Co-Designing the Deep End NENC: Initial Report, March 2021

A network for primary care practitioners in the most deprived communities of North East England

GPs at the Deep End NENC

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Executive Summary

Deep End NENC has been established as a network for primary care professionals working in the most deprived communities in the region. As part of a co-design process, interviews were carried out with those who work in the region between October-December 2020: the findings of these will guide the development of our region's Deep End Network.

What are the challenges facing those in the Deep End?

The most frequently cited clinical challenge for Deep End practitioners was mental health. Their patients' mental health needs were often very complex and co-morbid substance misuse was common. Existing services were not felt to meet their needs.

Other clinical challenges were drug and alcohol abuse, chronic pain, opiate and gabapentinoid overuse, child health, persistent physical symptoms and conditions that were a result of poor public health measures, e.g. smoking and COPD, obesity and type 2 diabetes. In some areas there were high numbers of asylum seekers, who also often had complex mental health needs. Housebound patients were sometimes felt to be somewhat neglected by existing health or social care initiatives. Participants were also conscious of the wider determinants of health, such as childhood trauma, unemployment, and housing.

Non-clinical challenges centred around recruitment struggles and the difficulty in finding the time to be involved in education and training, or practice development.

The potential of a Deep End network

Participants saw the Deep End NENC as an opportunity to collaborate with fellow clinicians and share good practice. Being in the Deep End network brought a sense of identity, both locally and nationally. Those interviewed hoped that the network would be provide opportunities to trial new projections and initiatives, as well as be a source of advocacy for Deep End practices and patients.

Measuring success

Although reducing inequalities in health is at the heart of the Deep End agenda, participants recognised that it would be difficult to quantify the role of a network in achieving this. Surrogate markers of success included improved patients' satisfaction with their care, increasing the number of applicants for jobs and assessing staff wellbeing and levels of burnout.

The main barrier to establishing a Deep End network was the fact that clinicians in deprived areas are already struggling to find time to manage their existing commitments and a new network would need to be easy to link in with.

Covid-19

The coronavirus pandemic has brought new challenges to the Deep End. Participants described the problems they faced regarding digital poverty and access to care, low levels of health literacy and the impact of other services closing.

Dissemination

These findings will be presented to the Deep End Network at a webinar in early 2021. They will also be disseminated to the Integrated Care Service Prevention Board and regional research networks.

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Abbreviations

CCG	Clinical Commissioning Group
ICS	Integrated Care System
IMD	Indices of Multiple Deprivation
NENC	North East and North Cumbria
PCN	Primary Care Network
RCGP	Royal College of General Practitioners

Background

The first Deep End GP network was established in Scotland in 2009: an RCGP Scotland initiative that brought together the most deprived practices in the country and listened to the challenges they were facing and how they could be supported in addressing inequalities in health. Since then, the Deep End has gone on to give practitioners in the most deprived communities a voice and identity, lead the way on projects that aimed to mitigate the inverse care law and inspired the formation of similar Deep End networks around the world.

The North East of England is consistently ranked as having the highest poverty levels and the lowest health outcomes of any region in England. In early 2020, local GP and Public Health leaders collaborated to establish a Deep End Steering Group for the region and funding was granted from the North East and North Cumbria Integrated Care System (NENC ICS) Prevention strand to establish a network for the region.

Like the initial Scottish project, the Deep End NENC is initially focusing on areas of blanket deprivation. Practices in the region were ranked according to the proportion of patients registered who lived in the most deprived 15% of datazones according to the indices of multiple deprivation (IMD). This ranking was then linked to the national deprivation deciles and the initial 34 practices identified as Deep End were those that fell into the 10% most deprived practices in England. These practices have between 57.6% and 95.9% of registered patients living in the most deprived 15% of IMD datazones.

This report is the result of a series of interviews carried out between October-December 2020 with staff in Deep End practices. Its intention is to be used to guide the work of the Deep End steering group and clinical leads over the coming months and years.

Aims

1. Gather experiences of frontline clinicians who are working in the most deprived GP surgeries in the region: the challenges they face and the existing solutions in place to mitigate the effects of deprivation.
2. Understand what primary care staff would want from a Deep End network and any barriers they perceive to establishing it.
3. Establish the best ways of measuring the success of a Deep End network
4. Understand the effects of Covid-19 on patients and practitioners in the Deep End.

