GENERAL PRACTITIONERS AT THE DEEP END
INTERNATIONAL BULLETIN NO 15
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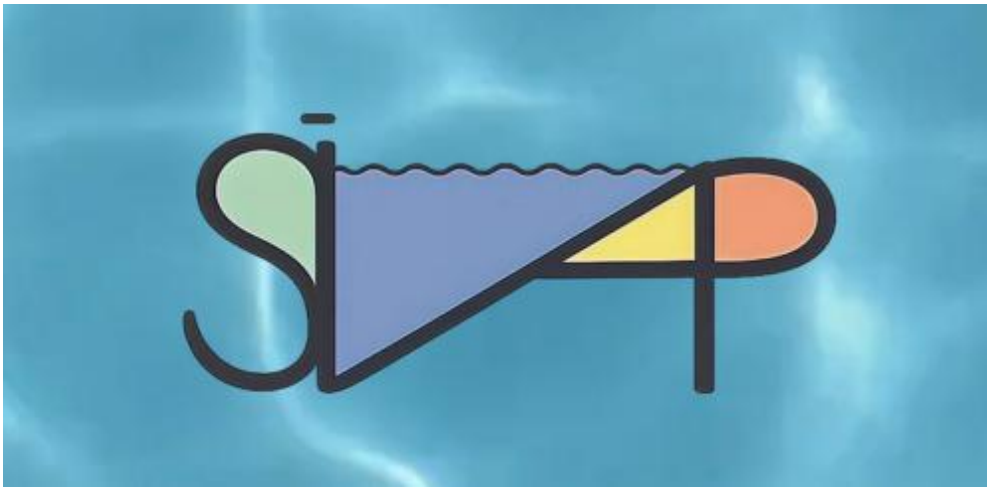
INTRODUCTION

Welcome to the 15th Deep End International Bulletin, with reports from 10 Deep End Projects in Canada, Denmark, Japan, Ireland, England and Scotland.

But the biggest news is from Spain. Earlier this year I was asked to provide a short discussion paper on the Deep End (Page 3), which fuelled a month long email conversation prior to the first Deep End meeting in Madrid. A week beforehand, Gemma Torrell, a general practitioner in Barcelona, had attended the Deep End International Conference in Dublin. On page 7 she describes the story so far.



In this Bulletin, there are reports from three Deep End conferences, all buzzing with energy and positivity. Highlights of the Dublin International Conference (Page 11) included Mogens Vestergaard's account of exciting political developments in Denmark and an overview of Professor Andrea Williamson's pioneering research on "missingness". Both Mogens (Page 21) and Andrea (Page 24) have written exclusively for the Bulletin.

It is a pleasure to include a first report from the Emergency Care Deep End Group (Page 38) and also to note the new logo of the Deep End Group in Cornwall (Page 30). But as you will read, there is much, much more

Catch up on previous Deep End International Bulletins (Page 50) on the Scottish Deep End website (www.gla.ac.uk/deepend).

Graham Watt graham.watt@glasgow.ac.uk **July 2026**

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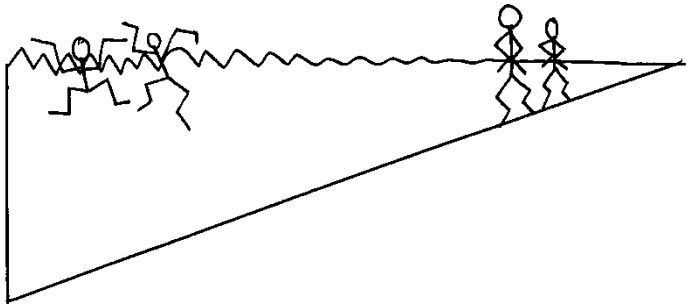
MÉDICOS DE FAMILIA EN EL DEEP END

El Proyecto escocés Deep End empezó en 2009 con una conferencia a la que fueron invitados los médicos de familia que servían a las 100 comunidades más deprivadas de Escocia. 17 años más tarde, existen 20 proyectos Deep End en 8 países de 4 continentes.

El "Deep End" es una metáfora basada en la idea de una piscina. Mirando a la piscina de lado, se puede ver que todas las personas que están en la piscina tienen la cabeza por encima del agua. Parecería que estuvieran en igualdad de condiciones. Pero los profesionales en el Deep End, que están en la zona profunda de la piscina, tienen dificultad para mantener sus cabezas fuera del agua pues sus pies no tocan el fondo, mientras que los profesionales en la zona menos profunda pueden apoyar sus pies en el fondo.



En realidad, revela dos temas importantes. El primero, que la esperanza de vida en buena salud de los pacientes en el Deep End es 15 años menor que en los pacientes de áreas más afluentes, proceso que suele empezar con la adquisición de una multitud de problemas, a veces llamados multimorbilidad, y no solo dos o más problemas médicos,

más allá del número, es la severidad y complejidad de los problemas médicos, psicológicos y sociales dentro de las familias y las viviendas.

Segundo, cuando los recursos no se corresponden con las necesidades, los profesionales de la salud disponen de tiempos de consulta insuficientes e insuficiente soporte para atender y hacerse cargo de los problemas de sus pacientes. Un estudio escocés de consultas de médicos de familia en el Deep End mostró que estas incluían típicamente multimorbilidad, escasez de tiempo, expectativas reducidas, resultados pobres (especialmente para pacientes con problemas mentales – siendo esta la comorbilidad más común-) y estrés de los profesionales.

La primera conferencia sobre el Deep End supuso la primera ocasión en la que se convocó o consultó a los médicos de familia escoceses en el Deep End. La disposición de los asientos fue circular, todos los asistentes en primera fila. No hubo "ponentes expertos", solo mesas redondas y debates plenarios donde todo que se dijo fue registrado y se incluyó en el informe de la conferencia.

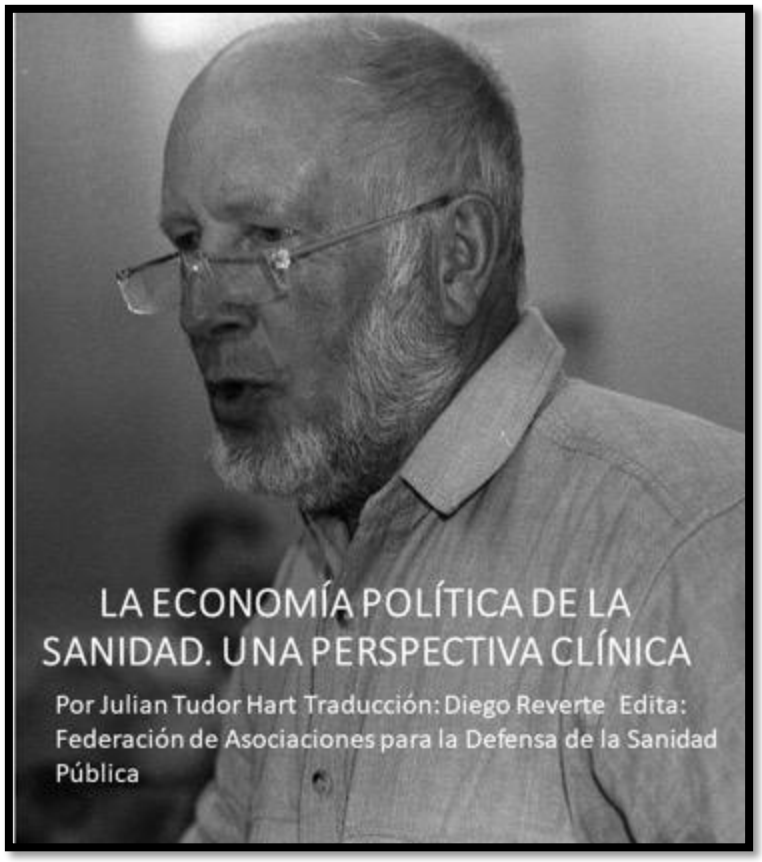
Mientras compartían sus experiencias y opiniones, se respiraba un ambiente lleno de energía en la sala. Todos estaban en la misma situación – a diferencia de la mayoría de las reuniones profesionales donde los profesionales del Deep End son una minoría. La formación médica no ha preparado a los profesionales del Deep End para el trabajo clínico en ese ámbito, y había mucho que aprender y mucha sabiduría por compartir.

En los últimos años, han surgido proyectos «Fast Forward» y «Deep End» en numerosos lugares y países. Aunque difieren en muchos aspectos —ya sean locales, regionales o nacionales—, sus actividades son similares y abarcan los ámbitos del empleo, la educación, la defensa de derechos y la investigación (WEAR).

Ahora disponemos de pruebas de que aumentar la duración de las consultas para determinados pacientes mejora los resultados; de que los coordinadores sociales y los asesores financieros son incorporaciones importantes al equipo de la consulta, sobre todo cuando forman parte integrante de la misma y no se limitan a estar ubicados en las inmediaciones; y de que incorporar a profesionales jóvenes a las consultas de Deep End no solo supone una experiencia transformadora para ellos, sino que también mejora la moral y la retención del personal con más experiencia.

En su libro Solidaridad: el pasado, el presente y el futuro de una idea que cambia el mundo, Hunt-Hendrix y Taylor escriben que «la organización es una especie de alquimia. Convierte la alienación en conexión, la desesperación en dedicación y la opresión en fuerza». Describen la «solidaridad interna» como la protección del grupo frente a las fuerzas externas, mientras que la «solidaridad externa» consiste en cambiar el mundo.

Cambiar el mundo es una tarea titánica, pero los médicos de cabecera de Deep End pueden cambiar el mundo de los pacientes a los que atienden; pueden cambiar su forma de trabajar en la consulta; pueden ampliar los recursos de que disponen mediante la mejora de las relaciones con los servicios locales; y, hablando en nombre de todos, pueden transmitir las necesidades de sus pacientes, comunidades y servicios a quienes ostentan el poder.



