



Research questions Deep End Cymru staff want answered

Research findings

Prepared for Deep End Cymru



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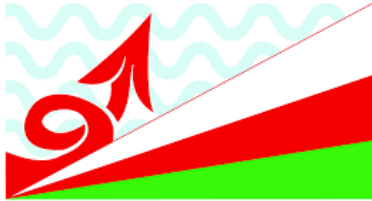
Cardiff

CF10 3BG

029 2037 8565

enquiries@beaufortresearch.co.uk

beaufortresearch.co.uk



Meddygon Teulu yn y Pen Dwrn
GPs at the Deep End

Contact details

Agency Contacts: Chris Timmins, Adam Blunt

Project: BBQ02431

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1. Summary and conclusions

Introduction

Deep End Cymru is keen to better understand what research and what questions Deep End Cymru clinicians want answered that would have the greatest positive impact on their work and the communities they serve.

To help meet this aim, Deep End Cymru commissioned Beaufort Research to carry out two mini-focus groups with Deep End practice staff. These findings then informed the development of an online survey of 378 adults in Wales living in quintiles 1 and 2 according to the Welsh Index of Multiple Deprivation (WIMD). The project fieldwork took place between 5 February and 23 March 2025.

Overview of topic areas of importance

The table overleaf summarises the two stages of the research. First, the question areas that arose among participants in the qualitative stage. Second, how members of the public in the quantitative stage perceived the question areas taken forward from the focus group stage.

Certain question areas that emerged from the focus groups were deemed not to be feasible to consult the public on. These related to funding, clinical, patient characteristics, and advocacy topic areas.

It should be noted that focus group timing limitations meant that less time was spent on the later topics of service organisation, advocacy and attitudes to research.

The most prevalent question topic areas generated from the focus group discussions are listed first in each section in the table below with other less prevalent, more individual mentions listed underneath:

| Focus group stage (GP staff) | Quantitative survey stage (general public living in WIMD quintiles 1 and 2) |
|---|--|
| Non-clinical issues | |
| <ul style="list-style-type: none">• How to encourage engagement with services and guidance.• How to encourage a sense of ownership for one's own health. | <ul style="list-style-type: none">• <i>How to encourage people to take responsibility for their own health</i> was ranked 2nd (out of 12) among the |

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|--|--|
| <ul style="list-style-type: none"> • Why there are issues with child immunisation rates. • Why are there issues with screening programme uptake. • What lies behind patient distrust of authority and healthcare professionals. <p>Further, less prevalent questions to arise included:</p> <ul style="list-style-type: none"> • What wider determinants of health are most likely to result in people needing to seek medical help and therefore need greater investment. • How can some patients be supported to better understand and navigate the healthcare system. • What drives DNAs and how they can be reduced. • What role poor transport options play in patients' decision-making on attending appointments and accessing services. | <p>general public as an area of research that would have the most impact on people's health.</p> <ul style="list-style-type: none"> • Research into how to <i>encourage screening programme uptake (e.g. cervical, bowel)</i> (ranked 3rd) was more likely to be seen as a research area impactful on health than research to <i>encourage people to get their child immunised</i> (ranked 7th). • Research into <i>how patients could be supported to understand how the healthcare system works</i> was less likely to be regarded as a research area that could improve people's health (ranked 10th). |
| <p>Workforce issues</p> | |
| <ul style="list-style-type: none"> • What would attract staff, including GPs and non-clinical staff, to work in Deep End GP practices and what will persuade them to stay other than increased pay. • How burnout, attrition, losing staff, sickness and absences compare between Deep End and non-Deep End staff. <p>Further, less prevalent questions to arise included:</p> <ul style="list-style-type: none"> • How to recruit and retain community based health staff / allied health professionals. • Whether the Deep End workforce reflects the populations it serves. | <ul style="list-style-type: none"> • Research into <i>how to fill vacant health professional jobs and encourage health professionals to continue to work in the community</i> was viewed positively among the general public in terms of impacting on health (ranked 4th). This resource issue may be linked to appointment availability – see below. |
| <p>Funding related issues</p> | |
| <ul style="list-style-type: none"> • How the extent of perceived underfunding in Deep End practices can be quantified. • How to measure the additional effort that Deep End practices have to make to try to change patient behaviours. <p>Further, less prevalent questions to arise included:</p> | <ul style="list-style-type: none"> • Not covered by survey |

