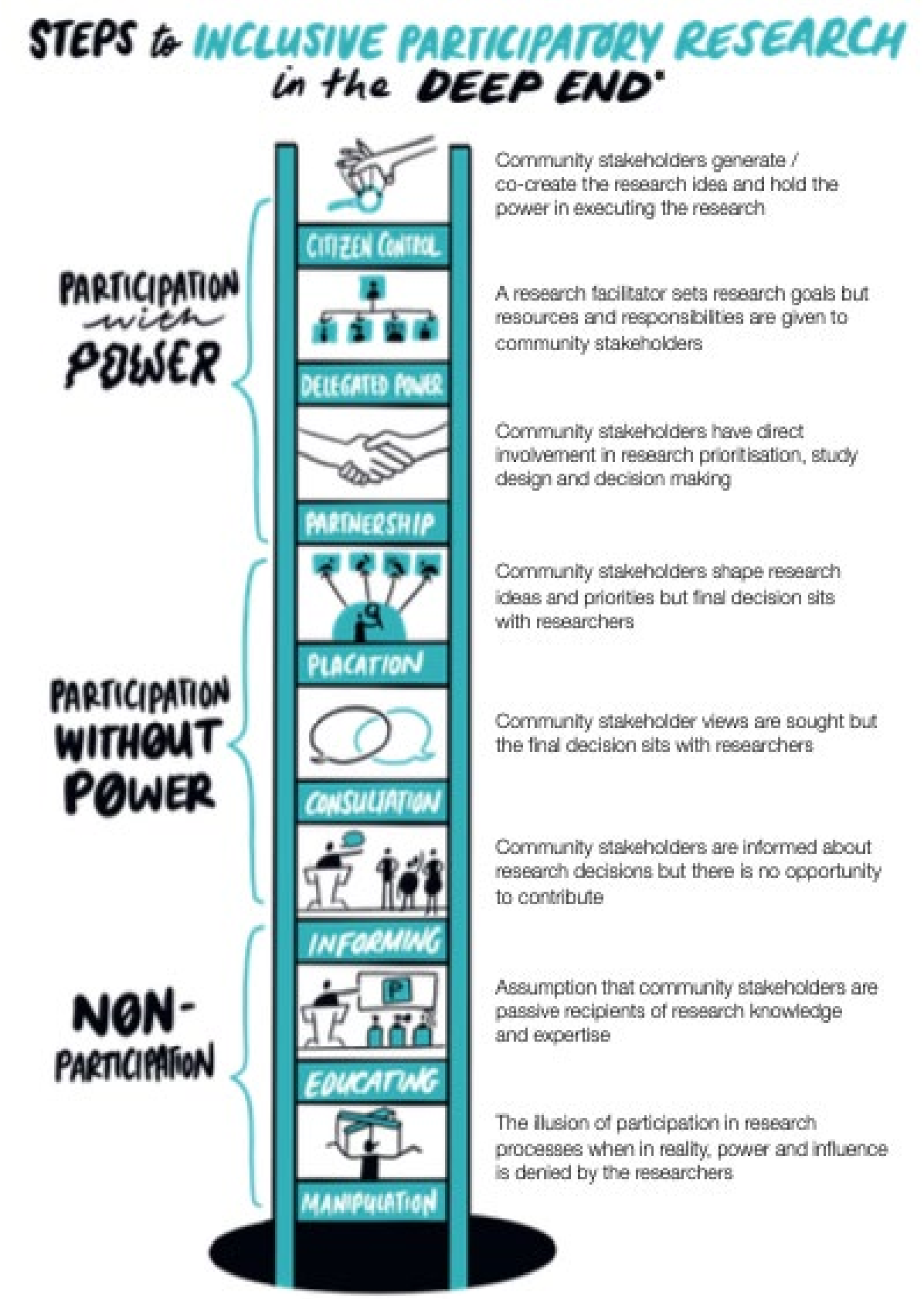
To support the two RCGP SfPB funded studies and a third UKRC UoS ‘Research Culture transformation’ grant, we co-developed a training programme for community research link workers (CRLW)with our community partner SACHMA (Sheffield African Caribbean Mental Health Association) to recruit for, and facilitate focus groups from culturally diverse communities. These community link workers are usually bilingual and include people from West African, Roma, Chinese, South Asian and African Caribbean communities. THE CRLW have transformed the pace of engagement of culturally diverse communities and the quality of our qualitative research, are co-analysing data with experienced researchers and co-authoring the study outputs.

Our DERA collaborative and inclusive culture has enabled us to diversify our team membership. We have used autoethnography and reflective research practice, alongside an adaptation of Sherry Arnstein’s ‘Ladder of Participation’ to evolve as a group and start to address power imbalance in research culture and practice.

DERA YH website: https://sites.google.com/sheffield.ac.uk/dera/home/partners

Ben Jackson and Caroline Mitchell

A



* An adaption of Arnstein's 'Ladder of Participation' - Sherry R. Arnstein's "A Ladder of Citizen Participation,"

CONNECTING IN THE KITCHEN - MORE FROM YORKSHIRE HUMBER

The other project that has been running in Yorkshire/Humber is the 'Connecting in the Kitchen' wellbeing evenings hosted by the Deep End Network.

This has been funded by the ICS. These have been running for over a year now. We have held 10 events in total. The sessions focus on the needs of professionals working in the Deep End, but are open to professionals working in General Practice throughout Sheffield and surrounding areas.

We have just completed our last set of events entitled Hidden Stories, in which health professionals working in general practice have shared their stories about significant life events and experiences.

We have had sessions exploring childlessness, being a refugee, post natal depression, burnout, PTSD. In addition we had a session talking about Schwatz rounds and local poet sharing poems about Sheffield and his experiences of anxiety.

More recently these events have been held at South Street Kitchen, a lovely social venue with great atmosphere and amazing food. We have had around 20 to 35 people at each event.

In addition to these events the wellbeing fund has been used to fund a wellbeing event for reception and admin staff, and PAs based in Sheffield practices.

South Yorkshire
Integrated Care System

Supporting practices at the deep end

Blending education with social events let busy Sheffield general practice teams know their wellbeing was a priority.

What we did

The issue

Healthy life expectancy varies greatly depending where you live. For example, a woman living at one end of the number 83 bus route in Sheffield is predicted to live almost 10 years longer than a woman living at the other end.

South Yorkshire Integrated Care System (ICS) is investing in the wellbeing of primary care teams working in communities with significant health inequalities. There are a variety of wellbeing activities available for healthcare staff, but busy primary care professionals may not be able to take part day to day. We wanted to try something a little different.

The solution

The 'Deep End' movement supports general practices working in the most deprived communities in the UK and beyond. The Yorkshire and Humber Deep End network was set up in 2015 to reduce health inequalities through advocacy, education, workforce support and research.

In 2022/23, the Deep End network organised eight educational dinners for general practice teams in Sheffield. Having face to face events was important to help connect after the COVID-19 pandemic.

The events aimed to entice people to spend time learning, socialising and recharging together after hours. They were open to any Sheffield general practice staff, particularly those working with marginalised groups or in areas of deprivation.

We balanced being open to all with keeping events small enough so they felt personal. The direct cost paid out for each dinner event averaged around £1,000, or £40 per place.

What we achieved

More than 70 people attended one or more sessions. There were between 20 and 34 people at each session, with about 200 places filled in total. Momentum built as the sessions became a regular occurrence, with the number and variety of professionals growing over time.

About 70% of people attending were GPs and GP trainees. The rest were Nursing staff, Midwives, Social Prescribers, Community Care Coordinators, Physiotherapists, Emotional Wellbeing Workers and Physician Associates.

Staff were positive about the content, atmosphere and using local food venues as a way to bring people together. They said they felt supported, informed, connected and inspired. They also said they learnt things they could apply immediately at work to support patients - so it is possible to blend wellbeing and educational activities.