Según mi experiencia, la principal motivación de los profesionales de Deep End no es una idea abstracta, como las desigualdades en materia de salud: se trata, sencillamente, de querer ofrecer una mejor atención a sus pacientes, reduciendo la brecha entre lo que pueden hacer y lo que podrían hacer si contaran con más tiempo y más apoyo. En Escocia defendemos que «la asistencia sanitaria debe prestarse allí donde más se necesita», algo fácil de decir, pero difícil de llevar a la práctica cuando hay tantos intereses en conflicto.

Aspiramos a seguir el ejemplo del difunto Dr Julian Tudor Hart, quien visitó España en numerosas ocasiones y fue el autor de la «Ley de Cuidados Inversos», pero sobre todo por el ejemplo que dio en su propia práctica, en un antiguo pueblo minero del sur de Gales: trabajando y viviendo en, con y para su comunidad local, permaneciendo el tiempo suficiente para marcar la diferencia; el último paciente tan importante como el primero; generando conocimiento, confianza, autonomía y seguridad; trabajando inicialmente cara

a cara para pasar gradualmente a trabajar codo con codo; evaluando lo que hacía y siendo honesto con el resultado; la epidemiología era su mapa y la ciencia su brújula.

Puede ser una frase vacía decir que «todo el mundo importa» cuando hay tantos factores de exclusión en la vida moderna. Algunos dicen que el Movimiento Deep End es un movimiento de resistencia, que une a profesionales que esperan y trabajan por tiempos mejores, practicando una atención sanitaria inclusiva, excluyendo las exclusiones y construyendo relaciones, como una fuerza civilizadora en un mundo cada vez más incierto, fragmentado y peligroso.

Algunas preguntas para reflexionar:

- Cuál es la mejor manera de caracterizar e identificar las prácticas de Deep End en vuestro contexto?

- Qué es lo que marcaría una mayor diferencia para los profesionales y los pacientes de Deep End en vuestro contexto?

- Hasta qué punto «todos importan»?

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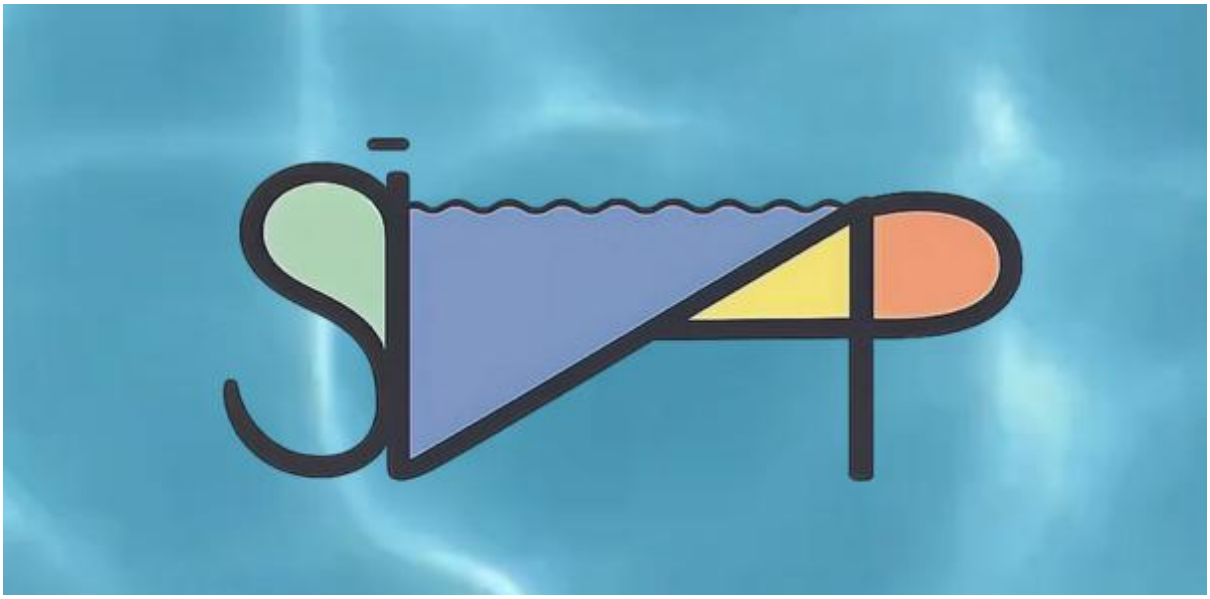
The Editor at the Alhambra in Andalucia, a long time ago

WHAT ABOUT A DEEP END PROJECT IN SPAIN?



Spain, apart from sunny days and paella, has higher-than-average levels of risk of poverty, material deprivation and inequality within the European Union. According to the AROPE survey, the proportion of the population at risk of social exclusion in Spain is higher than the European average (25.8% compared with 21%).

The distribution of these indicators varies significantly across the autonomous communities, with the communities having the highest rates of risk of social exclusion being Andalusia (35.6 per cent), Castilla-La Mancha (34.2 per cent), Extremadura (32.4 per cent) and the Region of Murcia (32.4 per cent), compared with lower figures in the Basque Country (14.8 per cent), the Balearic Islands (16.2 per cent) and the Comunidad Foral de Navarra (18.3 per cent). These figures indicate that poverty, material deprivation and inequality remain a problem in our context, with wide regional differences and foreseeable consequences for the health of the population (1).

We see the consequences of these figures on health every day in our practice. We see also how the health system sometimes contributes to widen these inequities instead of narrowing them. SIAP Deep End was born out of the sense of injustice that this arises.

It makes my head spin a little to think about everything that has happened in only a month. Just a month ago, as I was on my way to Dublin for the Deep End International Meeting, I wasn't quite sure what to expect, but I had a gut feeling that I needed to go. And how right I was! To hear about experiences with Deep End in other places, to confirm the urgent need to protect longitudinality (what you used to call continuity of care), to learn about vital topics such as informed trauma care, to encounter new terms like 'missingness' for a concept we have observed in practice, and to see how, despite the differences between

healthcare systems and between different regions within the same country, there were professionals everywhere committed to trying to provide the best possible care to these communities and to advocate and fight alongside them for better conditions so that they could deliver a better service and try to reduce these inequalities – I found this truly inspiring.

Not with a touch of envy I was delighted to see how important (and useful) it is to have primary care departments at a university level, which is nowadays as rare as seeing a unicorn, in Spain (although we're starting to see some unicorns, in Zaragoza, for example) - we sometimes say that primary care must break into the university.

A sense of belonging blossomed within me during the meeting. The warmth shown by everyone I spoked to and the sense of familiarity with which they treated me touched me deeply. I can only thank you all - especially Graham Watt, Patrick O'Donnell, David Blane, Andrea Williamson and Morgen Vestegaard- for supporting me throughout the programme. The bonds that the Deep End can forge are profound.

A week later, on May 22nd-23rd the SIAP Deep End (Primary Care Innovation Seminar on the Deep End)[1] took place, in which 44 people (mainly primary care professionals) from different places in Spain and Portugal were able to share experiences, concerns, and reflections on working in centres located in areas with high levels of deprivation. These perspectives were linked, thanks to Professor Graham Watt's presentation, to the Scottish and international Deep End Projects. A month earlier, a virtual debate on the same topic was held, which more than 100 participants took part.

This journey, however, began a couple of years earlier, at another SIAP in Granada, on the Inverse Care Law, whilst listening to Professor Anita Berlin speak about Deep Ends and the Deep End Project. That made some of the attendees realise that we might be working in a Deep End. How could it be that this wasn't known in Spain? What was being done in Spain to support health centres and professionals working in areas of high deprivation? Was it known which centres were located in these areas? I began to investigate. It was vital to do so. From there, at the SIAP del Futuro 2025, a group of GPs from Vallecas and Barcelona envisaged a SIAP on the Deep End to raise awareness of this reality in Spain and so that other professionals who might be experiencing it could recognise it. Perhaps it could be the starting point for creating a network of professionals at the Deep End in Spain.

[1] SIAP stands for Seminario de Innovación en Atención Primaria. They were launched in 2005 on the initiative of Juan Gervas and Mercedes Pérez, both GPs, and emerged as a critical and independent forum dedicated to discussing key issues relating to day-to-day practice, clinical work and public health that were often overlooked in the traditional academic curriculum. The aim of these seminars is to share experiences and to generate knowledge. There are between two and four seminars per year, two located in Spain or Portugal and two located in Latin America countries.

Other colleagues from Murcia and Granada also joined this organisation. And, of course, we had a beautiful logo inspired by a swimming pool.

Eight months later, the SIAP Deep End event took place at the Parish of St Carlos Borromeo in Entrevía (Madrid). The final venue was chosen out of necessity, not by choice as venue we had initially chosen cancelled at short notice a month before the meeting – though perhaps the parish chose us and by no coincidence, as it is a place of welcome and integration for young people in difficulty, victims of drug abuse, their families, prisoners, migrants and, in general, human beings whom our society excludes.

Attendees at the first Spanish Deep End meeting, Gemma Torrell in the doorway

The programme sought to explore different perspectives: what was known and what could be done at a macro level to identify and improve the funding and support responsibilities of these teams? How was complexity identified? Here we present the Catalan experience, which utilises a territorial socio-economic index based on census data to help to determine funding for each health centre and has helped to adjust the number of patients assigned to each GP and nurse working in the most deprived areas. We also share the successful organizational approaches adopted by certain health centres that had already identified themselves as 'Deep End' health centres; the experiences of the neighbourhoods themselves, the 'Deep End' areas and other stakeholders working there (e.g. in education)

and how their work was interconnected; the characteristics of clinical reasoning in a 'Deep End', and how does one's reasonings adapt to the health needs of the population and the health problems they face. And finally, in what ways does working in the 'Deep End' affect professionals, and what forms of care for these professionals might be envisaged. It was a small, intimate gathering, with some people realising they were working at a Deep End (and somehow, relieving themselves of pressure), others broadening their understanding of Deep End issues, and others strengthening their advocacy for their health centres and the people they care for.