| | |
|---|--|
| <ul style="list-style-type: none"> • Whether the Carr-Hill funding formula is fit for purpose for Deep End practices. • How much investment has been made in public health initiatives specifically tailored to Deep End practices. | |
| Clinical issues | |
| <ul style="list-style-type: none"> • How to better understand what's happening with parents / children's behavioural issues, and parents wanting an ADHD or autism diagnosis. • Wanting a clearer understanding of how fit for purpose 'fit notes' are. • To have a better understanding what is best for 14-20-year-old-patients and what exactly lies behind the issues they present with. • To have a better understanding of what diseases are more likely to occur among patients living in deprived areas. • How research could help to establish what treatment would work best for patients with ACEs and chronic pain. <p>Further, less prevalent questions to arise included:</p> <ul style="list-style-type: none"> • How to deal with unmanageable expectations from patients. • Whether national clinical guidelines are sufficiently adapted for minority ethnic populations and deprivation levels. | <ul style="list-style-type: none"> • Not covered by survey |
| Questions linked to patient characteristics | |
| <ul style="list-style-type: none"> • What steps can be taken to overcome challenges associated with language barriers. <p>Further, less prevalent questions to arise included:</p> <ul style="list-style-type: none"> • Regarding religious / cultural beliefs, how to overcome persistent misperceptions that a vaccine still contained gelatine. • How to manage differences in end-of-life expectations among some minority ethnic patients so that complications with advanced care planning are limited. • How to manage expectations among some communities for all possible interventions to take place in hospital even when this may not be in the patient's best interest. | <ul style="list-style-type: none"> • Not covered by survey |
| Service organisation issues | |
| <ul style="list-style-type: none"> • Several questions emerged regarding improving access, such as whether Deep End communities are at a disadvantage in accessing health services; and how | <ul style="list-style-type: none"> • Research <i>into what can be done to improve GP appointment availability</i> was the top ranked area of |

| | |
|--|---|
| <p>access can be made equitable for those with challenging health needs and language barriers.</p> <ul style="list-style-type: none">• A number of questions were asked regarding quality from patients' perspective, including how to solve the difficulties of getting an appointment and trying to discuss all their issues in one appointment.• Further less prevalent questions to arise related to the leadership traits required to run a Deep End practice and what data is available on Deep End practices' workload compared with non-Deep End practices. | <p>research to improve people's health among the general public.</p> <ul style="list-style-type: none">• This issue was also ranked first as the factor which was currently impacting on people's health in their area.• Research <i>into adapting health services to better suit local communities</i> was also view relatively positively (ranked 5th). |
|--|---|

2. Background, objectives and method

2.1 The situation

Deep End Cymru is a grassroots movement started in September 2022 to develop mutual support between GP practices serving the most deprived communities.

Its principal aim is to engage with the 100 practices identified as having the highest proportion of patients living in the most deprived areas in Wales. Deep End Cymru offers these practices a community for mutual support and seeks to identify the common challenges and find the best solutions. According to the Deep End Cymru evaluation report '85% of eligible practices responded positively. Of these, 31% attended at least one of the four events, some sending more than one member of staff'.¹

Deep End Cymru is keen to better understand what research and what questions Deep End Cymru clinicians want answered that would have the greatest positive impact on their work and the communities they serve. To help meet this aim, Deep End Cymru commissioned Beaufort Research to carry out two stages of research.

The results will be used to inform Deep End Cymru's ongoing work to support clinicians by advocating for more targeted and relevant research. Deep End Cymru is in the process of building links with the Welsh Government and Health and Care Research Wales (HCRW) to influence how they decide what is important to research. This document reports on these findings which will feed into related work carried out by Deep End Cymru.

2.2 Research objectives

The overall objective for this research was to explore what research and what questions Deep End Cymru clinicians want answered that would have the greatest positive impact on their work and the communities they serve.

¹ Deep End Cymru: Evaluation of the first phase (PDF file, 2.2 MB)

The research also measured the views among people living in more deprived areas of Wales on which areas they felt should be prioritised for research.

2.3 Research method

We used a two-stage approach. The first stage involved two exploratory mini-focus groups conducted via Teams. Participants were sourced via a call for volunteers by Deep End Cymru. Qualitative discussion enabled participants to talk in-depth about research needs and questions they wanted answered. Participants also sometimes took the opportunity to ask each other questions about their work. They were reimbursed for taking part.

Eight participants contributed to this qualitative stage, one via written responses as they were unable to attend. Staff roles included GP Partner, Salaried GP, Practice Manager, and Advanced Nurse Practitioner. The sample included inner city / urban and South Wales Valleys practices, and some with higher proportions of minority ethnic patients. The groups lasted 90 minutes and discussions took place 5 and 6 February 2025.