What helped

1

We focused on **making it attractive for people to attend after hours**. We had a variety of speakers, content and food. At some sessions, speakers from general practice shared their stories. Other sessions included patient ambassadors, the voluntary and community sector, drug and alcohol services and a local poet.

2

Investing **a little bit of resource went a long way**. The ICS contributed £14,500. So far we have used this to pay for 10 educational dinners (eight complete, two forthcoming) plus two social events for reception and administrative staff.

3

We used attendee's feedback to help plan next steps. In some sessions people drew smiley faces on a card to show whether they gained anything or listed a few key words to describe the evening. We originally planned an afternoon session, but we decided against this after listening to feedback. People's comments also guided the venue and topics for the final sessions. This way people could see that we were responding to what they wanted.

Feedback

"The venue was perfect as was the food, and it was lovely to meet and reconnect with people." (GP)

"What a great event. Full of energy and emotion, laughter and tears. I'm definitely re-energised." (GP)

"Really good and informative training and knowledge … well worth attending and better than being at home with TV. So grateful that the speakers gave up their time to share their wisdom." (Practice Nurse)

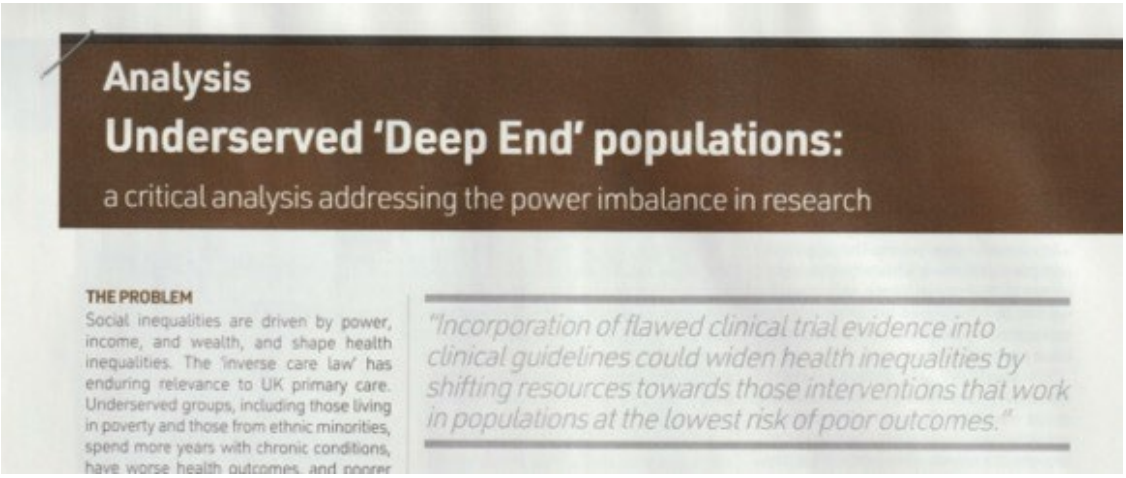
"Professionals need to feel valued and that their development and wellbeing are prioritised. We provided an opportunity for people to gather together to discuss experiences, share ideas about managing in the current difficult work environment and to spend time on professional development activities over a meal." (Organising Team)

Learn more

Email : brigitte.kaviani@nhs.net

Website : https://syics.co.uk/workforce-wellbeing

ARTICLE TO NOTE



Analysis

Underserved 'Deep End' populations:

a critical analysis addressing the power imbalance in research

THE PROBLEM

Social inequalities are driven by power, income, and wealth, and shape health inequalities. The 'inverse care law' has enduring relevance to UK primary care. Underserved groups, including those living in poverty and those from ethnic minorities, spend more years with chronic conditions, have worse health outcomes, and poorer

"Incorporation of flawed clinical trial evidence into clinical guidelines could widen health inequalities by shifting resources towards those interventions that work in populations at the lowest risk of poor outcomes."

Mitchell C, Fryer K, Guess N, Aminu H, Jackson B, et al; Underserved 'Deep End' populations: a critical analysis addressing the power imbalance in research. Br J Gen Pract. 2023 Jun 29;73(732):326-329. doi: 10.3399/bjgp23X733461. PMID: 37385767.

DEEP END DENMARK

In Denmark, we reached an exciting milestone in the project:

Invitations!

After months of work defining the project, collaborations, creating a website, and identifying Deep End practices we were finally ready to send out invitations to 100 practices on 1 June. We waited with excitement. After 6 days: 6 participants. After 14 days: 14 participants. Maybe if we wait 100 days, we will have 100 participants. Recruitment takes time and requires patience.

The website is in Danish, so it might all be gibberish to you, but we have nice illustrations: https://www.deepend-denmark.dk/

Escape from Inequity

We are currently working on developing an educational concept for use in healthcare education. An important aspect of reducing inequality in patients' encounters with the healthcare system is to inform and educate healthcare students and professionals about the mechanisms of inequality in health and treatment. The concept is a teaching model based on "gamification" methods that focus on creative, playful, and active participation in learning situations. The initiative is based on experiences from the Spanish group of general practitioners, where their developed concept is used in higher healthcare education and in the continuing education of healthcare professionals.

In the middle of June, we visited the founders in Madrid and got to see the concept in live action among a class of medical students. In groups, the students are assigned a role as a patient who must “escape” from their healthcare issues by navigating the healthcare system. The patient characters will encounter different levels of difficulties in obtaining health care. The goal is to provide insight into the challenges that patients can face and elucidate the inequalities that exist in acquiring health care. The students were engaged, and participating created feelings of joy, frustration, and injustice. The plan is to develop a similar educational concept in Danish and adapted it to a Danish healthcare context.

Health structure commission

One evening in March Mogens got a call from our Danish Minister of Health, Sophie Løhde, who asked if he wanted to be a part of a new health structure commission together with eight others.

The Danish healthcare sector is under pressure and faces many challenges. Demographic changes, where more citizens need care and treatment, and serious challenges in recruiting health professionals are almost everywhere in health services.

The task from the government sounds simple: The whole healthcare system is thrown into the air, and the commission's job is to catch the pieces and put them together in a new model of how the distribution of tasks and responsibilities should be. The task is anything but simple: within 12 months the commission is to rethink the healthcare system and to make suggestions on the structure and organization within 8 focus points:

1. Region structure and equal access to specialist treatment
2. Municipal health and prevention efforts
3. Cross-sectional healthcare
4. Organization and management of general practice
5. Financing and incentive structures, as well as culture and management in the healthcare system
6. Coordination of quality development in the healthcare area
7. Organization of digital solutions and IT infrastructure in the healthcare system
8. A regulation that supports free choice and patient rights

Being a member of the commission is a unique possibility to advocate for general practice, the inverse care law, and inequality in health. Of course, Mogens said yes, and in many ways the two projects complement each other very well.

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

P.S.
We changed the logo to have more calm colors. But fear not, our ambitions are as vibrant as ever!

DEEP END GPs | DENMARK

DEEP END GPs | DENMARK

REPORT FROM NORTH EAST AND NORTH CUMBRIA DEEP END

Over the last 10 months, our educational workstream has made good progress in engaging students and trainees about Deep End Primary Care from medical school to GP training and beyond according to our 'Roadmap to the Deep End'. Highlights have included :

- an RCGP-sponsored evening event for GP trainees with talks from our co-clinical Deep End NENC lead, an ST3 GP trainee currently placed in the Deep End, first 5 GP similarly in a Deep End practice and a couple established GPs from two of our member Deep End practices currently looking to recruit. A good number of students have expressed interest in joining a Deep End Peer Learning Group.

- 3 hour multidisciplinary workshop session for second-year medical students at the University of Sunderland, with representatives from local social prescribing initiatives, community projects and drugs/alcohol/homeless services, as well as the clinical psychologist from our Deep End MINDED pilot who explored barriers to mental health and an academic midwife talking about refugee and asylum seeker health.

- F2 teaching sessions across two of our foundation trusts, which have resulted in three F2s applying for taster weeks in the Deep End.