Data gathering

Thirteen semi-structured interviews were carried out between October-December 2020. The researcher was Claire Norman, an academic GP registrar in the region. Due to the pandemic and social-distancing guidance, all interviews were carried out remotely using the platform Zoom.

Who did we speak to?

We spoke to eleven GPs (three salaried and eight partners), one district nurse and one nurse practitioner. There was a balanced gender split of interviewees, with seven male and six female participants. Participants had spent a wide range of time working in the Deep End, ranging from 3 months to 31 years, with a mean of 11 years. Staff from all Clinical Commissioning Groups (CCG) with Deep End practices in NENC were represented, with the exception of NHS County Durham CCG. Eight of the participants had attended previous webinars; the five who had not attended a webinar included the two nurses and two doctors from Teesside, indicating that more engagement may be required with these groups.

Our sampling strategy was purposive in that we endeavoured to speak to practitioners from across the region and ideally from a range of staff backgrounds, not just doctors. However, we recognise the effect of the Covid-19 pandemic on patient care and workforce availability will have had a negative effect on primary care staff availability to participate in these interviews. All practices in the region were contacted via their practice managers but most interviews were arranged on the basis of direct contact with the clinician and onward snowball sampling.

TABLE 1. PARTICIPANT CHARACTERISTICS

CHARACTERISTIC	*N*
GENDER	
Male	7
Female	6
OCCUPATION	
GP partner	8
Salaried GP	3
Nurse practitioner	1
District nurse	1
TIME SPENT WORKING IN THE DEEP END	
0-3 years	3
4-9 years	3
10-20 years	3
21-31 years	4
CLINICAL COMMISSIONING GROUP	
Newcastle	7
Tees Valley	3
Sunderland	1
North Tyneside	1
South Tyneside	1
PREVIOUS WEBINAR ATTENDEE	
Yes	8
No	5

Experiences of working in the Deep End

Clinical challenges

All participants interviewed recognised the impact that deprivation had on the health of their populations. This was seen in the sheer volume of chronic diseases in relatively young people and also in the low expectations that patients had for their health. Intergenerational cycles of ill health were remarked upon, with "getting to 55" being seen as an acceptable aim.

Deep End practitioners were keen to move away from the medical model of health and illness but were often met with resistance from patients, for whom a pill from the doctor was seen as the only acceptable solution to their condition. There was a lot of awareness that they were practicing 'social medicine' rather than biomedicine and that many of the physical and psychological conditions they saw were rooted in years of living in poverty, unemployment or job insecurity and childhood trauma.

High levels of smoking, substance misuse, obesity and alcohol dependence were seen throughout the region. A few practitioners attributed this to poor lifestyle choices but most acknowledged that these issues went hand-in-hand with deprivation and were often ingrained in communities. When asked about current strategies to reduce these public health problems, participants felt that they often did not adequately target those most in need. Housebound patients in particularly were rarely included in health promotion strategies and struggled to find smoking cessation support. One GP said of brief interventions:

> *"You've got less buy-in, you've got less motivation, you've got less education, less self-motivation. So I think, you know, ninety second intervention really with many of our patients If it's understood will be falling on deaf, deaf ears really much of the time" Interview 5*

A few conditions were mentioned specifically as being particularly challenging or prevalent, with Mental Health being addressed below. Chronic pain, persistent physical symptoms, prescription drug dependence and supporting young families with child health were areas that Deep End practitioners felt more support would be beneficial.

Mental health

Mental health was singled out as the main area that staff in Deep End GP surgeries felt overwhelmed by. Practitioners were sympathetic to the difficult lives that their patients had had, often involving complex trauma, childhood abuse and domestic violence. Comorbid substance misuse or alcoholism were common. The current sources of primary care mental health support were not felt to be

adequate and clinicians felt uncomfortable with the options that they were able to offer. There were long waiting lists for Talking Therapies services (9-18 months depending on the region) and it was felt that the therapies offered were unlikely to be adequate to deal with the complex histories of Deep End patients.

Practitioners spoke of the challenges of patients with a dual diagnosis of mental health and alcoholism or substance misuse, which meant that they were 'bounced' from one service to another, too complex for the narrow inclusion criteria for either community mental health teams or substance misuse services. This could lead to patients feeling consistently rejected and even more reluctant to engage with specialist services, resulting in more responsibility and complex care for their GP.