I imagine the Deep End Project as a floating buoy in the swimming pool, for both professionals and patients, who weather the onslaught of the waves whilst this undercurrent of inequality remains unresolved – with the difference, as a colleague in the organisation puts it, that we, the professionals, are only in the deep end for a few hours, whereas our patients spend, in many cases, a whole lifetime there.

The day after the meeting, we had already received an email from Graham Watt asking us, 'What's next?'. And that's what we're up to. For now, we're gathering feedback and comments to compile a report reflecting everything that was shared, and we hope that, whether at a local, regional or national level, we can soon join all of you in the Deep End project, knowing that it is not a destination but a journey – one that we in Spain – hopefully- have already begun to embark upon.

However, as you know, in Spain, responsibility for healthcare has been devolved to the various autonomous communities (17 in total), which means that we have 17 health services across the country, some with better data collection practices, whilst others have significant shortcomings in this area – to give just one example of the disparities that exist alongside the political ones. Launching Deep End in Spain may take some time, as it will be to find a logo that suits everyone. It might be easier to launch local Deep End initiatives in each autonomous community.

Thanks to everyone who has made the Deep End Project possible all over the world; you have been, and continue to be, a source of inspiration for us. We look forward to being part of this movement soon.

Gemma Torrell

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DEEP END IRELAND INTERNATIONAL CONFERENCE, DUBLIN

The Deep End Ireland International Conference, held on the 15th and 16th of May 2026 at Trinity College Dublin, brought together colleagues from across the international Deep End network alongside policymakers, patients, and practitioners working at the coalface of health equity in general practice in Ireland. We are deeply grateful to all who contributed - as speakers, panellists, workshop facilitators, and delegates. Most of the presentations are available to view on our website at deepend.ie.

Dr Mike Ryan, giving the opening address

The conference opened with a keynote address from Dr Mike Ryan, former deputy director general of the WHO, whose words set the tone for everything that followed. He challenged us to confront the uncomfortable reality that as a society we continue to resource healthcare not on the basis of need, but on the basis of influence. If we are serious about improving health outcomes, he argued, we must be equally serious about addressing the social determinants of health. He pointed out that the most vulnerable patients actually need excellent care, not just 'good enough' care. He asked whether governments are prepared

to measure success in healthcare not by how many patients are seen in a day, but by how well we are managing equity. He reminded us that our work matters profoundly, including economically and socially, and he left us with a rallying call: we need to resist the temptation to normalise injustice.

David Blane

Dr David Blane from Deep End Scotland spoke next about the origins of the Deep End movement and the activities of Deep End Scotland since 2009, including workforce improvements such as the Link Worker Programme, education at undergraduate, postgraduate, and lifelong learning level, advocacy, and an extensive body of research. He highlighted that while health inequalities have high visibility in policy, there remains a significant implementation gap – a common thread that seemed to run across Deep End groups internationally throughout the conference.

Mogens Vestergaard

Professor Mogens Vestergaard then offered some grounds for hope, drawing on developments in Denmark. He described a health reform currently underway there, shifting focus from hospital-centred care towards stronger primary care and the allocation of resources according to need. The number of GPs nationally is set to rise from 2,600 to 5,000, supporting a transition of resources from hospitals to primary care. He spoke of huge enthusiasm for change in Denmark, noting that the Prime Minister, in her 2026 New Year's address, said: "Allow me to share a striking paradox: there are fewer doctors in places where there are more sick people. It's time to do something about it!"

Professor Susan Smith and Dr Bríd Shanahan presented on the Irish context and the Deep End experience here. They outlined the structure of general practice in Ireland - a mixed public-private system in which GP care is not universally free at the point of use, with approximately 42% of the population covered by a medical card entitling them to free GP care, while the remainder pay out of pocket. This medical card system uses a capitation model based on age and gender but contains no weighting for social deprivation. The Social Deprivation Grant was a small, deprivation-targeted supplement introduced in 2020 to fund additional services such as link workers and extended consultations in GP. Earlier this year the maximum funding per practice list was significantly increased, making it possible to employ additional staff where needed. This is a meaningful step, though mapping challenges and structural limitations remain.

Finally, they also outlined Deep End Ireland's contribution to the current national Strategic Review of General Practice - a government-commissioned process examining the future of GP care in Ireland. The submission called for deprivation-weighted capitation funding, infrastructure supports for practices in deprived areas, expanded multidisciplinary team roles including link workers and focused care workers, and the establishment of a Primary Care Health Equity Working Group with representation from frontline services and patients living in areas of deprivation.

The contributions from the Deep End Ireland Patient and Public Involvement (PPI) group were among the most memorable of the conference. One member of the group, Nasra, described her experience of social prescribing with a clarity that stopped the room. She spoke about how connection, routine, confidence, and a sense of belonging are not luxuries but foundations and how the social prescribing service had helped her build these. She reflected that the greatest barrier is often not illness itself but disconnection, and that as a newly arrived migrant she had sometimes felt as though she were out at sea. She then explained that one consultation, one referral, one person listening, had the power to bring a person back to shore.

The theme of participation continued with a keynote lecture from Prof Caroline Mitchell showing how participatory approaches led to more relevant research in the Deep End. There is no health equity, she argued, without research equity.

Professor Graham Watt chaired a session giving international updates. A number of our international colleagues who could not join us in person sent video updates (Canada, Japan, Australia, Bristol, London, East of England) which are also available on our website. We were very grateful to have in person updates from Deep End Cymru, Plymouth, Cornwall and North East and North Cumbria.

Dr Eoin Monahan, a Deep End GP and musician, provided a musical interlude with a piece he wrote that was inspired by his Deep End colleagues and patients. I encourage you to listen to this via the link on our website.

Professor Andrea Williamson closed the Friday sessions presenting her research on the importance of missingness as a risk factor for adverse outcomes including premature mortality but also importantly the development of interventions to address risk in this vulnerable population.

Our own Anna Beug opened Saturday with a keynote based on the article she published in BJGP Life - "Making Mosaics" (https://bjgplife.com/making-mosaics/). She uses the analogy of making mosaics to describe the act of listening by the same doctor, in tiny pieces over long periods of time and spoke about the particular power of general practice to do this kind of listening.

There were many workshops over the weekend, most of which are available on the website, including sessions on training GPs at the Deep End, addiction recovery, management of children at risk, moral injury, use of interpreters, trauma informed care, research and audit and women's health at the Deep End.

The importance of finding your tribe was mentioned a few times over the conference – we are very fortunate to have our international Deep End tribe to look to for inspiration and support. We look forward to the next International Deep End conference!

Bríd Shanahan

SCOTTISH DEEP END / QNIS CONFERENCE, GLASGOW

On Friday 6th February 2026, the Scottish Deep End project and the Queens Nursing Institute Scotland (QNIS) delivered a one-day, in-person conference titled *'The essential role of GPs and GPNs in tackling health inequalities'*. The focus of the day was to recognise and celebrate the vital role that generalist training plays in improving health equity in Scotland – and the challenges that practitioners currently face.

Conference focus

In systems under stress, we can often become driven by professional protectionism, isolation, and uncertainty about the future. This conference celebrated how we can collaborate and learn from each other, and support each other to improve our working lives, the cohesiveness of our teams, and the care we provide.

Co-designed and delivered by the Scottish Deep End Project and QNIS, with a focus on the roles of GPs and GPNs, the themes of the conference focussed on:

- understanding the causes and consequences of 'missingness' in healthcare and how applying a 'missingness lens' can address health equity;
- how we deliver appropriate, tailored, and evidence-based 'lifestyle advice' to support health behaviour change for marginalised groups;
- how relational approaches support the care of patients experiencing suicidality;
- the importance of long-term personalised continuity of care in improving patient outcomes.

Workshops in the morning included: GP nurses' involvement in the Inclusion Health Action in General Practice (IHAGP) initiative, the impact of multimorbidity at the Deep End, and recognising and responding to Gender-Based Violence (GBV) and domestic abuse within general practice. Afternoon workshops covered: the importance of relational continuity of care, exploring substance dependence and recovery through comics and dialogue, and practical approaches to reduce health inequalities related to language and cultural differences.

Carey Lunan, Chair of the Scottish Deep End Project and a conference session

The event was fully booked, and participants paid a small fee to enable a social event at the Pearce Institute in Govan afterwards, important for building the kinds of relationships that strengthen multiprofessional working.

A report summarising the key messages from the plenary sessions and workshops is available online here. The evaluation report (feedback from delegates) for the conference can be accessed here.

We would like to thank RCGP Scotland colleagues for fantastic administrative support, the venue (Civic House), our caterers (Soul Food Sisters), and all who attended and participated.

David Blane

MEDICINE ON THE MARGINS CONFERENCE IN DUBLIN, 30TH JANUARY 2026
Health Equity Focused Training. The Impact of Poverty

Austin O'Carroll, introducing the Conference

This was the third Medicine on the Margins Conference, convened and chaired by Austin O'Carroll and bringing together GP trainees and Fellows – about 150 in total, two thirds from Ireland and a third from the UK. Speakers and workshops were chosen to show :-

- How poverty creates the conditions for childhood trauma, and how that trauma shapes later health and life outcomes
- The political drivers of poverty and why GPs must understand them

- The ways in which poverty generates marginalization across the life course

  Alongside clinical and policy discussion, the conference explored poverty through the arts—with a photographic exercise examining the built environment, and a spoken-word session drawing on working-class voices to express life in deprivation - because patients in the Deep End need doctors who are trained to understand their lives.