We have also supported the Northumbria GP training scheme to offer a 'Deep End' strand, whereby trainees are allocated to Deep End placements and also benefit from the funded HEFT training offer delivered by Fair Health. We understand this has been met with huge interest, with 1 in 3 applicants for the August 2023 intake requesting this option, beyond the capacity which can be offered!

We are now focusing on looking at ways to support more of our Deep End practices to engage with GP training and, from our engagement activities with our member practices, it is clear that money is not always the enabling factor - the gift of time is much more valuable. Watch this space...!

Leisa Smith, Programme Support Officer

Creating a Roadmap to a Career in the Deep End

What has been achieved so far

UoS Social Determinants of Health half day workshop session March 23

Mandatory F2 teaching sessions on Deep End GP (NUTH & S.Tyneside / Sunderland)

3 x Taster Week in Deep End GP

Deep End GP training strand with HEFT teaching (Northumbria) oversubscribe

3 hour Mandatory Deep End teaching session (Cumbria) Nov 22

RCGP sponsored Deep End Engagement Session May 23

Peer Learning Group List

Deep End Fellowship

Peer-Support WhatsApp Group for First Five Deep End GPs

What else we want to achieve

Develop a Deep End Student Selected Component

Extend number of practices hosting medical students

Expand the number of F2s doing a Deep End taster week

Run annual mandatory Deep End teaching session for Northumbria and DTV schemes

Introduce Deep End Integrated Training Post

Extend number of practices hosting GP trainees

Develop a GP trainee Deep End peer-learning group

Improve the Deep End Fellowship offer

Host a programme of CPD events open to all Deep End clinicians

Deep End-related CPD resource sharing via website

DEEP END REPORT RCGP NWL FACULTY

Led by two local GPs with support from the RCGP NWL Faculty, the focus is on a community of practice accessible to anyone who wants to take part, spotlight innovation, support joined up working and promote wellbeing among colleagues in outer NWL working in areas of deprivation and superdiversity characteristic of Deep End practices. Supporting colleagues working in challenging conditions to address inequities in health and healthcare is at the core of this project through providing a safe space for rich, meaningful and deliberative discussions and inspired action.

Following our reading group discussions, members attended a theatre production of The Beekeeper of Aleppo.
The next sessions will be locality based meetings for people to connect in person.
The community of practice is growing and still remains small enough for people to feel safe for meaningful conversations. People have connected with each other through it, supporting each other's work in practical ways as well as celebrating success and coaching each other through challenges. Please contact us if you would like to join!

Dr Hina J Shahid & Dr Camille Gajria

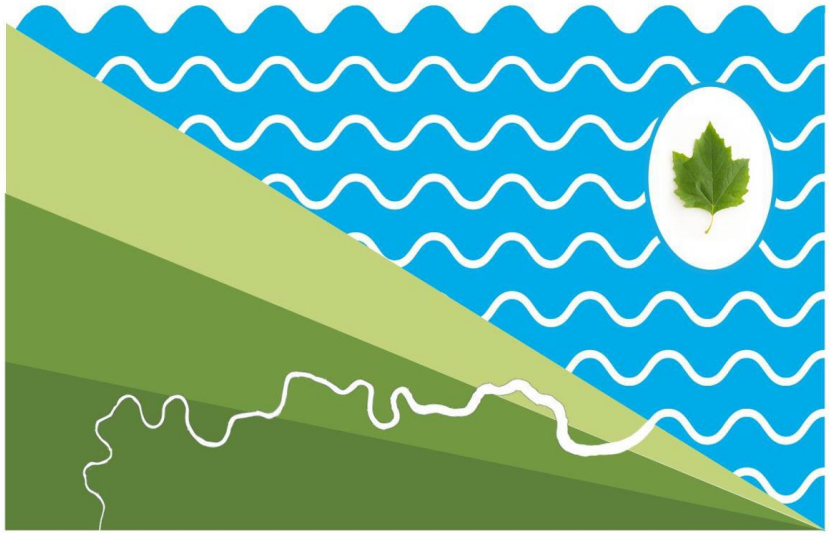
The following report has been contributed by Lili Risi, and while much longer than usual contributions to the Bulletin, shows the very substantial amount of thinking, organising and activity by Deep End colleagues in London. References on request.

Report

THE LONDON DEEP END HEALTH EQUITY MOVEMENT SEPT 2020 – FEB 2023

Growing leaders for fairer systems

and healthier places during the Covid-19 Syndemic



London Deep End Health Equity

The ‘London Deep End Health Equity’ logo captures the shades of green, which is climate health creation, the curve of the Thames from West to East, from pocket to blanket deprivation and the leaf of the plane tree which is all over London is valued for its ability to adapt to urban conditions and for its resistance to pollution. It has the largest leaf area of all tree species in Inner London, potentially bringing the most benefits for air quality and shade. The logo name also includes the starting point ‘Deep End’ i.e., areas of deprivation and the destination ‘Health Equity’. It is also a broader movement than General Practice to capture population rather than provider driven health.

"I took on the new health equity lead role in my local training hub in November 2020 and joined the West London Deep End programme. This learning experience enabled me to explore many of the issues I witnessed in my daily work and to consider how I could, individually and collaboratively, act to improve health equity.

Alongside the WhatsApp group, these sessions provided a safe space for me to connect with colleagues, share experiences and seek inspiration. I have led a local change project to support all GP surgeries in the borough to sign up to the Doctors of the World Safe Surgeries Initiative to promote inclusive primary care. I also contributed to the Equity Festival in February 2021.

Overall, this experience has restored my hope and equipped me with the skills and confidence to step up and work collaboratively in my locality to develop and deliver projects that improve health equity".

Lucy Langford, Newham Health Equity Lead

BUILDING KNOWLEDGE AND RECOMMENDATIONS

The virtual London Deep End Health Equity distributed leadership group which started in Sept 2020 is now established with a logo lodged with the Scottish Deep End. It has been based on support, learning, improvement, and advocacy.

The aim was to provide an opportunity for digital social innovation[2] for health equity during Covid-19 and advocate for fairer systems and healthier places. Key moments which have shaped this leadership journey since the onset of Covid-19 have been the Black Lives Matter movement after the death of George Floyd in June 2020[3] and the coroner ruling in Dec 2020[4] that the medical cause of death was air pollution which contributed to the death from asthma of Ella Adoo Kissi-Debrah.

Climate health creation has been an overriding theme arising from shared learning and evidence over the past twenty-eight months. Improvement ideas took the form of Health Equity Festivals which led to conceptual shifts towards a Syndemics framework and climate health creation. WhatsApp platform continues to provide immediacy of connection and community around ideas and shared values for social justice. There are 174 people on the WhatsApp group >70% of whom read posts. 60% (>100 people) are in age 30-45y and have >10-20 years ahead as leaders so this is a critical formative environment. >60% of members are also part of the London Greener Practice[5] movement. The 'permission architecture' has been inclusive and now all members have administrative rights and can bring others into the group.

Momentum has been driven by the NWL Deep End curriculum, Trauma informed work at a clinical and system level, initiatives at QMUL in the establishment of the Community Diagnosis and Flourishing modules for medical students, testing of Health Equity Leads linked to HEE training Hubs and collaborative Health Equity Festivals facilitated through the RCGP NEL Faculty. Festivals have involved NHS CCG/ICS, HEE Training Hubs, NHSE, NHS Acute Trusts and Voluntary Sector.

Smaller geographical groups have started and may be the best way to connect around projects and activism as this is about strength of relationships, trust, and safety.

It may be necessary to encourage break off communities of values and practice that can shape system practically at different levels in the Integrated Care Board geography i.e.,

Practice level, PCN, Acute Care
Face to face events carry weight and are opportunities to meet.

Change needs to be rooted and targeted in multiple small-scale initiatives. An online platform such as Fairhealth platform could be a place to demonstrate small scale change projects.

Momentum is still evident and informal conversations have captured that it is a place to consult/ share ideas and build knowledge. ('Oracle of Delphi'[6]).