It should be noted that the sample for this stage was small and was not, by design, representative of the wider population. However, qualitative investigation is intended to provide in-depth understanding which was required for exploring the research objectives. Its strengths lie in the ability to identify themes and provide illustrative examples of experiences and opinions.

Stage two consisted of placing questions on the Beaufort Wales Omnibus Survey - a nationally representative online survey of 1,000 adults in Wales. Questions were targeted specifically at those living in areas classified as quintiles 1 and 2 (most deprived quintiles) of the Welsh Index of Multiple Deprivation (WIMD) - 378 responses were received among this group.

The survey question areas were informed by the qualitative stage and were designed to provide a general public view on the importance of researching some of the issues that health professionals had raised. Fieldwork took place 3 - 23 March 2025.

2.4 Topic guide, survey questionnaire, analysis, and reporting

The topic guide for the discussions with practice staff was developed based on question areas provided by Deep End Cymru (see appendix A). The

conversations began with a broad question asking what research and what questions participants wanted answered. The discussion then prompted follow-up topics regarding patient characteristics, clinical and non-clinical, and workforce related research needs or questions they would like to know more about.

The discussions lasted 90 minutes and were digitally recorded with participants' consent. Inductive thematic analysis was used for the qualitative discussions whereby the researcher categorised the data to develop themes. These were broadly framed within the key research objectives and topic areas.

The analysis of qualitative data uses quantifiers (e.g. 'some', 'a few') to help determine patterns of opinions among participants. However, these quantifiers should not be generalised and must be interpreted only as applicable to the research sample.

Anonymous verbatim comments made by participants at the qualitative stage are included in the report. These comments should not be interpreted as defining the views of all. Instead they give insight into individual views on the themes identified.

The emerging qualitative themes were used by Beaufort and Deep End Cymru to inform the quantitative survey questions. The questionnaire for this survey can be found in Appendix B.

3. Research questions raised

The findings in this chapter are based on the feedback from the two mini-focus groups with Deep End practice staff. Participants articulated the questions they wanted answered that would have the greatest positive impact on their work and the communities they serve They cover the following topics which were prompted during the discussions:

- Non-clinical
- Workforce
- Funding
- Clinical
- Patient characteristics
- Service organisation
- Advocacy
- Attitudes to research.

The order of the topics in this chapter is broadly based on the prevalence of the themes identified and volume of discussion generated. There was not sufficient time to cover all the topics in detail.

3.1 Spontaneous feedback

Before participants in the focus groups were prompted with topics to consider, they had the opportunity to spontaneously raise research questions and needs that were important to them. These themes centred on:

- Non-clinical questions (e.g. patient education around screening and vaccination, healthcare system illiteracy)
- Workforce related questions (e.g. attraction and retention issues)
- Funding related questions (e.g. how to quantify the extent of underfunding)
- Clinical research questions (e.g. referral thresholds, dealing with ACEs and chronic pain)
- Patient characteristic questions (e.g. language barriers).

The following sections are ordered very broadly by the amount of discussion generated.

3.2 Non-clinical research questions

Patient health education and health beliefs / behaviours

The question was sometimes raised regarding how to effectively encourage and support patients to **effectively engage** with services and **follow guidance** (e.g. T2DM, chronic disease, health and wellbeing generally etc.). This included GPs knowing when was the right time to intervene with a patient on education and how to effectively engage with central / Eastern European patients.

We have a lot of people who just don't really understand how to manage their conditions at home. And it's about trying to access that and educate that. But obviously you just fight fires. . . . You try and educate them, but then they're back the next week or the two weeks later with the same problem. . . . A lot of health education I think would be really beneficial for us. But getting that into the community and how's the best way to do that?

There is a significant lack of awareness and education among our patients regarding screening, vaccinations, and chronic disease management.

Patient education as a whole. Do we know how to evaluate when we step in and try and spend that time with them.

Linked to this, some participants wanted to know how to encourage a sense of **ownership for one's own health** and related interactions. This was thought to be a key challenge among patients in Deep End communities versus non-Deep End communities. Is it down to education and capability or are other belief factors involved?

That sense of ownership of your own health and of your own kind of interactions with like us, you know, healthcare professionals. And I wonder if that's kind of at the root of stuff like diabetes, are you going to bother changing your diet?

Additionally, it was pointed out that transient populations including asylum seekers and refugees **did not necessarily understand the healthcare system** very well. More broadly, there was a query over how well informed Deep End populations were of which **primary care route** to follow for which health needs; and understanding that they did not necessarily need to see a GP.

Maybe we don't understand why some people and some populations seem to understand the healthcare system and some populations just can't kind of navigate their way around it. So maybe this value in sort of researching whether that's a problem in deprived communities or in certain populations and how therefore that could be addressed.