  Unusually there were presentations by two brothers, Brian Kirwan, Social Inclusion Lead at HSE, and Emmet Kirwan, a poet activist – a fascinating example of how "Nature spreads its bets". Senator Lynee Ruane described the political dimension in Ireland, while Sharon Lambert gave vivid descriptions not only of how childhood trauma can shape the future, but also how health professionals can engage in order to make a difference.

  Workshops included sessions on Theatre of the Oppressed, Drug Addiction, Homelessness, Sex Working, Prison Health, Migrant Health, Narrative-Based Medicine and Spoken Word Poetry. Throughout there were transferable lessons on how experience and learning from Medicine on the Margins can inform health practitioners working in mainstream health care.

  It was a privilege to be invited to give some closing remarks, as repeated below

  Closing Remarks

  Just as Lenin echoed Tolstoy and Tolstoy echoed Luke Chapter 3, verses 10-14, the question we need to ask is *"What needs to be done?"*

  As Edmund Burke probably didn't say, *"All that's needed for evil to triumph is for good men to do nothing"*.

  Doing nothing is not a good option. It encourages bullies to continue bullying. As Desmond Tutu said, in situations of oppression, it sides with the oppressor. And generally, doing nothing supports the status quo, the current establishment, how power and resource are distributed, to the satisfaction of those who currently hold power and resource.

  But what to do? As Sydney Smith said, *"it is the greatest mistake to do nothing because you can only do a little. Do what you can."*

  Advocacy is not only what you say. It's also what you do, and keep doing, not taking No for an answer, refusing to be discouraged, outlasting the opposition, persistence being key.

Speaking out has its place but on its own is usually ineffective. There is a risk of hubris. As a character says in Andrew O'Hagan's novel Caledonian Road*, "it's immoral to delude yourself that you are doing good when what you are doing is making yourself feel good."*

William Blake said – *"He who would do good to another must do so in Minute Particulars; the Common Good is the plea of the scoundrel, hypocrite and flatterer."*

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

The first level of action, which almost everyone has the power to do, involves encounters with individual patients.

In a study of 3000 general practice consultations in Scotland, Stewart Mercer showed that while patients might report empathy in practitioners they have just seen, without being enabled, they never reported enablement without also reporting empathy - whether the practitioner listened, remembered, cared, tuned in.

As Oscar Wilde said, "*the smallest act of kindness*".

Most of the other things that individuals can do involve working with others, organising their work within teams to best effect, and looking outwards to engage and work more effectively with other professionals and services in their local community.

In Scotland, we are 16 years into the Deep End Project, beginning with a conference inviting practitioners from the 100 most deprived communities in Scotland, the first time they had ever been convened or consulted. The seating plan was a circle with everyone in the front row. The atmosphere was immediately positive.

Now there are 20 Deep End Projects in 8 countries on 4 continents. Some are national, like Scotland, Ireland, Denmark and Canada; others are regional like many in England, while some are small and local, like Cornwall, Frankston near Melbourne in Australia, and Kawasaki/Yokohama in Japan; but they are all the same, working on the margins of mainstream health care in advanced economies, practitioners confident and determined they can make a difference. We didn't realise, back in 2009, the fuse we were igniting

The Deep End International Bulletin, which I have the privilege of editing, now in its 15th edition, reports activity within each of the Projects, covering Workforce, Education, Advocacy and Research. It is a Learning Organisation, sharing experience, views, activities, successes and failures, and giving voice not only to Deep End Practitioners but also the communities they represent.

Building a compendium of patient stories; building strong local health systems; building networks of local health systems

Socrates advised*, "A wise man learns from experience, but a wiser man learns from the experience of others".*

Such as the experience of the late Julian Tudor Hart, whose personal example has inspired many : living and working in, with and for a local community; staying long enough to make a difference; initially face to face, gradually shifting to side by side; the last person as important as the first; measuring omission – what he hadn't done – as the key to population care; epidemiology his map and science his compass.

He was fond of quoting the Ballad of Joe Hill, an early trade unionist in the United States, murdered for his activism.

I dreamed I saw Joe Hill last night
Alive as you or me
Says I, but Joe, you're ten years dead
I never died said he
I never died said he.

And standing there as big as life
And smiling with his eyes,
Says Joe what they forgot
To kill, went on to organise,
Went on to organise

As Astra Taylor and Leah-Hunt-Hendrix, say in their book, *"Solidarity: The Past, Present and Future of a World-Changing Idea"*

Organising is a kind of alchemy:
It turns alienation into connection,
Despair into dedication,
And oppression into strength - the strength of numbers

Margaret Mead, the American anthropologist said*, "Never doubt that a small group of committed individuals can change the world; indeed, it is the only thing that ever has".* If not changing the world, then certainly their part of the world and their role within it.

John Berger wrote,

"In the dark age in which we are living
And the new world order,
The sharing of pain is one of the essential preconditions
For a re-finding of dignity and hope.

Much pain is unshareable
But the will to share pain is shareable
And from that inevitably inadequate sharing comes a resistance"

Gramsci wrote in prison, *"The Old World is dying and the New World struggles to be born. Now is a time of Monsters".*

By excluding exclusions, and building relationships, inclusive health care is a civilising force in this increasingly dangerous, fragmented and uncertain world.

Finally, from Robert Louis Stevenson, *"Do not judge each day by the harvest you reap, but by the seeds that you plant."*

Planting the future you want. No one will do it for you.

Graham Watt

POLITICAL MOMENTUM AND THE CHALLENGE OF IMPLEMENTATION

Deep End Denmark has entered 2026 with a strong sense of momentum. In her New Year's address, the Danish Prime Minister, Mette Frederiksen, gave a clear political voice to the inverse care law:

"For many years, there have been fewest doctors in the parts of Denmark where there are most sick people. It should be the other way around. And we are going to change that."

For Deep End Denmark, this was an important moment. The inverse care law is no longer only a professional concern raised by general practitioners working in areas of high need. It has become part of the national political language. The Prime Minister also acknowledged that inequality has grown too much, and that her government wants to reduce it. This creates both an opportunity and an obligation to turn political words into practical change.

Denmark has since had a general election and, after historically long negotiations, a new government has been formed. Mette Frederiksen continues as Prime Minister, now with

parliamentary support that is more clearly to the centre left. From a health equity perspective, this may create a favourable political environment.

The new Minister for Health and Church Affairs is Ida Auken. She is an experienced and respected politician, trained as a theologian, and known for a strong commitment to people in vulnerable positions. Her appointment may be interpreted as a signal that the government wants to give the health sector political stability while major reforms are implemented. At the same time, she does not have extensive experience in health policy, and the coming years will show whether this becomes a limitation or an advantage.

The key issue now is implementation. Denmark is already in the process of major reforms in healthcare, psychiatry and cancer care. From a Deep End perspective, the central question is whether the ambition to allocate resources according to need will be translated into everyday reality in general practice.

This is especially important in the ongoing negotiations on a new remuneration structure for Danish general practice. The current payment system does not sufficiently reflect social complexity, multimorbidity, mental illness, language barriers, low health literacy or the additional time needed to build trust with patients living under difficult circumstances. If the reform is to reduce the inverse care law, practices with many complex patients must be able to provide high quality care with smaller patient lists and still remain financially sustainable.

The negotiations are complex and time is short. The new agreement must be implemented in January 2027 and must be approved by Danish general practitioners before it can take effect. This creates a political risk. If differentiated remuneration is perceived as a loss by GPs with fewer complex patients, necessary change may be obstructed. Deep End Denmark therefore has an important advocacy role in the coming months. We must show that fairer allocation of resources is not a privilege for some practices, but a necessary correction of a structural imbalance that harms patients and weakens the whole health system.

At the same time, the Deep End Denmark network itself is growing. Led by Nynne Bech Utoft, we have recently invited more Danish GPs to join. All practices in Denmark have been assigned a score using the Danish Deprivation Score, based on register data from Statistics Denmark on patients' education, income, employment, ethnicity and place of residence. We have invited practices with the highest proportion of patients with limited socioeconomic resources.

The response has been highly encouraging. In the first week alone, 24 GPs joined the network. Deep End Denmark now includes 104 GPs. We see this as a major success and

as evidence that the network has become both an important professional community and an increasingly recognised voice in the national debate.

Research is also becoming an increasingly important part of Deep End Denmark. A research programme has been developed to support the network with stronger evidence on how social complexity is distributed across general practice, how it affects clinical work, and which organisational and policy responses may help reduce inequity. This includes register-based analyses of patient populations and practice characteristics, qualitative studies of effective strategies to mitigate inequities in everyday work in Deep End practices, and evaluation of emerging initiatives in Danish general practice, such as social prescribing. The ambition is not only to document the problem, but also to generate knowledge that can be used for education and for the development of more equitable models of Danish general practice.