We now need a period of questions:

- What do systems need to be fairer and have healthier populations?
- Where is stakeholder mapping happening?
- Who is getting meaningful data on deprivation at a ward level?
- What data would make a difference in building knowledge for fairer systems and healthier places?
- Increasing improvement through testing ideas of change?

Transitional Guardians to be established: Terms of reference are to provide informal mentorship as the group transitions into the system in an institution/s or online.

OVERVIEW

Several initiatives addressing the inverse care law[7] have their origins in the University of Glasgow 'Deep End' Project[8] and focus on supporting communities of practice in areas of socio-economic deprivation. The Inverse Care Law manifests in patients consulting more yet feeling less enabled after consultations and primary care teams are left more stressed. In some areas both patients and primary care teams breathe the worst air quality in London. Prior to Covid-19 Syndemic (March 2019), an inclusive, formative social movement for health equity was facilitated in North West London, drawing from the 'Deep End' Project, which had started to deliver a curriculum linked to a change program.

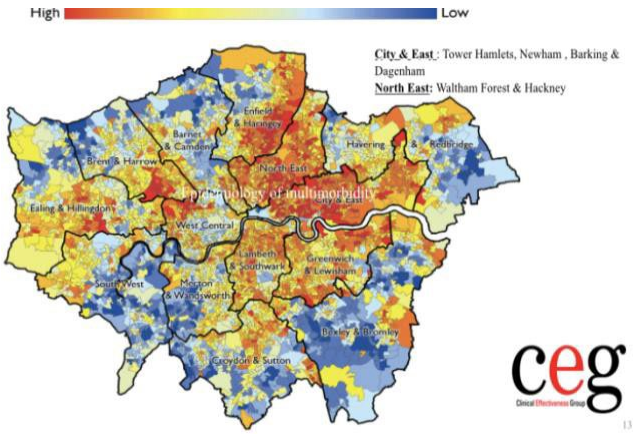
The combination of the disproportionate impact of Covid-19 in the North East London community and the Black Lives Matter movement prompted a small group of leaders from the RCGP NEL Faculty to own the problem and respond to longstanding structural racism, deprivation, and exclusion. Leaders with values of social justice felt isolated, powerless, anxious, and hopeless. There was a loss of trust in the system at every level. The leadership task was to share ownership of the pre-existing problems of racism, deprivation, and the impact of Covid-19.

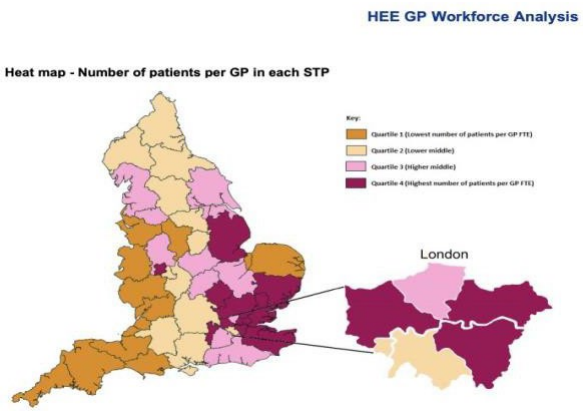
Six local leaders connected to facilitate a supportive safe, space for others to share support and information on WhatsApp. Using the virtual connecting opportunities offered by the Covid-19 Syndemic, local healthcare leaders could start to focus on advocacy. The initial team was a group of leaders from the RCGP North East London (NEL) Faculty who connected with other local leaders in NHS organisations (NHS Integrated Care Systems, NHSE, HEE) and the medical school (QMUL). The target group were local leaders and activists from primary care, community health and the third sector with shared values around social justice and health equity.

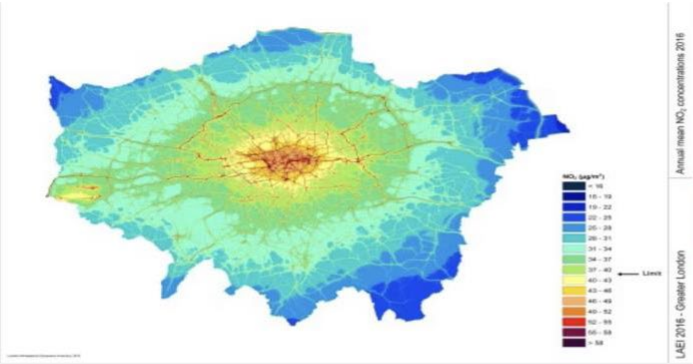
There was an appreciation of the allostatic load[9], moral distress, loneliness, loss of trust and perceived helplessness of those working in areas of deprivation. The WhatsApp platform was an easy, quick way to connect, exchange information and share dialogue. The goal was to promote a culture of support, inclusion, and belonging for GPs and teams, and to move to a Syndemics[10] narrative to understand the impact of Covid- 19 and structural racism and exclusion. This involved integrating environmental, social, and medical causation with a vision of health equity (Marmot Informed[11]) through climate health creation[12] for fairer systems and healthier places.

APPRECIATING LONDON DEEP END

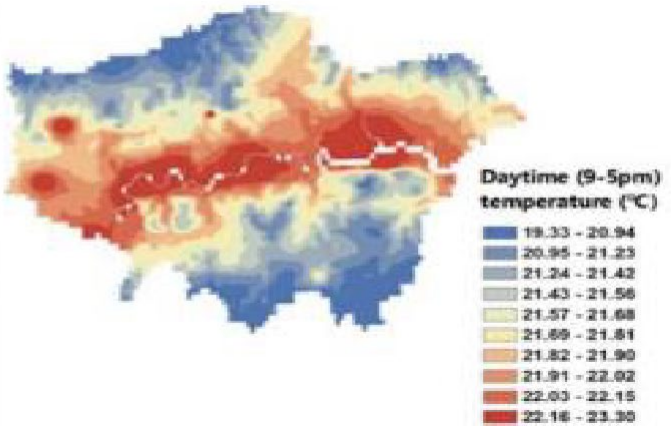
Indices of multiple deprivation (1), HEE GP Workforce analysis (2), Air Quality (3) and Heat (4) , London map Language Diversity (5)

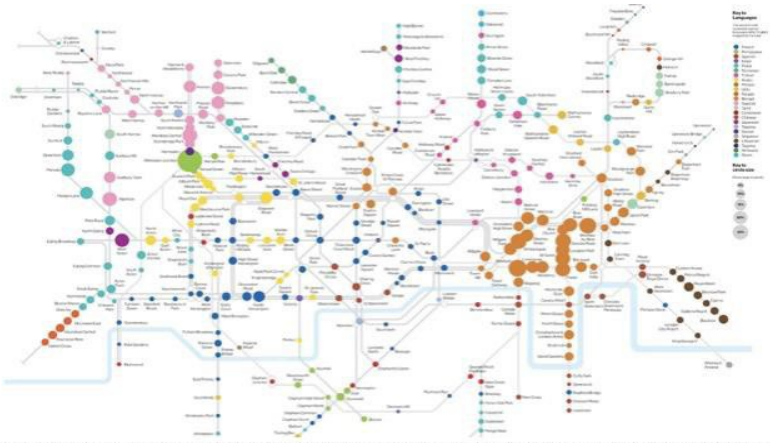






Picture: Map showing areas of London with the highest levels of nitrogen dioxide. Annual mean NO2 concentrations, 2016 – London Atmospheric Emissions Inventory, 2016





This 'Tube tongues' graphic shows London's diversity by displaying the second most common languages (after English) spoken by residents, according to the 2011 census. created by Oliver O'Brien, a researcher at UCL Department of Geography. www.oobrien.com
https://www.chathamhouse.org/publication/mind-language-gap-map-diversity