Access to services

Practitioners acknowledged there were high rates of 'DNAs' (Did Not Attend) among their patients and improving access was an area that practices were keen to address. Appointments for talking therapies and pain clinics were specifically mentioned. Often the barriers were practical, with patients not having the means to attend appointments in central hospitals – they did not drive and public transport was expensive and time consuming. There was a perception that some patients were reluctant travel to areas they were unfamiliar with, that might be socioeconomically different. For others, a lack of time and health literacy meant they did not prioritise their own health over many competing priorities.

> *"And we often don't have chance to kind of dig into more, well what can we do to support your family, to support you, so it's about looking at that person, looking at the patient as a whole person and everything that's going on around that makes their life really difficult, probably in ways that we could not imagine having to live through, and all we're seeing is "Oh they've disengaged again". Well, there's obviously loads of reasons behind that. And it's easy to just say "well they didn't go to the appointment." To be able to have time with a patient to just sit and say, Look what's going on. Tell me about your life. Tell me what it is what it is that's going on that's really hard or what is it that we can help you with to support you so we can get your underlying problems, you know, you can't give up smoking cos you're so stressed, well what's making you so stressed, what can we support you with, kind of thing. Okay. That's all social. It's not medical. But it does have an impact on their medical health" Interview 3*

Frequent attenders or users of services

A lot of GPs acknowledged that a small number of patients took up a disproportionate amount of practice time. Often this was reflective of complex social circumstances or alcohol or drug dependency. Some had already worked on solutions to this (e.g. coffee mornings for socially isolated patients, child health education sessions for vulnerable parents) but others mentioned it was something they would like support with.

> *"She pointed out that you know 40% of our appointment book is taken up by 5% of our patients. And so those 5% of patients are not having their needs met so it's about standing back and going well, what can we do at a system level to meet these people's needs better" Interview 1*

Frequent attendance at Emergency Departments was also a concern because this had financial implications for the CCG. It was felt that improving access to GP services might reduce ED attendance and save money overall.

Asylum seekers and non-English speaking patients

While some participants practised in relatively un-diverse areas, with largely white working-class patient registers, a common theme was the increasing number of asylum seekers and refugees who had been re-housed in the North East. In the Teesside area there are two practices that have been specially commissioned to be specialist asylum seeker practices. Clinicians who worked there again described mental health as a big challenge: given that the majority of asylum seekers had by definition come from incredibly difficult social circumstances, often with a tortuous journey to the UK, there are no specialist mental health services for this group in the region. There are some therapy providers with a special interest in the area, but this was never established as a specific service. Working with these populations also involved a lot of liaising with legal charities and services and writing time consuming reports.

Some areas also had a high proportion of patients for whom English was not their first language. This was challenging for clinicians who worried that they were not able to provide appropriate care or that their patients did not understand the way that the NHS worked, particularly around maternity services and diabetes care. One practice had previously had an in-house interpreter who assisted patients with making appointments and arranging prescriptions, but this had been stopped due to funding cuts.

Recruitment and staffing

Experiences of recruitment were variable although most GPs acknowledged that this was becoming harder. Some doctors spoke of senior doctors retiring early due to the increasing demands of their

NHS work. Interestingly, the nurses interviewed spoke positively about recruitment and of working in Deep End communities, citing a generally younger and more vibrant patient group that led to more enjoyable interactions than in more affluent areas.

Recruitment challenges in the Deep End must be set against a national picture of increasing demand for GPs. However, clinicians described particular challenges that they were facing with regards to recruitment:

- There seems to be an increasing preference for working in larger practices whereas Deep End practices were often smaller or single-handed
- The high level of clinical and administrative demands on practices meant they often did not have the time or headspace to apply for fellowship or career-start posts
- Newly qualified GPs (and other professionals) were wary of working in Deep End practices due to the perception that it was all just "sick notes and saying no to diazepam."

Nevertheless, some Deep End practices in the region were thriving, with far-reaching reputations of high-quality care, close-knit teams, and innovative approaches to managing the challenges of deprivation medicine. There appeared to be a dichotomy between practices that were doing very well and others who really struggling and often needing to merge or be taken over by bigger surgeries who didn't have the recruitment difficulties. We are conscious that the practices who are facing the greatest difficulties are probably not represented in these interviews due to the pressures on their time, particularly in the Durham and Teesside region.