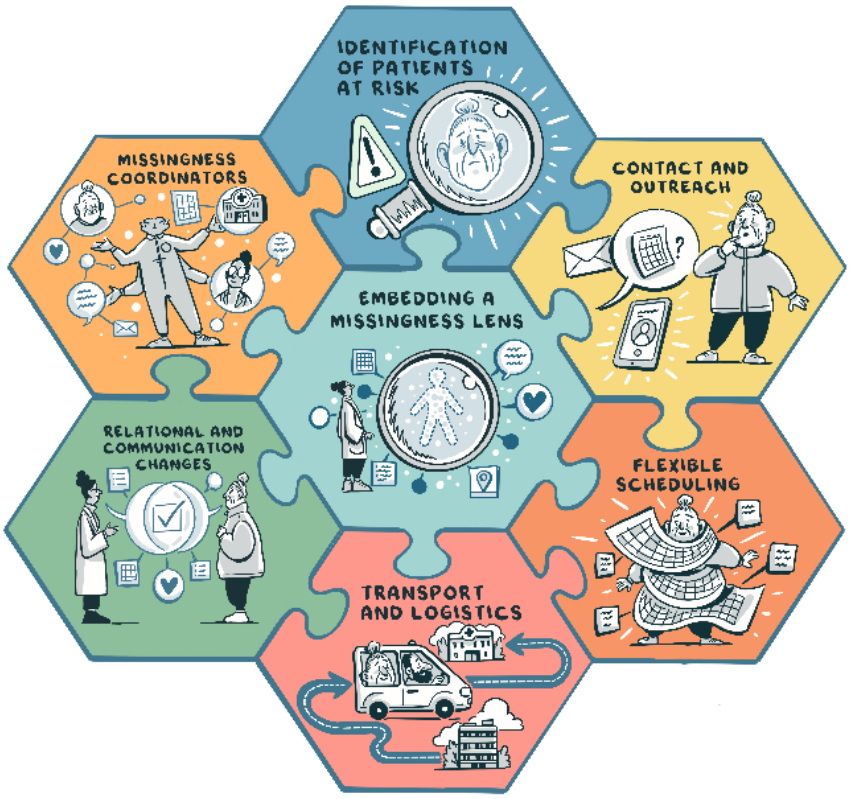
The coming year will be decisive. If health systems are serious about reducing inequality, this requires more than powerful words. It requires the courage to prioritise resources according to need, to invest in relational and continuous care, and to recognise complexity as a central condition of modern medicine. Denmark may be closer than ever to turning the inverse care law from a well known principle into a practical policy challenge that can be acted upon. Deep End Denmark will work to make sure that this opportunity is not lost.

Mogens Vestergaard

STOP PRESS

Mogens Vestergaard confirms that the next Deep End International Conference will be held in Denmark in2028

MISSINGNESS IN HEALTHCARE AND THE POWER OF COLLECTIVE ACTION



I've been amazed and delighted by the influence so far that this work inspired by Deep End Scotland has had on individual practitioners, health policy colleagues and the research community. Addressing missingness is part of Scottish health policy for the next 10 years, has been an important part of Inclusion Health Action in GP funding which is set to continue, at UK level is a key part of the Royal College of GPs Fairer Practice Toolkit and has influenced change in individual practices and regional initiatives across the UK and Ireland.

There have been important ingredients to that success:

- tackling an issue that is important to practitioners - though relatively invisible to many when we started out, supported by the Deep End
- achieving research rigour - so big numbers in the epidemiological work, theoretical depth in the qualitative work - which means being ambitious and being sure to convene research expertise in the team

- ensuring people who are experts by experience are involved in the research and evident in what is produced
- Providing short, accessible formats of the key messages - illustrations, short format films, that are easy to access and use

However overwhelmingly it has been the collective action of Deep End colleagues that have ensured current progress. I and the team have been invited to give over 60 presentations or workshops with audiences as diverse as a Deep End practice in Govan Glasgow and the British HIV Association because colleagues have enthused about the work and connected us. We have had more conversations with policy and commissioning colleagues than we can count for the same reason. It has been the championing of the work across the policy and practice world in the many roles we have as Deep End GPs, with clarity and persistence that is meaning that the concept of missingness is being understood and taken seriously within public health and healthcare.

Of course, there is still lots to do - not least being able to meet the challenge made by Chris Whitty (England's Chief Medical Officer) to evidence the cost effectiveness of our approach, which may then influence further uptake. However, I remain optimistic and committed (rather than overwhelmed) because of the collective action of our amazing Deep End community! Thank you!

Andrea Williamson

Ten out of ten for the Deep End Manifesto! Everything depends on leaders at practice level, demanding media attention, gaining public support, and insisting on material resourcing from governments, in return for which they can guarantee immensely greater efficiency of care generated by people who know each other.

Julian Tudor Hart

Deep End Research Alliance at 10: Delivering a National Alliance for Inclusive Primary Care Research

Communities, primary care practitioners and all stage career clinical academics working together at the Deep End

In 2026, we mark ten years of the Deep End Research Alliance (DERA), established in 2016 through the development of a Deep End PPI group and an NIHR-supported Deep End Research Delivery Network in South Yorkshire: the first of its kind in the UK. Co-founded by Liz Walton, Ben Jackson, Caroline Mitchell, and Brigitte Delaney, and supported by a dynamic board of early and mid-career academics at the University of Sheffield, DERA was created to complement and extend the WEAR (Workforce, Education, Advocacy, Research) model across Yorkshire and the Humber and internationally.

Over the past five years, this work, co-led by Caroline Mitchell and Kate Fryer at the University of Sheffield, with Kate Fryer now leading (CM now at Keele University) has significantly strengthened and expanded partnerships between communities, frontline practitioners, and academic primary care to co-design and deliver more inclusive research. Building on established Deep End and NIHR-linked networks, we have enabled meaningful involvement of underserved communities and practitioners in shaping research priorities, study design, and delivery. This has included sustained co-production with community partners, increased engagement of general practices in research activity, and the development of scalable models to support inclusive participation through our Community

Research Link Worker training and research delivery programme and research active community organisations

-https://www.sacmha.org.uk/wp-content/uploads/2024/03/Shirleys-bio.pdf and https://sites.google.com/sheffield.ac.uk/dera/research-within-communities/community-researcher-toolkit?authuser=1

Two major highlights from the past 12 months illustrate this progress. First, NIHR has formally recognised the importance of Deep End approaches within its latest Research Delivery Strategy, endorsing the development of Deep End research networks across England to replicate our model of engaging underserved communities in research - communities who experience the highest burden of ill health and poorest outcomes (4a- 'More support for Deep End practices and an increase in practices considered to be 'Deep End' classified as research-ready'; https://rdn.nihr.ac.uk/documents/nihr-rdn-5-year-strategic-plan). CM now sits on the national Deep End and inclusive research strategy group as an advisor.

Second, our 2025 NIHR-supported Deep End and Inclusive Primary Care Research Conference brought together over 200 delegates, including community members, patients, frontline practitioners, and research leaders from across the UK, to share best practice and shape the future of inclusive primary care research across the four nations. Our National report has been shared by the NIHR https://docs.google.com/document/d/19MjsMdXx6c-7CVtTxj8fPj1JgmLh3_eZ7PGnia7EdOo/edit?usp=sharing

While funding and delivery constraints outside England remain a significant challenge for colleagues in Scotland, Wales, and Northern Ireland, we have developed shared principles through a tripartite collaborative model - uniting communities and patients, frontline practitioners, and academic primary care to co-create relevant and impactful research. This model is increasingly informing how research is prioritised and funded, and we are actively sharing this practical intelligence to accelerate change. There can be no health equity without research equity: building an inclusive evidence base is essential to improving care and delivering the ambitions of the NHS 10-Year Plan.

The programme has also built capacity across sectors - supporting practitioners, community organisations, and early career researchers to taken leadership roles - while strengthening the translation of research into practice through close collaboration with local health systems. Collectively, these achievements represent a significant step towards more equitable, practice-relevant, and community-informed primary care research.

Caroline Mitchell

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

PRIMARY HEALTH CARE AT THE DEEP END CANADA REPORT – JUNE 2026

Primary Health Care at the Deep End Canada has now grown to approximately 10 organizations and 5 patient partners representing over 30 clinics from 7 provinces out of 13 provinces and territories. We host network meetings quarterly, provide individual support to clinics in one-on-one meetings, and provide over 30 resources on social determinants of health data collection and support projects that empower health equity.

What have we done recently?

We have built an internal portal within our website for members to access information about the network including training materials on advocacy, a resource bank on social determinants of health and profiles of our members and patient advisors.

Deep End Canada has recently hosted separate meetings for each region and one for researchers specifically. The regional meetings include Western Canada, Ontario and Quebec, and Atlantic Canada, creating spaces for members to engage in discussions grounded in local contexts. These groups provide opportunities to connect with nearby clinics, share experiences with social determinants of health data collection tools, and discuss region-specific challenges and solutions.

Clinic Spotlight (Montréal, Québec):

GMF-U des Montérégiennes / University Family Medicine Group of the Montérégiennes

The relocation of our recently established University-affiliated family medicine clinic to a new site with limited public transportation access brought an important issue to the fore: our patients facing the greatest social and economic challenges were also those finding it hardest to access care. We observed that these patients were less likely to attend follow-up appointments, highlighting the social determinants affecting our patient population.

These experiences prompted our involvement in the Deep End Canada network and the SPARK project. Building on the implementation work conducted across several provinces in Canada, we are exploring how SPARK can be integrated in the Quebec primary care setting. With Health Excellence Canada funding to integrate patient engagement into the project, we are building partnerships with patients and exploring ways to build links with community resources. Our involvement in the Deep End Canada Network has defined and shaped this work by connecting us with colleagues across the country facing similar challenges and pursuing approaches to addressing health inequities in primary care. We look forward to continuing to learn from and contribute to this growing community of practice as the project develops.

Event Spotlight

We held an event on February 9, 2026, entitled, Deep End Canada Learning Series: Governance of demographic and social needs data. We heard from a panel of family physicians and members of the Health Equity Questionnaire Data Working Group at the

St. Michael's Hospital Academic Family Health Team in Toronto. The panel, moderated by Dr. Archna Gupta, featured Dr. Noor Ramji, Nassim Vahidi-Williams, and Talia Levitt, who discussed their work collecting and using sociodemographic data in primary care and their research on data governance in primary care settings.

What are our goals for the rest of 2026?

Our goals for the remainder of 2026 and beyond are to continue growing the network, engage organizations that can provide operational funding and resources, and support clinicians and patients in advocating for improvements in primary care and health equity.