SUPPORT AND THE HUMAN SIDE OF CHANGE

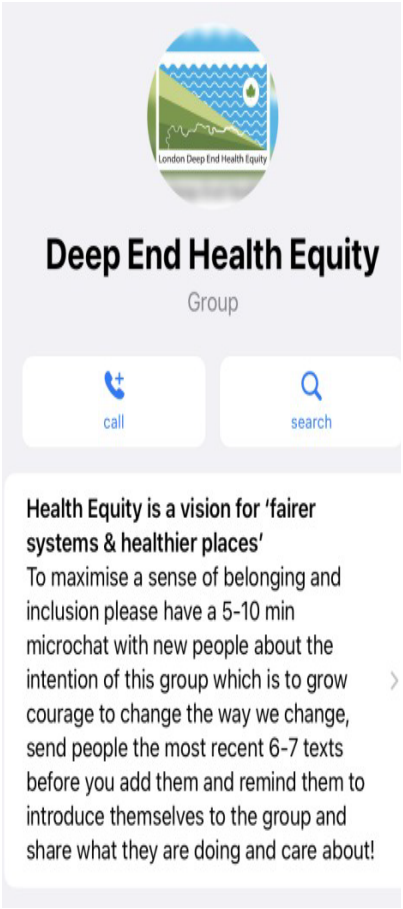
Leadership approaches

High levels of mistrust predated Covid-19 Syndemic. Ansell and Gash's work on Collaborative Governance theory was one of the earliest posts. To restore trust, they identified "a series of factors that are crucial within the collaborative process itself. These factors include face-to-face dialogue, trust building, and the development of commitment and shared understanding. We found that a virtuous cycle of collaboration tends to develop when collaborative forums focus on "small wins" that deepen trust, commitment, and shared understanding" [13]

The WhatsApp group grew through word of mouth and social networks to establish collaboration. At the first NWL Deep End Curriculum on 3/11/2020, the emotional impact of unmitigated social complexity and deprivation on professionals was captured.

The ‘collaborative governance’ approach informed the concept of the ‘microchat’ which was a timed 5-10min initial phone call to connect, to feel known and to establish a sense of belonging before being added to the group.
The intention of this brief conversation was to increase trust by 10% in every conversation in the context of virtual working in time poor contexts.
The microchat approach was summarised on the WhatsApp Group Info page to support administrators in how to maximise inclusion with an easy link to send out to others to join https://chat.whatsapp.com/HQaCSvQY2OQHPV41z4xKGm

By Feb 2023 all 174 members had been given administrator status. The “permission architecture” of the group aimed to maximise agency and to encourage new groups through a distributed leadership approach.



Restoring trust

Building and restoring trust, at the outset, focused on the appreciation of adversity in childhood with the aim of building resilient communities[14]. A trauma informed servant leadership[15] approach was adopted based on the evidence that Covid-19 posed complex leadership challenges in supporting a demoralised health care workforce faced with acute on chronic loss of meaning in work, exclusion based on structural racism especially for those working in areas of deprivation. Trauma informed leadership encourages reflective practice; makes meaning out of the past, is orientated towards growth and prevention, is collaborative, equitable and accountable and works in relationship with other leaders[16] and aims to minimise re-traumatisation [17] in healthcare and to develop a real-world commissioning approach based on inclusion and healing for staff and patients[18]

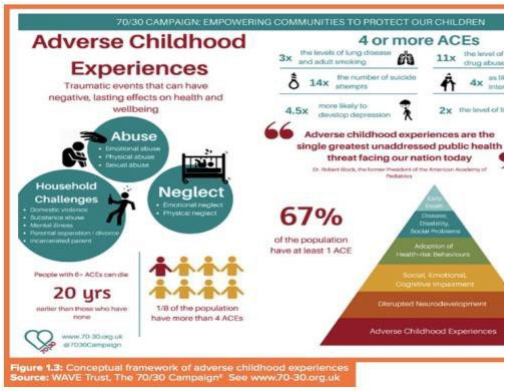
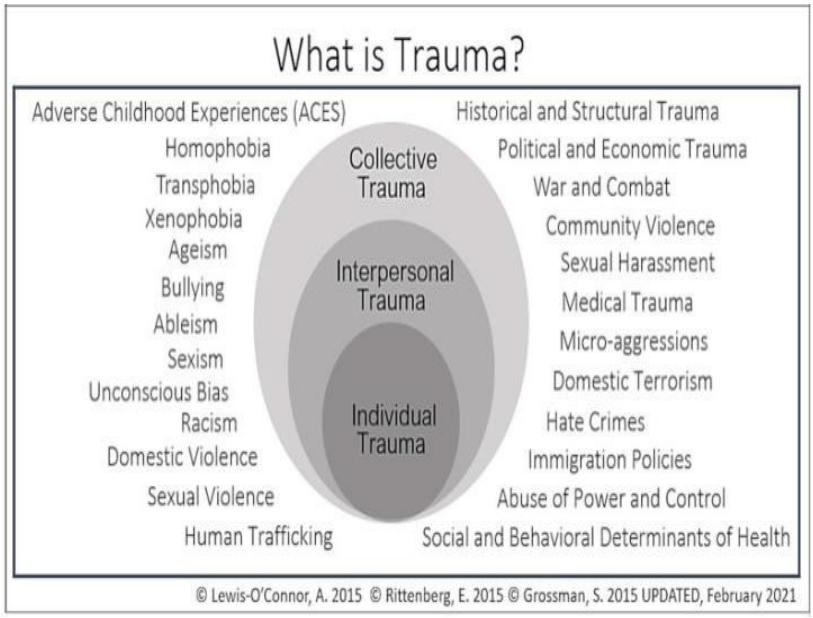
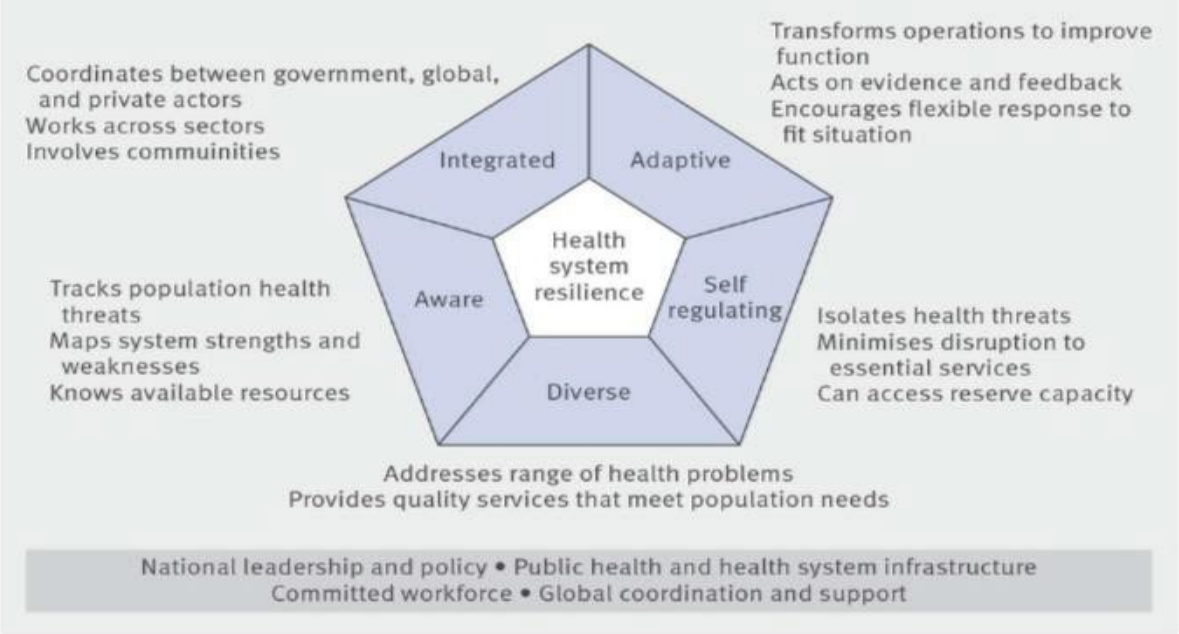