We see it quite a lot in our Asian and Eastern European population. They don't really want to see the MDT; they they'd much rather see a doctor.

It was also believed that some **young people** did not have anyone to educate them on positive health and wellbeing behaviours which raised the question of what more could be done to educate people at an early age.

We are documenting if [young people] have got dentists, if they're sexually active, if they're smokers, if they're drinkers. And the stats are awful. . . . Is it trying to educate them at a younger age because they've got nobody educating them? . . . if we educate patients at a younger age, does that change the outcome when they're sort of older?

Given the work that went into patient education generally, one participant wanted to know what research could be carried out to determine the **effectiveness of patient education efforts** at their practice. Knowing when and how to make the greatest difference to patients via education was raised as well.

Immunisation and screening

How to improve rates of **child immunisation** was a critical question raised by some participants. Examples were given of DNAs at clinics despite concerted efforts from health professionals to encourage parents to attend. The challenge was believed to be more significant in Deep End practices than non-Deep End; and practices were thought to be unfairly penalised financially through not hitting targets. (One participant aware of ongoing research in Wales on this subject.)

Imms nurses have sent them texts, they've normally phoned them, they've spoken to them every time they come, they reiterate about the next one. You know, there's a lot of energy has gone in. But then funding-wise, we get paid nothing. Zero, because we didn't do it enough, like we didn't get enough people in the door. . . . I think it finding out why people don't come for things is helpful because they wouldn't necessarily want to tell us. I think that's something that, you know, the parents would nod and smile to me. 'Yes, yes, we're definitely going to have their imms' and then they'll just go downstairs and leave instead of going and having these.

Some research into why that is because God knows the nurses and health visitors and sometimes face to face the GPs try our best.

Similarly, low levels of **uptake of screening programmes** was identified as an area where research would be helpful. As part of this, an observation was made it would help to better understand why some patients over 50 had not taken part in any **cervical screening**. One participant wondered if the population was suffering from **vaccine fatigue** post-Covid as they were seeing a drop in flu jab uptake and nasal flu vaccination as well.

Trust

From time to time, the issue was raised of what lay behind patient **mistrust of authority and healthcare professionals** and what could be done to overcome it.

A lot of our patients have a lot of distrust of authority, really and, and healthcare professionals and health visitors and social services. And they see us all as a sort of amalgamated bunch really. And, you know, almost like we're spies for the, for the, the state.

One of our [Eastern European] patients came to see me and asked to be referred to a real doctor in the hospital.

Maybe not always telling the truth because they don't trust us. And they're on the back foot. They're trying to get what they think they need. But it means we can't sometimes do our job very well because we're working on the basis of information that's not actually true.

Further non-clinical question areas

Further question areas to arise mentioned on a mostly individual basis included the following:

- Weight management issues were flagged on a couple of occasions. What impact did limited resources for **childhood obesity** prevention and support activities have on these individuals later in life. Also, better understanding what more GPs could do help patients 'make better food choices'

School nurses at the moment, but they sort of just don't really do anything because of the pressures of time. And then the childhood weight management service don't really seem to do much either. But it's then how does that have a knock-on effect for those children in their later life and what sort of impacts is that going to have for them going forward? That would be quite useful.

It would be useful to know how can we support patients to make better food choices? What resources could we direct them to or what advice can we give them taking into consideration that they don't have the money. . . . I guess it's a lack of understanding from my point of view as to what their limitations are.

- How Deep End practices can be **kept up to date** on what initiatives are available to support their patients

It gets called something else and then we have to work out what that is and how to access it and what to explain to patients it is. And it takes time. It's like turning a tank. . . . Often things don't last long enough.

- How to encourage children to **attend school** and to have **aspirations**
- Understanding what drives **DNAs** and how to reduce them – ‘What produces lasting changes in behaviour?’ summed up one participant. They frustrated health professionals and wasted valuable time and resource
- What can research do to help staff better understand what would have the most positive impact on patients who have experienced **trauma**. Examples given included among refugees, asylum seekers, and patients with adverse childhood experiences such as abuse. As part of this research topic, the participant was keen to know how **effective and consistent** help for wider determinants of health was for such patients

What are the key things that would change the trajectory of someone's life. . . . I feel like we've got quite a lot of services, but I'm not sure how many of them are that effective.

- What role **poor transport** options play in patients' decision-making on attending appointments and accessing services

Where we are, as well as lack of transport, you know, if you're trying to get a mum of three young children down to a surgery on two buses to get some immunisations, it's just overwhelmingly difficult. So yes, you know, hammering down on, on what the exact reasons are, because I don't think truly they're anti-vaxxers.