Shankavi Nandakumar and Joseph O'Rourke, Upstream Lab, St Michael's Hospital, Unity Health Toronto; Nadia Rebecca Llanwarne, GMF-U des Montérégiennes, Santé Québec Montérégie-Est

General Practice at the Deep End, Cornwall

Deep End Cornwall continues to grow and develop. This year has seen funding for a clinical lead role under Cornwall Training Hub which has enabled greater integration and reach of the work.

Health Inequalities Symposium

Now in its third year, this event brings together people working across the system to mitigate health inequalities; colleagues from public health, GP training, the medical school,

charities as well as commissioners. We have had wonderful speakers from our Deep End tribe join us through the years and has resulted in increasing recognition of the issues of practicing in the Deep End resulting in specific funding and better collaboration across the system. This year did not disappoint, and we were thrilled to be joined by Beth Winn from Deep End Bristol and Ben Jackson from Sheffield who delivered an interactive session on the FAIRSTEPS framework.

Here's a selection of the feedback received for the event:

'I loved the inspiration and the collaborative energy'

'It helped me remember what really matters in general practice'

'Experiencing a feeling of hope - so many incredible people striving to make the world better'

'It was great collaborating to share ideas. Our work can be isolating at times, but by working together we can do more.'

This year we were also able to host a Health Inequalities training day for GP trainees utilising many of the same speakers. This was a real highlight with incredible energy and certainly left me feeling excited about this cohort of GP trainees taking on roles in areas of deprivation in the future.

Health Inequalities Fellowships

One of the benefits of the symposium has been the way in which it has activated clinicians across the county and some of those clinicians have joined our health inequalities fellowship scheme, which is in its second year.

The remit of the projects has been wide; from implementing a microteams model in a large practice improving continuity of care, to providing wraparound care for those receiving mounjaro for obesity.

Another fellow has looked at families living in temporary accommodation. In Cornwall housing is a huge issue and as a result we have among the highest rates of families living in temporary accommodation nationally. One of the fellows is currently utilising her fellowship looking at how we better identify these families and assess their health needs. She has been working with Shared Health in Manchester where they have run a 'safe' protocol pilot scheme whereby Local authorities notify the schools and GPs of children that have been placed into temporary accommodation and then relevant services are equipped

to appropriately support children and their families when they become homeless. She is working closely with the Local Authority and Public Health to bring this to Cornwall.

We also have a fellow working on food inequity and health in children and young people. Focusing on the increased dietary exposure to ultra processed food in areas of deprivation. She has developed and piloted a school-based intervention that improves food and microbiome literacy collaborating with Sustainable Food Cornwall's "Youth Food Forum" a multi-school student engagement group and the school has invested in a polytunnel.

Deep End International Conference

It was a huge pleasure to represent and present on behalf of Deep End Cornwall at the recent Deep End International Conference in Dublin. Such an inspiring and informative event.

Fond farewells

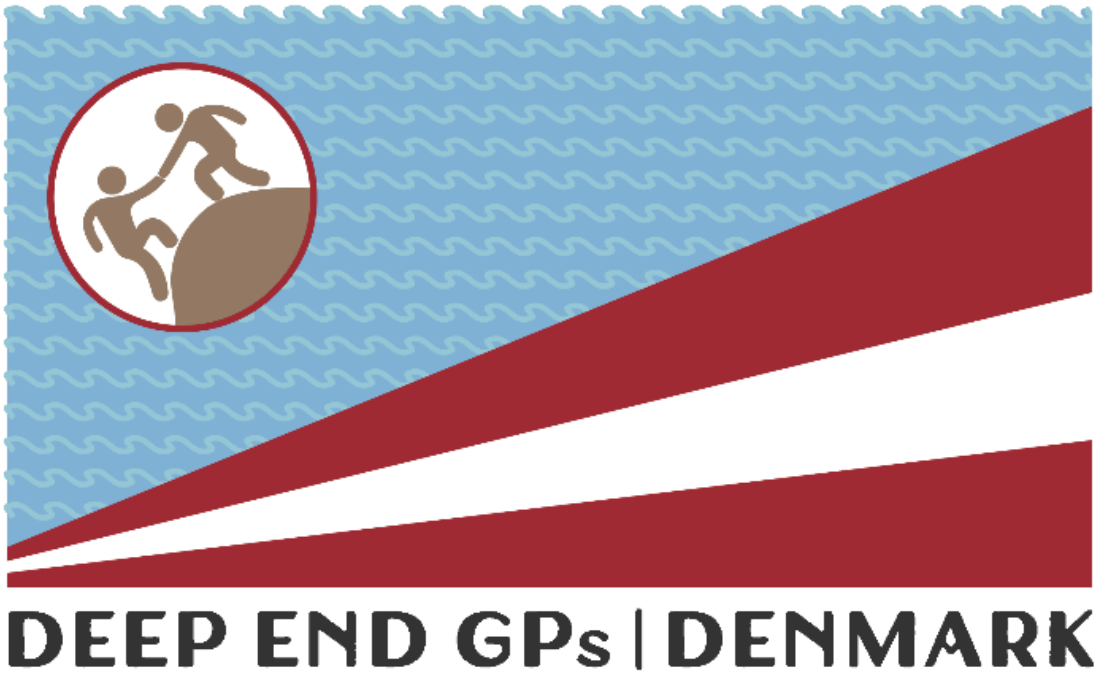
It is with great sadness that we say our farewells to Judit Konya as she relocates away from Cornwall. Judit established Deep End Cornwall in 2022 and has been a driving force in all that is has achieved. Though she leaves our Cornish shores she certainly leaves a significant legacy and we wish her well in all her new endeavours!

Ruth Gilbert

No one is a stranger; they are not only patients but fellow citizens. From many direct and indirect contacts, in schools, shops and gossip, I have come to understand how ignorant I would be if I knew them only as a doctor seeing them when they were ill.

With great effort any doctor can get to know all his patients., even in a city with a high migrant turnover. Only then can he learn to think of a responsibility, not only to the patient siting in the surgery, but to the whole population for whose care he is paid and for whose health he is responsible. He can then see his role as the ultimate custodian of the public health on a defined section of a world front against misery and disease.

Julian Tudor Hart



Deep End Denmark Invites GP Trainees

For a long time, Deep End Denmark has wanted to involve GP trainees in our national meetings. The idea became a reality when funding became available through a national initiative aimed at recruiting and retaining GPs in underserved areas. Based on GP trainees' perspectives on the future of general practice, I developed a proposal for a national congress, which fortunately received funding.

I had the overall responsibility for planning the congress, working closely with a steering group consisting of both Deep End GPs and GP trainees. The trainees' contributions were essential in ensuring that the programme was relevant and engaging. The project was developed in collaboration with researchers, and the Danish Organization of General Practitioners. Planning the congress was a multifaceted process and gave my professional life additional meaning along the way.

The aim of the congress was to give GP trainees insight into life and work in Deep End practices and to highlight the opportunities and job satisfaction that many Deep End GPs experience. At the same time, we wanted to strengthen networking, inspire professional development, and spark interest in working in areas with significant social and health challenges.

The Congress

The congress was held in May 2026 and brought together 30 GP trainees, and it took place alongside the national Deep End Denmark meeting. The number of trainees was carefully matched to the expected number of participating Deep End GPs to create the best possible conditions for networking and dialogue. The congress lasted one and a half days and combined trainee-only sessions with joint sessions involving both trainees and experienced Deep End GPs.

Congress Programme, Friday

Arrival and introduction to the Deep End

Deep Dive into the Deep End. What is it?

What makes my practice a Deep End practice?

Formulating Questions for Speed-dating

Joint Welcome Session

Presentations on Deep End Initiatives

Speed-dating between GP trainees and Deep End GPs

Saturday

Joint morning singing and start of the day

Managing Complex Multimorbidity in General Practice

Presentation on Heath Inequalities

Building Deep End Networks among GP trainees

The first day began with an introduction to Deep End. I used the illustration of a tree bending in the wind, symbolising the remarkable adaptability required of Deep End GPs. It also conveys an important message: the need for constant adaptation is reduced when we build communities and support one another. The GP trainees then introduced themselves to one another, allowing participants to get to know each other and giving the facilitators insight into their training experiences and motivations for attending. The session highlighted that Deep End practices vary considerably in their organisation and local context, yet all share a common feature: a high concentration of patients facing social disadvantage.

Several themes emerged throughout the congress, reflecting both the realities of working in Deep End practices and the aspirations of the next generation of GPs. The first theme centred on the question: What makes my practice a Deep End practice? The discussions revealed a shared understanding that Deep End patients rarely fit into predefined categories. Many face socioeconomic challenges, struggle to navigate public services, and require more time, continuity of care, and individually tailored solutions than standard healthcare pathways.

Another central theme was networking. All participants took part in a speed-networking session, where GP trainees met experienced Deep End GPs and exchanged experiences and reflections on working in Deep End practices. The session was followed by a shared dinner and lively conversations about life as a GP caring for socially vulnerable patients.

Finally, a session on complex multimorbidity focused on one of the challenges of working in Deep End practices. GP trainees took part in a role-play exercise centred on a Deep End patient with multimorbidity. A Deep End practice also presented how they organise care for patients with multimorbidity, including the use of goal-oriented care to tailor efforts according to patients' individual needs.

Impact of the Congress

To assess whether the congress influenced GP trainees' understanding of and interest in Deep End practice, we conducted a questionnaire survey before and after the event.
After the congress, participants reported greater knowledge of Deep End practice, as well as increased inspiration and motivation to work there. The largest change was seen in participants' sense of having a professional network within Deep End. While many reported only a limited sense of such a network before the congress, a majority afterwards reported feeling, to a high or very high degree, part of a professional community. These findings suggest that the congress not only increased knowledge and engagement but also fostered new connections among GP trainees interested in working in Deep End practices.