Figure 1.3: Conceptual framework of adverse childhood experiences
Source: WAVE Trust, The 70/30 Campaign[6] See www.70-30.org.uk

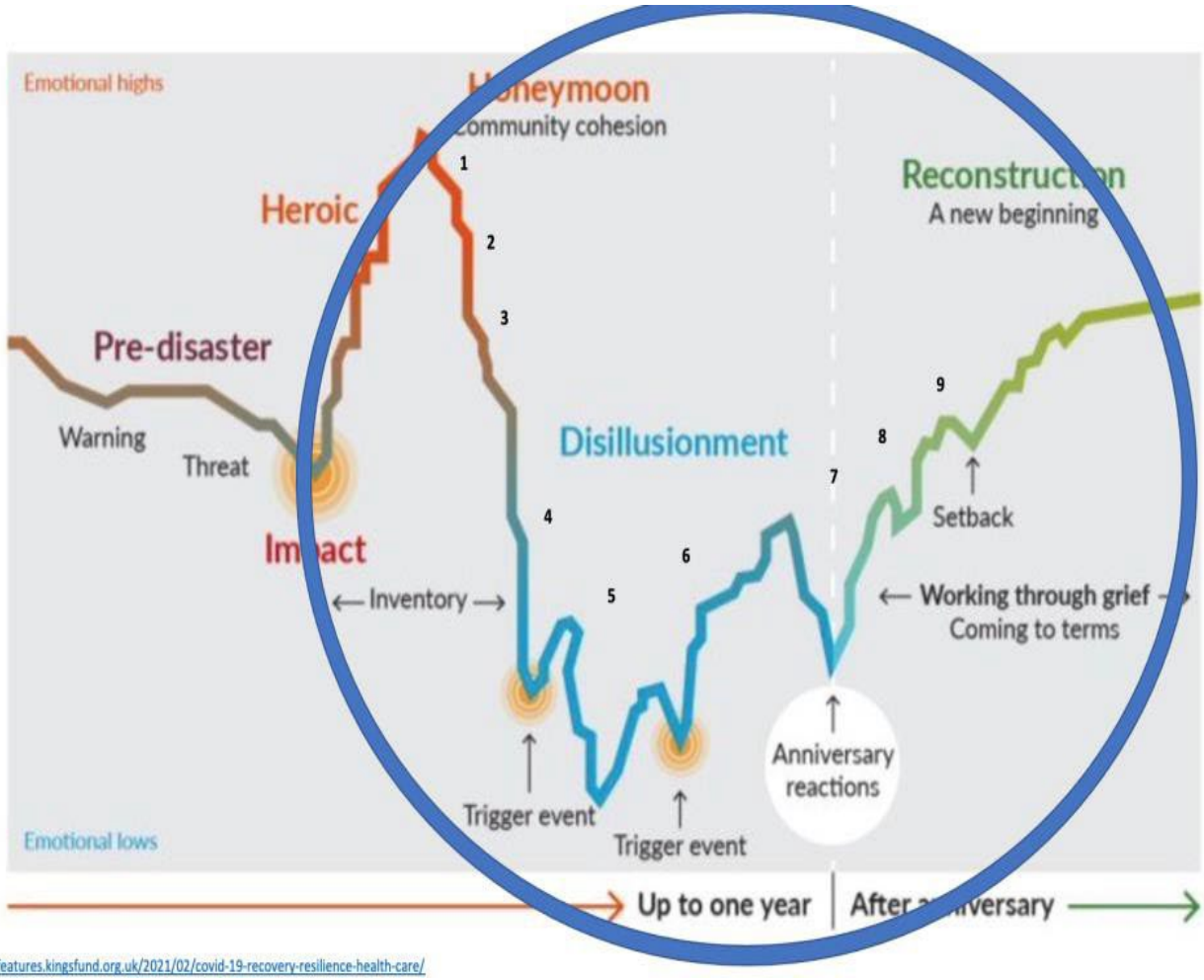


Trauma informed servant leadership[19] was central to modelling the atmosphere on the WhatsApp group. This is a 'unique focus on emotional healing, service to others as the first priority, in addition to the growth, well-being and personal and professional development of key stakeholders.' Encouragement to invite other super-connectors[20] to join was based on 'first follower' principles in the necessity of nurturing the first follower[21] and eco- leadership[22]. The former encourages nurturing the 'early adopters' which has shown that in ensuring the success of the first follower, leaders can improve the probability of change taking place. The latter conceptualizes organizations as 'ecosystems within wider ecosystems with attention to networks, connectivity, and interdependence, breaking down barriers and distributing leadership widely.

Membership of the group organically grew beyond the original definition of the Glasgow 'GPs in the Deep End' and north east London is now pan-London. Leadership grew, based on work done on health system resilience[23], where connections with colleagues who share values for health equity were encouraged in the Acute care sector, voluntary sector, wider primary care team and not just GPs.



Nine thematic phases emerged over a 28 -month period which matched the emotional trajectory of the Covid-19 Syndemic[24]



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

NINE PHASES

Phase 1	**Proliferation of virtual connections**	WhatsApp allows easy connecting and sharing of information
Phase 2	**Sense making**	Covid-19 death data highlight disproportionate impact of racism and deprivation on outcomes
Phase 3	**Fragility of trust**	Emergence of a new social justice movement after from Black Lives Matter
Phase 4	**Owning the problem**	Agreement to initiate a Deep End movement in September 2020 inclusive of support; learning; improvement and advocacy. Six people connect on 10/9/20 to for a virtual network for leaders on WhatsApp
Phase 5	**Beacon in the storm**	Fortnightly nurturing Deep End Change Program starts which allows for connection and catharsis. Aim to increase trust by 10% in every conversation**.** Three Boroughs agree to test funding Health Equity leads to attend Deep End Program in Nov 2020. The Medical School initiates a Community Diagnosis Health Equity Module
Phase 6	**Integrating Narratives**	Climate Health becomes a theme. Name of WhatsApp group changes to Deep End/Health Equity
Phase 7	**Restoring hope**	Evidence of high levels of social capital in communities in response to Covid-19 emerges. Curation starts for a first Health Equity Festival in Feb 2021 (PDSA 1). Virtual group opens to include wider primary care team – nurses, social prescribers, commissioners, secondary care but still within the local geography
Phase 8	**Harvesting sustainable seeds of change**	Completion of Deep End programme prompts a second Health Equity Festival in Oct 2021 located in two sites which have established health creation: The Story Garden and Bromley by Bow. Group widens geographically to become London wide.
Phase 9	**Regeneration and restoring trust**	Trauma informed resilience-orientated approach defines the third Health Creation Festival in May 2022 (PDSA 3) with a focus on healing from individuals to the climate. A symposium on Syndemics & Health Creation (PDSA 4) is held in October 2022. In Nov 2022 a reflective event is held on Compassionate Equitable Appraisal focusing GMC Appraisal Domain 4 (PDSA 5). A final event Health Equity Festival of the Future Now: Hospital without walls (PDSA 6) is held on 29/11/22

LEARNING

Assessment of issue and analysis of its causes

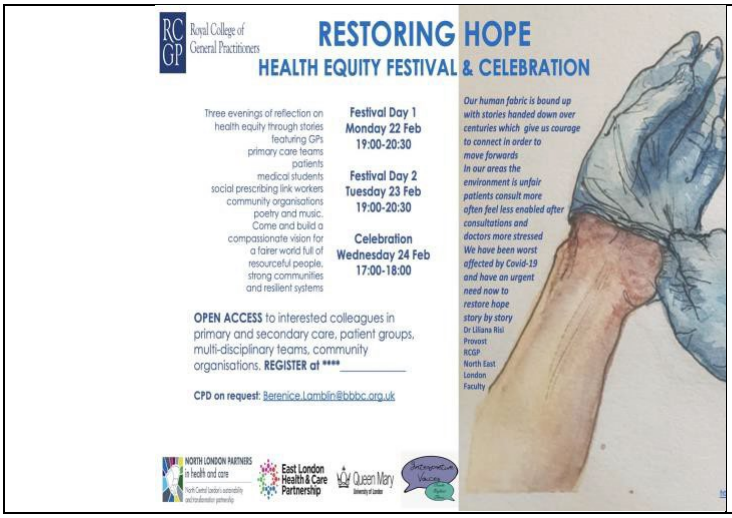
Key stakeholders were local leaders with shared values identified through community connections who were invited to attend an open access “Deep End” online course in North West London for primary care workers while simultaneously participating in the WhatsApp group.