Some participants believed that Deep End practices should be prioritised for any recruitment strategies over surgeries in more affluent areas in order to mitigate the effects of the Inverse Care Law.

Education and training

Being a training practice (for medical and nursing students, GP registrars, practice nurses and physician's associates) was often cited as being a crucial factor in successfully recruiting staff further down the line.

> *"I think because we're large and we're a training practice and do a lot of teaching and are quite well known. Certainly, medical clinical staff wasn't a problem before… And yeah generally, we keep our trainees. So trainees who come and actually like us, stay" Interview 8*

In addition to providing exposure to working in the Deep End, being a training practice means that

there is a lot of oversight from the university or the GP training scheme which provides a reassuring level of quality control and accountability. Being a training practice also brings additional income.

Unfortunately, several practices described the challenges of becoming a training practice. Not only are there the additional time requirements to incorporate teaching and training into the working day, the process of becoming an accredited trainer was very time-consuming, involving reflective essays and producing video-recordings of the potential trainer in action. The practice building itself needs to become accredited: again, this was a challenge for smaller surgeries who did not have enough rooms to bring in an extra trainee or student.

It's not all bad…

Although working in the Deep End could be stressful and challenging, not a single participant expressed a desire to work anywhere else and most made a point of stating that they were much happier working in the Deep End than in areas of affluence, perceiving the challenges of the 'demanding' patient to be universal, just taking different forms in different areas. Some participants had actively sought out a very deprived practice to work in, others had spent time there in training and decided to stay.

Working in the Deep End was felt to be more rewarding and practitioners felt that they were working where they were most needed. Several referred back to their medical school personal statements and their desire to help people and make a difference: they felt working in the Deep End was the best place to meaningfully do this. Left-leaning political ideals and an interest in public health were also common characteristics.

The North East in general is a desirable place to live and work – every participant was either born in the region or had done part of their training here and stayed. Good quality of life, affordable housing, and the relative ease of both halves of medical couples being able to get jobs in the region were cited as positives.

Existing strategies

The participants spoken to had often pro-actively developed innovations to help overcome some of these challenges. These included:

- Attendance reduction strategies - Educational workshops for young or otherwise vulnerable parents and social coffee mornings for isolated patients
- Employing a practice psychologist to do GP sessions
- Proactively contacting all patients who did not attend appointments or screening

- Having food, clothing or hygiene products available in the waiting room
- Group consultations for patients with persistent pain
- Nurse-practitioner led chronic disease appointments for housebound patients, with a focus on personalised goal setting rather than numerical targets or QOF
- In-practice smoking cessation service
- Pharmacist-led opiate and gabapentinoid reduction service
- Promoting local food charities or food banks in the waiting room or via social media channels.

One practice in Middlesbrough had been specifically commissioned for asylum seekers and patients with substance misuse problems: this allowed them to employ staff with specialist skills and their relatively low list size meant there was more time to be flexible with appointment times and provide support for patients with legal claims and other social problems.

Link workers

Most GPs were aware of the social prescribing link workers and spoke very highly of them. Some felt that they would prefer more autonomy over work done by the link workers because at present they are generally employed by the PCN. Some raised concerns about the level of risk that link workers were asked to take on, relative to their level of qualification or expertise. There was also a concern that due to Covid-19 there had been a reduction in the number of services available to refer people into, coupled with an increase in the number of patients who might benefit from them. The district nurse participant was not aware of the link workers although felt they could be a very useful source of support for housebound patients, indicating that some wider promotion of these services was required.

External Organisations

Some GP surgeries already had existing links with local organisations or were aware of the work they were doing to support people who live in areas of high deprivation.

Aspirations for a Deep End network

Participants who had attended the webinars, or were aware of the Deep End work by Graham Watt et al in Glasgow, were generally enthusiastic about the prospect of a Deep End network for NENC.

Forming relationships

The idea of having a collegiate network of practitioners who face similar challenges was very welcome. Building relationships was recognised as a way to establish change and share good practice.

> *"Basically, the stuff you're doing in one area is applicable to somewhere else and having some means of sharing that and having a forum for discussion is really useful" Interview 6*

Advocacy

Several GPs hoped that a Deep End network would be an opportunity for practices and practitioners in the most deprived areas to have a seat at 'high level tables', particularly around areas of funding and resource allocation. Practices who were the only Deep End surgery in their PCN or CCG hoped that being part of the network might help to champion their cause more locally.