A Congress That Inspires Hope

The congress strengthened our hope that more young GPs will actively choose to work in Deep End practices. At the same time, it offers an important source of optimism for current Deep End GPs, as the care of the most vulnerable patients may in future be shared by a growing number of committed colleagues.

The engagement shown by the GP trainees, their awareness to share responsibility and workload, and their ideas for organising practice give reason to hope that care for the most vulnerable patients can continue to improve in the years ahead. At the end of the congress, participants were asked to describe their experience in a few words. The responses repeatedly included: curiosity, engagement, gratitude, inspiration, passion, motivation, hope, and perspective.

Anna Rørbæk Uldall, Deep End GP

We need more liberty, more equality, but above all more fraternity; the doctor living and working within a community, sharing as much as he can of the common experience, is better able than any other to discard privilege and stand on two firm legs of earned respect.

Julian Tudor Hart

EAST OF ENGLAND

This past year, we are really pleased that Deep End: EoE has more than 500 people connected across the region. Most of our activity is via weekly WhatsApp - describing papers, CPD, articles and webinars of interest. We are looking forward to our annual **September Symposium on Tuesday 22nd September 1300-1430hrs** and we are focusing on Neighbourhood Health, hearing from the EoE PCN Test Site pilots who will describe the work they have delivered with their **'Neighbourhood' Proactive Care Teams** and the clinical improvements achieved for their patients, as well as the reduction in unscheduled care for their local health economies. Dianne Addei, Health Inequalities Lead for NHSE will be our keynote speaker.

To join us, please use this link

https://teams.microsoft.com/l/meetup-join/19%3ameeting_OTU0NzJlMmUtYjU1Mi00ZmFlLTkzYjktODc1OTdmNzk5ZTA0%40thread.v2/0?context=%7b%22Tid%22%3a%2237c354b2-85b0-47f5-b222-07b48d774ee3%22%2c%22Oid%22%3a%222b634bfe-c0e3-468f-82f4-7f82d7bc91b9%22%7d

Over this past year, we have continued to engage with local Medical Schools and GP training schemes, as well local ICS Training Hubs delivering 'Deep End' topics to AHPs, Nursing colleagues and doctors.

Jessica has also been appointed the NHSE Long Term Conditions Lead for Primary Care and has used that role to encourage a proportionate universalist approach through advising

teams developing the National GP Dashboard and the Model Health System (Federated Data Platform). Hopefully the additional future contextual information (such as deprivation score of the practice etc) will add helpful insights to decision-makers.

We remain hopeful for a partnership with a local higher education institution and have been having exploratory conversations (any offers please email emily.clark2@nhs.net).

We contributed a video to the Deep End Ireland conference with a video about wellbeing. We recognize in the Deep End that psychological recovery at work involves actively replenishing cognitive and emotional resources at work as well as after work. The video covered how people working across the Deep End EoE recover from a day working in general practice at the Deep End, restore themselves, support their colleaugues, enhance their windows of tolerance and ultimately thrive in the long term. Watch here https://www.youtube.com/watch?v=xP8uo-THLaQ

Emily Clark and Jessica Randall-Carrick

Greetings from Emergency Medicine at the Deep End, and we're delighted to share an update from the group as it enters its third year.

As is likely a shared experience of establishing a group, run entirely voluntarily by busy clinicians with competing demands, activity has ebbed and flowed over the past year. Though with each meeting many of us are leaving re-energised by the enthusiasm in the room, and engagement from across the country.

We've settled into a rhythm of thrice-yearly meetings, with sporadic activity from core members between these larger events, which have increasingly drawn interested emergency clinicians from across the country. Recent meetings have focussed on refugee health, high intensity users and mental health in the ED. If anyone is interested in the discussion, summaries have been posted on our website www.ematthedeepend.com.

Dr Marion Campbell and I had the opportunity to showcase the group (and recruit new collaborators) at the Royal College of Emergency Medicine Scottish and UK conferences respectively. At one of these, the sign-up rate to the mailing list managed to crash our website!

On a personal note, in a project that has grown up within and around the Deep End group, I recently completed my MD at the University of Glasgow with a thesis titled *"The relationship between social deprivation, geographic isolation, and emergency, pre-hospital and critical care medicine*"; though in retrospect, it could easily just have been called *"The Inverse Care Law in Emergency Care*", such was the influence of the Deep End movement and Tudor Hart's seminal work. It was a delight to have Dr David Blane convening the viva, examined by Dr David Walsh and Professor Mike Christian, and to be able to acknowledge the Deep End movement as it applies to emergency care (and of course, to see a friendly face in a stressful day).

In summary, the thesis demonstrates that the Inverse Care Law operates in emergency care, just as we know it does in General Practice. We have shown that Emergency Departments in the most deprived areas experience significantly worse waits (and so greater pressures) than those in affluent areas, that the distribution of the high-acuity pre-hospital critical care is inequitable across the UK (with more affluent areas having the highest concentrations of services for dramatically lower need), and that the most deprived are significantly more likely to both require, and die, following, admission to critical care. If you're having trouble getting to sleep, the thesis is available here - https://theses.gla.ac.uk/85875/.

On a final note, publications have continued, most recently in the Emergency Medical Journal, with a piece featuring authors from both the Scottish Deep End movement and the EM at the Deep End group. It demonstrated that the most deprived are more likely to be 'redirected' or turned away from Emergency Departments, despite having higher health needs and poorer access to services. This work, and an extension of the analysis showing that the most deprived were also more likely to return to the ED after being turned away, won the prestigious Rod Little prize, presented by The Princess Royal at the Royal College of Emergency Medicine Annual Conference - the paper is here https://emj.bmj.com/content/early/2026/01/22/emermed-2025-215742.long.

We're on the road for our next meeting, hosted by a group of enthusiastic clinicians in North Tees in October. There are bright things ahead, momentum is growing, and also challenges as we balance the administration of the group with our busy clinical lives. If anyone has a silver bullet for balancing such competing demands, we'd be glad to hear them, so do get in touch!

Ryan McHenry
ryan.mchenry2@nhs.scot

REPORT FROM DEEP END KAWASAKI/YOKOHAMA
EXPANSION OF THE DEEP END CASE CONFERENCE (DECC)

Since its launch in 2025, the Deep End Case Conference (DECC) has continued to expand as a national learning community for professionals committed to caring for socially and economically marginalized populations. What began as a small online gathering following the Japan Primary Care Association conference has evolved into a regular bi-monthly event, attracting participants from across Japan. Clinicians, researchers, social workers, nurses, and public health professionals join online to discuss challenging cases, share experiences, and reflect on the realities of practicing at the “Deep End.”

In March 2026, we hosted a special DECC session featuring Professor Masahiko Kishi, a leading sociologist known for his work exploring poverty, inequality, and everyday life in marginalized communities. His insights stimulated rich interdisciplinary discussions and highlighted the importance of integrating social science perspectives into primary care practice and education.

The DECC also reached a new milestone at the 2026 Annual Conference of the Japan Primary Care Association in Kyoto, where an in-person DECC session attracted more than 70 participants. The session brought together healthcare professionals, researchers, and local government representatives to discuss real-world cases and structural determinants of health. Notably, a senior official from the City of Yokohama participated as a presenter, demonstrating the growing collaboration between healthcare providers and local government. Discussions emphasized that addressing health inequalities requires stronger partnerships between clinical practice, community organizations, and public policy.

As the Deep End movement continues to develop in Japan, we hope that the DECC will serve not only as a forum for case discussion but also as a platform for interdisciplinary collaboration, advocacy, research, and policy development aimed at reducing health inequalities nationwide.

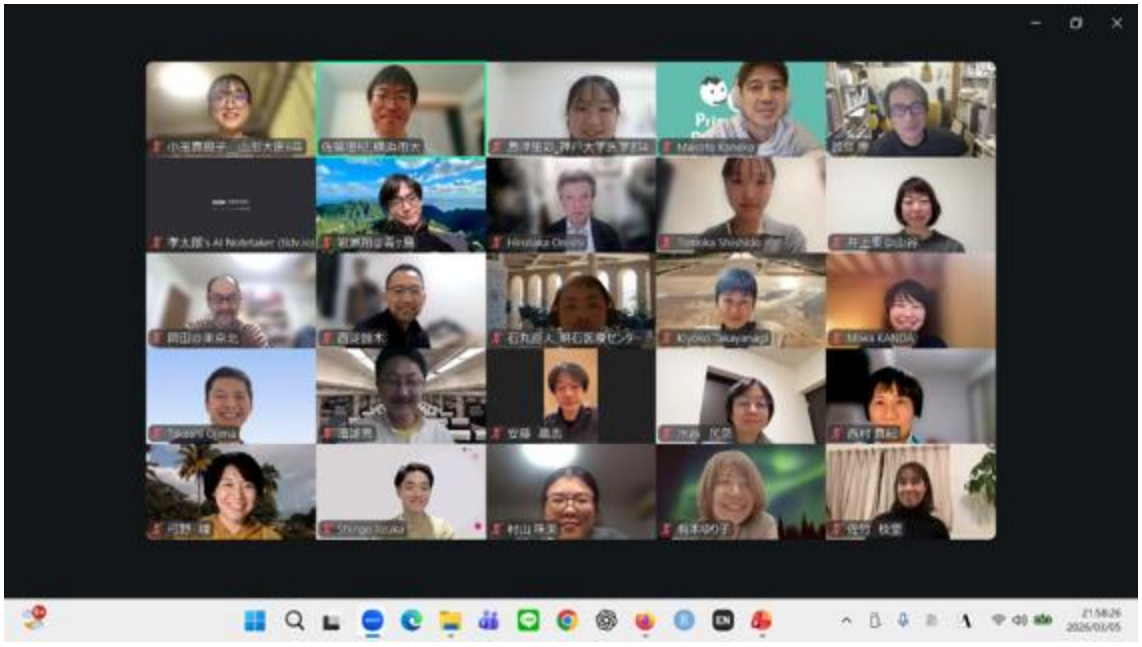


Figure 1. Deep End Case Conference with Masahiko Kishi, a leading sociologist in Japan

Figure 2a and 2b Deep End Case Conference in 17th Annual Conference of the Japan Primary Care Association

I wanted to share an important career update with you. I was recently selected through a competitive chair/professor selection process at Kitasato University. Following this appointment, I began a new position on June 1 as Chair and Professor of the Department of General Medicine at Kitasato University.https://www.kitasato-u.ac.jp/en/

Kitasato University is located in Kanagawa Prefecture, neighbouring Tokyo. Although the department is translated into English as “Department of General Medicine,” in Japan these departments often integrate both general internal medicine and primary care/family medicine. In this role, I am responsible for leading both areas.