Topics included:
Understanding complexity: life in the 'deep end'; The power of consultations: the impact of empathy; Understanding vulnerability: domains of resilience; Understanding dependence: creation of demand; Self-care and wellness: rational choice & agency; Access and candidacy: literacy & digital exclusion; Promoting continuity: narrative & relational approaches; Mental health and wellbeing: 'depression' & loneliness; Advocacy: power, privilege, status & passivity; Financial wellbeing: social capital & resilience; Food poverty: the social gradient to diabetes & obesity; Living in pain: pain as the expression of social distress; Trauma informed care: cycles of adverse experiences; Care in the last years of life: dying in poverty & compassion; Data and research: community participatory research; Peer support: communities & professional resilience.

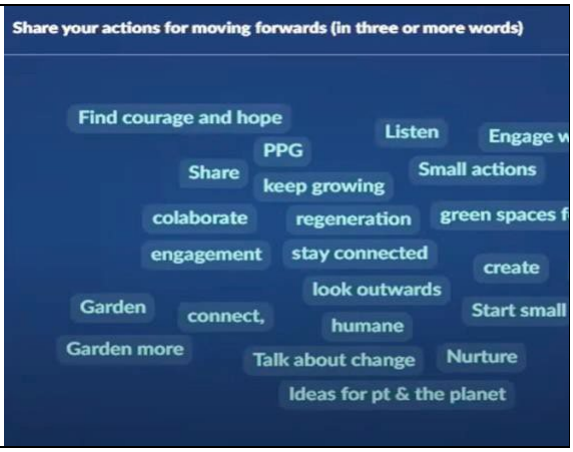
IMPROVEMENT AND CHANGE IDEAS (PDSA: PLAN/ DO/ STUDY/ ACT)

The Health Equity Festivals[25] were initially virtual and then hybrid to encourage ‘face-to-face dialogue, trust building, and the development of commitment and shared understanding and focused on “small wins” that deepened trust, commitment, and shared understanding’[26] Word clouds asked for actions for moving forwards were captured at each festival and informed the planning for the next cycle and numbers increased after each festival from six leaders (Sept 2020) to 174 (Feb 2023)

PDSA 1: Health Equity: Restoring Hope story by story[27]

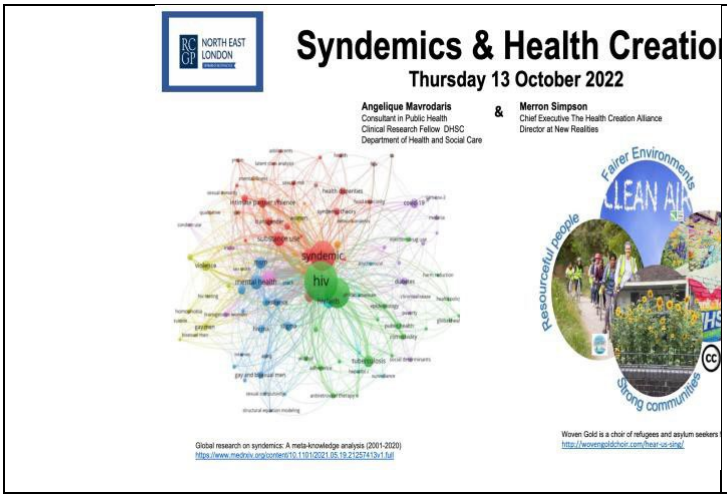


PDSA 2: Health Equity: Harvesting sustainable seeds of change[28]



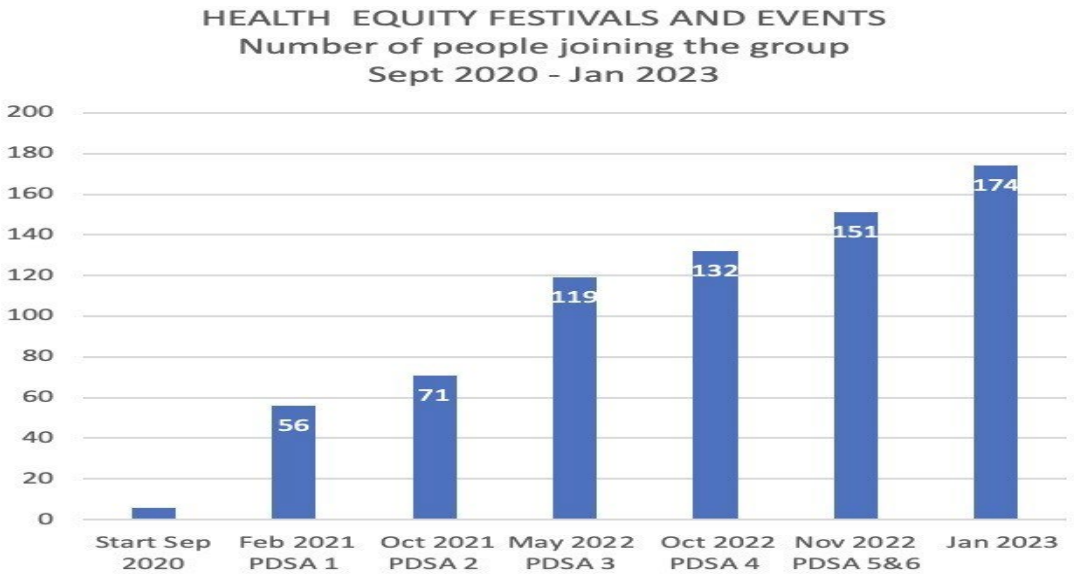
PDSA 3: Health Creation: Regenerating ourselves, our systems, our world[29]

PDSA 4: Syndemics and Health Creation[30]



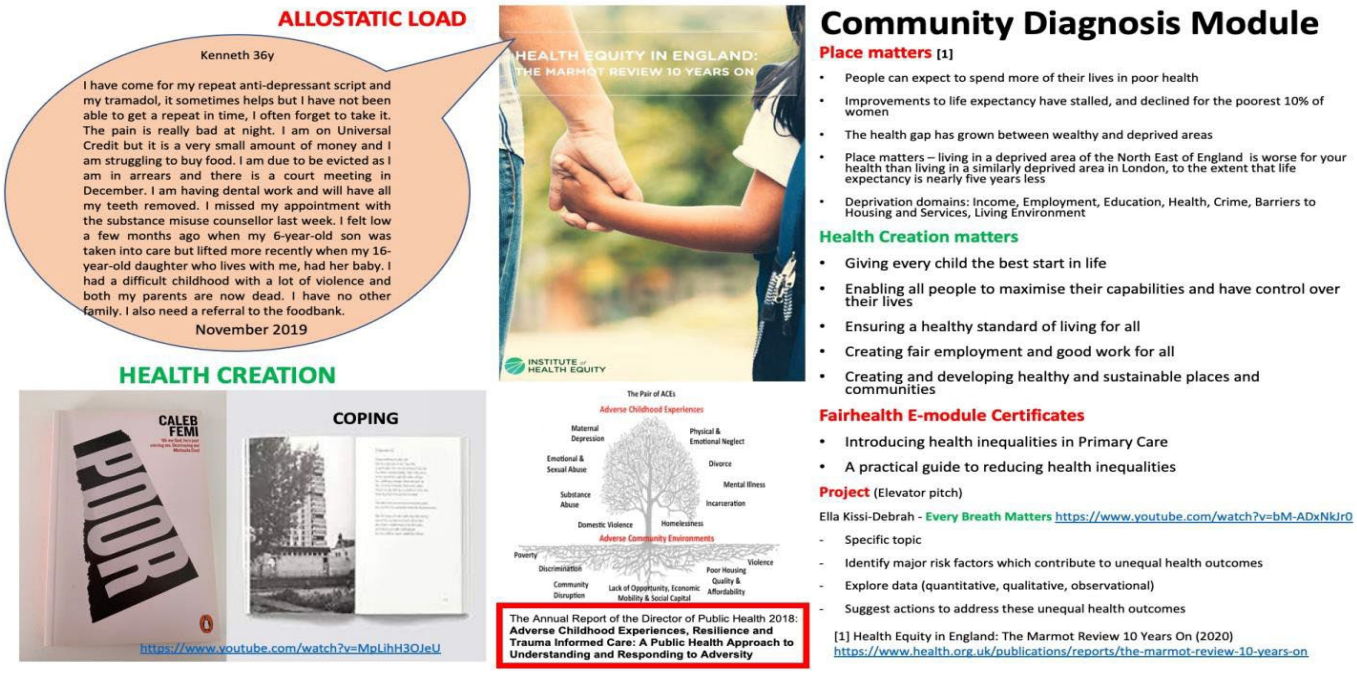
PDSA 5: Compassionate Equitable Appraisal - GMC Domain 4 Maintaining Trust[31]