Recognition

Being part of a Deep End network, and in turn part of the wider, global Deep End movement, gave practitioners a sense of identity.

> *"The first step is actually to recognise. I mean, I never realized we were a Deep End practice, you know, I mean, I knew I worked in a deprived area and I knew there were challenges that came with that but also just a recognition that actually you are working with some of the, perhaps most difficult parts… just a recognition and kind of giving you a bit of an extra bit of your identity, which I think is really is really helpful already" Interview 10*

Trialling projects and interventions

In keeping with the projects trialled in Glasgow and Deep End networks, participants were often keen for new projects or initiatives to be trialled, with the general aim of reducing health inequalities and mitigating the inverse care law.

Project ideas included:

- More time and longer consultations to work with frequent attenders and complex patients

- Protected and/or facilitated time to look at the way the practice is run and ways it could be improved, particularly patient access
- Having services more local to the communities that needed them, e.g. drug and alcohol services, Recovery College, talking therapies, pain management services
- Improving health promotion for housebound patients, particularly around cancer screening and smoking cessation
- A reminder service to encourage patients to attend appointments or to follow up DNAs and find out the barriers to attendance
- Introducing longer consultations or pharmacy support for helping patients reduce their opiate or gabapentinoid use
- Practice-level link workers rather than PCN-level
- Groups for young parents to provide emotional and educational support.

Recruitment and retention

The Deep End network was seen by participants as a way to overcome recruitment challenges and promote the idea that the Deep End is an interesting and rewarding place to work. Giving the most deprived practices priority for funded fellowship opportunities was cited as one way of achieving this.

Education

Having a presence in the local medical schools and the GP training scheme were felt to be important. Participants felt strongly that the Deep End was a valuable place to teach students about the social determinants of health.

> *"Certainly when I was at medical school, it was very much done delivered from a kind of a social science, public health perspective …I think it needs to be a bit more real and a bit more meaty… just saying like okay this is your surgery, morning surgery in a deprived practice. You know what, what are the issues here. You know, why are you seeing people that are dying young? Why are you seeing patients, you know, why do you have high suicide rates? Why have you got girls that are pregnant at thirteen? You know, what's going on?" Interview 10*

Measuring success

It was important for the Steering Group to know how the success of the network could be measured. While reducing health inequalities and increasing healthy life expectancy were recognised as the ultimate goals for the network, most participants were realistic about what could be achieved, particularly in a short timeframe.

Improving recruitment and staffing levels was seen as one tangible way of measuring success. Participants were keen to stress that although patient outcomes were very important, staff wellbeing and levels of burnout should also be priority outcome measures. Several participants were sceptical about the need to produce concrete evidence about the positive impacts of the Deep End and were keen for softer measures and intuitive feelings not to be dismissed.

A desirable legacy of the Deep End network was for it to be sustainable and still in existence in 5-10 years' time!

Barriers to establishing Deep End NENC

Primary care practitioners are no strangers to re-organisation and the introduction of new and shiny networks making ambitious promises. As such, there was some scepticism among participants – some wanted to see tangible projects or advocacy work in action before committing to any involvement. Several years ago, there had been an attempt to establish a Deep End network in Middlesbrough but this had seemingly fallen by the wayside, adding to uncertainty about the feasibility of a new project.

Time is a limited resource and some participants felt that they already had adequate professional support between their own surgery colleagues and their PCN – they were unsure what the added value of a Deep End network would be. Others worried that attendance at meetings or webinars would be hampered by the availability of clinical cover or "backfill". Although the webinar format was initially a biproduct of Covid-19, attending webinars was felt to be easier and more accessible than attending a meeting that was held somewhere centrally in the region.

The historical lack of a geographical surgery "catchment area" in Middlesbrough means that all practices draw from the same pool of patients and the dividing line between practices that are Deep End or not felt somewhat arbitrary when most practices are facing very similar challenges of deprivation. Out with Middlesbrough, similar concerns were shared around the likelihood of getting PCNs to agree to any extra support for Deep End practices – either due to other PCN practices being very deprived but not quite meeting Deep End criteria, or due to them being very affluent with different priorities.

The fact that some of the participants had never heard of the Deep End network, let alone attended webinars, implied that communication and engagement needed to be increased. Practices in Teesside and professional groups other than GPs could be prioritised for this.