I am deeply honoured by this opportunity, and I see this new position as an important step in further developing academic general medicine and primary care in Japan. At the same time, I strongly hope to strengthen collaboration with Deep End project even further, particularly in research, education, and international academic exchange.

Professor Makoto Keneko

Makoto Kaneko
Kitasato University / Deep End Kawasaki-Yokohama

Workforce Voices

Leading research to shape a stronger, fairer future with our health and care staff

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London Deep End Health Equity

GPs at the Deep End
North East North Cumbria

WHAT DOES A "GOOD" WORKFORCE LOOK LIKE IN NEIGHBOURHOOD HEALTH?

LEARNING FROM TWO EVENTS WITH THE LONDON DEEP END HEALTH EQUITY GROUP AND WORKFORCE VOICES PARTNERSHIP, UK.

In Spring 2026, Workforce Voices brought together two groups working at the forefront of health equity: the London Deep End Health Equity Group and regional partners from the Workforce Voices research partnership, including members of the Deep End North East North Cumbria. For many attendees, the London workshop was especially meaningful as

it was the first time the London Deep End Health Equity Group had met in person since the group's formation. Workforce Voices is a National Institute for Health and Care Research (NIHR) Health Services and Delivery Research (HSDR) workforce research partnership co-led by Professor Gill Vance and Dr Bryan Burford (Newcastle University) that brings together universities, healthcare organisations, patients and communities to improve the working lives of National Health Service (NHS) staff and support equitable, high-quality care in the UK.

The events took place against the backdrop of the UK's emerging neighbourhood health agenda, a central feature of current health policy that aims to improve health outcomes and reduce health inequalities through more integrated, community-based care [1]. Facilitated by Professor Sophie Park and Dr Eleanor Hoverd (Nuffield Department of Primary Care Health Sciences at the University of Oxford) the workshops brought together clinicians, academics, policymakers and community representatives to explore a shared question: what does a "good" workforce look like in neighbourhood health? Using creative and participatory methods including Lego modelling and collaborative discussion, attendees explored workforce sustainability, health equity and the future of neighbourhood health in underserved communities.

Lego building at Newcastle workshop

Despite taking place in different settings (London and Newcastle), both events reached a strikingly similar conclusion: neighbourhood health is fundamentally relational. Effective neighbourhoods are not simply defined by organisational boundaries or structures; they are created through relationships, trust, local knowledge, and collaboration between health professionals, communities, and partner organisations.

Participants emphasised that neighbourhood health should build on the strengths already present within communities and primary care teams. Rather than imposing top-down models, neighbourhoods should be locally defined and shaped by the people who live and work within them. Community members were viewed not as passive recipients of care but as active partners whose lived experience is essential to improving health services.

Several themes emerged consistently across both workshops; a fuller account of the discussions can be found in the published booklet [2]. Attendees highlighted the importance of creating open, welcoming, and accessible services that are embedded within their communities. Healthcare teams should be approachable and responsive, while physical environments should support both staff wellbeing and patient experience. Participants also called for more distributed leadership, recognising the often-overlooked contributions of receptionists, administrative staff, community organisations, and other core, frontline roles that are critical to continuity of care.

Discussions at the events indicated that learning was seen as an everyday activity rather than something confined to formal education settings. Participants advocated for interprofessional learning, reflective practice, and opportunities to learn from communities as well as from colleagues. Alongside this, there was strong recognition of the value of "boundary work", the often invisible effort required to coordinate care across organisations and services. Attendees argued that this work should be formally recognised, resourced, and supported.

When a Conservative Minister of Health Keith Joseph announced that increased dental charges would give a financial incentive to patients to look after their teeth, Julian Tudor Hart commented that while the Government had not yet put a tax on coffins to reduce mortality, Sir Keith was assured of a place in the history of preventive medicine.

Attendees at London Deep End event

Trust and psychological safety emerged as essential foundations for workforce sustainability [3]. Attendees described the need for protected time to reflect, share experiences, and navigate the moral and emotional challenges of working in areas of deprivation. Particular attention was paid to the experiences of staff such as general practice receptionists and administrators who frequently manage complex patient interactions while carrying significant responsibility with limited recognition or support.

A notable theme from the London Deep End Health Equity group discussions was the value of small-scale, locally driven innovation, often described as “Trojan Mouse” approaches [4]. Rather than relying on large-scale reforms, participants highlighted the impact of modest, practical interventions that respond directly to local needs and can be adapted over time. Examples included proactive outreach initiatives, workforce retention projects, and community-focused health interventions.

The events also challenged conventional approaches to measuring success. Participants argued that existing performance metrics in the UK NHS often fail to capture the relational work that underpins effective neighbourhood health. They called for new approaches that recognise trust, continuity, community engagement, and the broader social value created by Deep End groups.

Overall, the events reinforced that sustainable neighbourhood health requires investment not only in services and structures but also in relationships, trust, learning, and community partnership. For Deep End members, the message was clear: the future of neighbourhood health depends on recognising and supporting the relational work that lies at the heart of equitable primary care.

We are grateful to colleagues from the London Deep End Health Equity Group and GPs at the Deep End North East North Cumbria whose experiences and reflections shaped these discussions.

A full summary of the workshops, What Does a “Good” Workforce Look Like in Neighbourhood Health?, can be found here: https://dx.doi.org/10.5287/ora-ambpyk5y4
Further information about Workforce Voices can be found here : www.workforcevoices.org

Eleanor Hoverd, and Sophie Park

References

1] DHSC 2026 Policy paper. Neighbourhood health framework. Published 17 March 2026. Available from : https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework?utm_source=chatgpt.com
2] What does a “good” workforce look like in neighbourhood health?'. Published 20 June 2026. Available from : https://dx.doi.org/10.5287/ora-ambpyk5y4
3] Brown MEL, Hoverd E, Montgomery A, Burford B, Vance G, Workforce Voices. When I say … workforce sustainability. Med Educ. 2026;60(5):487-489. doi:10.1111/medu.70072
4] The Health Creation Alliance [online] 2026. Available from: https://thehealthcreationalliance.org/

YORKSHIRE/HUMBER

SHEFFIELD DEEP END RESEARCH CLUSTER: BUILDING MOMENTUM

The Sheffield Deep End Research Cluster continues to strengthen its track record of delivering primary care research, building on over a decade of collaborative work. We are pleased to report a recently upgraded NIHR funding settlement, which reflects the increasing research delivery we are now able to sustain across our nine participating practices. The establishment of a dedicated Research Coordinator role has been

transformative, significantly improving efficiency and continuity of research delivery across the cluster and enabling coordinated working between all participating sites.

Our partnership with the Deep End Research Alliance (Page 26) remains central to our approach. Since 2021, DERA has worked closely with underserved communities to co-design research that is inclusive by design. This commitment has been further strengthened by recent RRDN funding to expand their work across Yorkshire and Humber, with a particular focus on identifying and supporting excellence in rural and coastal communities.

Locally, South Yorkshire colleagues continue to deliver our well-established 'Connecting in the Kitchen' Deep End networking and continuous development events. These occasions bring together primary care staff from across the region to hear from highly regarded speakers covering topics ranging from burnout and clinical governance to creative writing and wellbeing. Open to all primary care staff in South Yorkshire, these events have become a valued highlight, fostering both learning and community among our Deep End practitioners.

Following a successful pilot in 2025, the FAIRSTEPS health equity workshops will be delivered by the South Yorkshire Primary Care Workforce Hub in 2026. These Action Learning Sets are designed for anyone from a primary care team wishing to develop an intervention to address health equity. If you would like to know more about this initiative, please contact ben.jackson@sheffield.ac.uk.

Johanna White

The medical schools do not deliberately set out to impart smugness, careerism and values unrelated to the needs of real patents in the real world, it comes quite naturally to them. The personal ambitions and professional satisfactions of doctors overlap with the needs of patients, but they do not coincide; yet that is the assumption of a great part of medical education.

Intellectual opposition to social injustice, even when present, is only the beginning of understanding. If students are to retain patient-oriented rather than disease-oriented, they must learn to identify in complex, concrete, detailed terms with people they know only as crude stereotypes, and of whom they are usually afraid.

Julian Tudor Hart

PREVIOUS DEEP END INTERNATIONAL BULLETINS

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

- Deep End International Bulletin No 14 (December 2025)
- Deep End International Bulletin No 13 (June 2025)
- Deep End International Bulletin No 12 (November 2024)
- Deep End International Bulletin No 11 (June 2024)
- Deep End International Bulletin No 10 (December 2023)
- Deep End International Bulletin No 9 (July 2023)
- Deep End International Bulletin No 8 (December 2022)
- Deep End International Bulletin No 7 (July 2022)
- Deep End International Bulletin No 6 (December 2021)
- Deep End International Bulletin No 5 (June 2021)
- Deep End International Bulletin No 4 (November 2020)
- Deep End International Bulletin No 3 (June 2020)
- Deep End International Bulletin No 2 (December 2019)
- Deep End International Bulletin No 1 (June 2019)