PDSA 6: Health Equity Festival of the Future Now- Hospital without walls[32]


HEALTH EQUITY FESTIVALS AND EVENTS
Number of people joining the group
Sept 2020 - Jan 2023
200
180
160
140
120
100
80
60
40
20
0
56
71
119
132
151
174
Start Sep 2020
Feb 2021 PDSA 1
Oct 2021 PDSA 2
May 2022 PDSA 3
Oct 2022 PDSA 4
Nov 2022 PDSA 5&6
Jan 2023

BUILDING KNOWLEDGE

The Community diagnosis[33] module is now established at QMUL. It has been an effective cross-collaborative approach between primary care and public health and a practical application to build on previous theoretical public health learning with evidence of transformational learning for the students, helping them to understand the impact of health inequities. A vision for transforming education for a new kind of doctor is being developed in the Community Based Medical Education Department at QMUL.



STORIES OF CHANGE FROM THE DEEP END HEALTH EQUITY WHATSAPP GROUP

Story 1: Local GP Leader (LR)	I have always wanted to be involved with the Deep End Project. I worked in an area like those communities in Glasgow, yet nobody seemed engaged with trauma informed care or other Deep End concepts of change. I noticed that the inverse care law played out at multiple levels. Patients consulted more, we felt disconnected from each other and together with our patients we breathed polluted air. Doctors in our area were exposed to racism, received more complaints and were more likely to be referred to the General Medical Council. We felt misunderstood and censored by regulatory organisations who did not appreciate the burden of work in areas of deprivation. Our relentless fear of error and blame made us feel lonely, passive, and powerless. There was a loss of trust and confidence in the system to enable us to provide healing care. Repeated attempts asking for system educators to deliver a GP Deep End learning and change program failed. The combination of Covid-19 and the evidence of longstanding structural racism in my professional organisation catalysed me into owning the problem. I was aware of an existing Deep End curriculum and colleagues who were working in a trauma informed way as well as initiatives at the medical school. I had read that it took about 3% of people in a system to make change. So as a super connector I used my role as a local leader to link with other leaders whom I had known over the years with the aim of building a social justice movement for fairer systems and healthier places. Pragmatically, my role was to facilitate support through time sensitive connections and in testing a “community of ideas” forum with established and emerging leaders. I knew that if leaders were well informed and felt safe with a sense of belonging then they would feel empowered to implement change and lead upwards.

Story 2: GP Health Equity Fellow (LL)	I took on the new health equity lead role in my local training hub and joined the West London Deep End programme. This learning experience enabled me to explore many of the issues I witnessed in my daily work and to consider how I could, individually and collaboratively, act to improve health equity. Alongside the WhatsApp group, these sessions provided a safe space for me to connect with colleagues, share experiences and seek inspiration. I have led a local change project to support all GP surgeries in the borough to sign up to the Doctors of the World Safe Surgeries Initiative to promote inclusive primary care. I also contributed to the Equity Festival in February 2021.Overall, this experience has restored my hope and equipped me with the skills and confidence to step up and work collaboratively in my locality to develop and deliver projects that improve health equity.
Story 3: Secondary Care Doctor (AM)	I joined the Deep End group in mid-2021 to learn more about links between health equity and sustainable healthcare. The context for the group was clear and I understood the urgency of work, but much of the content was new to me – terms such as the “inverse care law”, “trauma” and “adverse childhood experiences” kept popping up and I initially found it hard to connect with them. A lot of what I read seemed to relate more to primary care than my area of work as a respiratory doctor in secondary care. I felt very peripheral, looking in – to something I wasn’t really part of. As I read and absorbed, the WhatsApp format enabling me to choose what to engage with and when, my eyes were opened to new ways of understanding health and healthcare, and what we risk missing in our secondary care setting. A key moment was reading a message containing the phrase “held hostage by your sympathetic nervous system” in between patients in my breathlessness clinic. Something clicked into place. For the first time I saw the need for trauma informed care; to counteract the potential damage done by our relentless, biomedical drive to investigate, diagnose and fix with drugs. This approach is so prevalent in secondary care, and so often prevents us appreciating and addressing the real underlying causes; poor housing, hunger, abuse, precarious, poorly paid employment… I realised the urgent need to share this learning with colleagues in secondary care but also started to recognise this approach and

	understanding in others from my trust. The facilitatory approach of the group's admin team meant that as I learned I was able to move from peripheral involvement to active participation: inviting secondary care colleagues to join the group, meeting locally to establish our own organisational network, and contributing to the Spring London Health Creation Festival with a short talk on my experience of engaging with trauma in people coming to our breathlessness clinic.
Story 4: Medical School Leader (JB)	Medical students were asking us what we as an institution were going to do in terms of curriculum content following on from COVID-19 and Black Lives Matter. We developed a "Community Diagnosis" module, that ran for the first time in the autumn of 2020. Students used large public health datasets to identify inequities in the areas they lived and consider community level interventions to address them. Feedback for this new module showed students experienced "transformative learning": they saw areas that they knew via new lenses. Feedback from GP tutors was also extremely positive-despite their own working conditions being particularly challenging at that time, they reported feeling energised and motivated by being involved in the teaching. Specific health equity teaching has now expanded to further academic years in the medical school, and across Primary Care, Public Health and Sociology teaching.

Story 5: Emergent leader (JW)	As the Deep End group grew and developed as a forum, I joined with other trainees. This was an immersive experience that was distinct from other elements of training in which we found ourselves more connected across our region and part of a greater body of general practitioners spanning regions and lifetimes of experience. It also crucially demonstrated the lack of health equity content within our own formal training. What was also notable was the lack of connectivity felt across the geographical area due to the absence of a forum or network like this one which could act as a community for local practitioners with these comment interests. This was also a stark contrast to our own regional trainee groups or smaller practices and at times could be overwhelming. To help enable trainees to ask questions in a more comfortable or smaller environment we created a Deep End Trainees group. This allowed us to have a separate, additional platform in which we could interact, enquire, and reflect on discussion in the main group or on things shared there. It also enabled us to ask questions that we may have felt unable to do in the main group or to explore our own experiences before sharing them in the primary group. Often, we also identified differences in our generational experiences of health equity, training and crucially our feelings around having the power to be agents of change in systems where trainees or newly qualified GPs we were less empowered than other more senior colleagues. This different context played a big part in our discussions and experiences of acting to deliver change locally and nationally. It also served as a forum for sharing opportunities for learning, training or roles that would enable our development. I suspect that as the community continues to grow and develop, small groups like may be needed to help create safe spaces for members to have more 'small scale' discussions that act as a bridge toward activity on the larger primary group'.