Covid-19

The Covid-19 pandemic had brought new challenges to the Deep End. Participants voiced concerns that the government and other health leaders were not adequately considering the needs of those in the most deprived areas and that not enough was being done to help these communities recover.

> *"I just worry that our communities are just going to get left behind even more, forgotten even more, because what seems a good idea to the people in the pearly towers is not what's a good idea on the ground for patients. And I don't profess that I know what's best for all of our patients. I don't live in the conditions they live in. But I'm probably a bit more in tune to it." Interview 10*

Access

Many participants were concerned that the move to remote consulting would disadvantage those from low incomes who might not have access to smartphones or reliable internet connections. There were some positives though: sending and receiving text messages from patients was heralded as an excellent new addition and a good way to contact some of those who were hardest to reach.

Most practitioners felt it was important to have some face-to-face appointments available and felt that their practice was seeing more people in-person than other surgeries in more affluent areas. Many felt nervous about the impact of remote consulting on clinical care and had concerns about missed diagnoses; others worried about the lasting negative impact between general practice and the community. Older patients were very reluctant to 'bother the doctor' and many felt they were downplaying their symptoms. DN1 described being asked to act beyond her competence when clinically assessing patients because certain GPs were asking the district nursing team to make more decisions as they were already visiting the patient. As well as being professionally uncomfortable for the nurses, this hands-off approach had upset some patients and their families, particularly in palliative care situations.

> *"So, even as far as palliative care - we have, we're having patients that haven't been seen that are dying. And it's been quite tough for the families because, you know, they would quite like to see a doctor." Interview 5*

One participant in Newcastle expressed concern about the fact that the coronavirus 'Hot Hub' for the local area (a service specially equipped to assess patients with symptoms of Covid-19) was located somewhere that was driving distance away: patients without cars were unable to access it, meaning they had to be seen in their local surgery instead. This may have resulted in higher levels of Covid-19

infection among practice staff. Similar concerns were raised about access to testing facilities and vaccine centres.

Health literacy and following the guidelines

Some practitioners expressed concern around patients being seemingly unaware of the government guidelines around getting tested for coronavirus. Even those who presented with classic symptoms such as a cough often needed prompting to seek out a test.

> *"A guy I spoke to last week, cough and breathlessness for the last week, getting worse, lives alone. Well, you know, "do you think it could be covid?" "Oh, I don't know." "Have you had a covid test?" "No." "Do you know how to get one?" "No, how do I do that doc?" And you just think, surely, with the last six months, the media, all the rest of it but just not not crossed his mind" Interview 8*

Concerns about health literacy and understanding also resulted in practitioners having a lower threshold for referring people with suspected Covid to hospital.

At the time of interviews (October-December 2020), most participants described seeing an increase in positive test rates in their community, but this was yet to translate into increasing hospitalisations or deaths out with care homes.

Service reduction

In addition to a general move to remote consulting, the pandemic meant that a lot of additional services were stopped or moved online. These included group consultations for chronic pain, befriending services for elderly or housebound patients, social coffee mornings for isolated patients. Due to digital poverty or lack of IT literacy, the online alternatives to these services were often inaccessible for Deep End patients and practitioners felt there was little point in trying to move them to a video platform.

> *"I think the loneliness thing is a big thing… if there was more that people could do to have these like befriending schemes and things and but at the moment, it's all kind of zoom based, isn't it, and none of our patients could really do that."*
> *Interview 5*

In the first wave of the pandemic, health visiting, social work and midwifery services were reduced due to staff redeployment: this, coupled with school closures, led to a lot of participants expressing concerns about the level of child safeguarding issues that were going undetected.

“The child safeguarding situation fills me with dread about what's happening in some of these families and some of these houses. The lack of other support like schools like social services, all that stuff really concerns me and throughout lockdown because we've been one of the services that's remained open and visible, we're being presented with a lot of this stuff which is difficult. And we're being presented with it without lots of the support that we normally have to manage it.” Interview 1

What next?

In keeping with co-design methodology, our findings will be fed back to the Deep End members to ensure they are representative of their wishes for a network. They will then be used to guide the work of the Deep End Steering Group and Clinical Leads over the coming months and years.

In addition to dissemination within the Steering Group, our findings will be fed back to the ICS Prevention Board and through research networks within the university. This initial qualitative research will also form the basis of several peer-reviewed journal articles.