- What the barriers are to **breastfeeding** in one particular part of the Valleys
- With **housing**, if GPs wrote letters for patients concerning their accommodation, would the letters make any difference? This participant remarked how many patients lived in substandard, overcrowded houses and some asked for GP letters because they believed the inadequate housing was adversely affecting mental and physical health problems. Another participant responded that they did write such letters and sometimes heard that the patient had been offered an alternative.

More broadly, **reducing health inequalities**, summed up one participant, was something they wanted to know as much as possible about. They stated that it was not an area that was taught in traditional learning streams. There was also

reference from another participant to what the impact is of gender, income, ethnicity, and geography on health outcomes; and what wider determinants of health are most likely to result in people needing to seek medical help and therefore need greater investment.

I'd like to know how I can help my patients with high unique needs better in my clinic room but at a higher level in cluster level.

What can you invest in in terms of social housing, early years education, all these kind of things that then stop people eventually needing to come and see us with their mental health problems?

Deep End patients were believed to be **more affected than non-Deep End patients** by a lack of access to resources, missing out on screening, vaccination and other health interventions, missing out on social support and lifestyle measures and interventions, and by higher levels of morbidity and mortality.

Quality and availability of determinants support

Views were **mixed** on experiences of the quality and availability of accessing help for wider determinants support. It was not clear to all what the quality and availability of support services were like, and how to access such help other than via public health officers. A couple of participants were interested to know if patients would experience more effective outcomes if there was better integration of services, and whether a 'hub' setting could help in this respect.

I don't actually have any experience of what the quality or availability of that support is because it's so unintegrated with health that we just don't know. . . . A possibility for research [is] whether integrating that sort of support into primary care and therefore being able to kind of link up with primary care, whether that support would be better provided as part of primary care. . . . Like if we had communication from the debt advisor or whatever, it might be quite useful for us.

A hub setting, whether that helps, if there's any evidence of like, I don't know, having financial support. Someone who can do a bit of mental health support, advocates and things like that. . . . if you're trying to send them off to different places and you're thinking, oh, they're not going to go, or they might go once, and they've not returned for the review or something. Like if it was all based in one central kind of hub, I don't know whether that would help.

It was suggested that the **visibility** of support could be improved along with **access**. A 'public dashboard or platforms for up to date data could help'

healthcare professionals, proposed one participant. If the support were better delivered, it was anticipated that practices would be able to work more effectively with their cluster and other primary care contractors to identify local, innovative solutions. Part of the process could involve educating patients and the population, as well as solutions being tailored to the data available.

I sometimes don't know what, what [refugees, asylum seekers and other transient patients] can access and what is necessarily available for them.

A further related issue raised with referral services was whether there were more effective ways of ensuring people **receive the communications** sent to them regarding a referral. This participant had in mind transient patients including those living in crowded accommodation where letters could be lost and where language barriers were an issue.

I find that often, it just gets lost, or a lot of our patients live in blocks of flats and things and, and like the post just gets mixed up. . . . When there are language barriers as well and cultural issues, are they actually going to see that as important?

We get a lot of people who are refugees who don't get their letters or as we've said, they don't understand the letters and we often to have to re-refer.

Public Health Wales and **The King's Fund** were suggested as two organisations that could facilitate research into areas related to determinants of health.

3.3 Workforce related questions participants want answered

The overall theme of workforce prompted a good deal of discussion. Key areas of interest related to attraction and retention: what would **attract** staff, including GPs and non-clinical staff, to work in Deep End GP practices and what would **persuade them to stay** including factors other than increased pay. It was anticipated that insights on this theme would guide workforce retention strategies and the development of innovative recruitment solutions.

The major issue, . . . retention of staff is a big thing for where I work. And we've seen this with practices going under and having to take patients from

other practices that those practices fail because they can't get doctors to work there.

How do you motivate people to want to work in areas where the work will be harder and more emotional?

We have a really high turnover of reception staff, which we don't really know why. . . . How do you have that retention? Because a good receptionist is really hard to come by these days

It will be interesting, I think for GP partners to [to know] because we do think, we guess basically, oh, let's be really nice to them. But it will be interesting maybe to have some research as to what actually works in terms of retaining staff because you can't pay them more money. We don't have any more money. . . . It's stuff we weren't taught at medical school, how to manage staff.

As part of this, there was interest in knowing why some newly qualified GPs **choose non-Deep End practices** and what can be done with their training to address this situation. Exploring this issue could also identify unmet training needs that deter them from choosing Deep End practices, for example around trauma. There was also a desire to know what difference it would make if a trainee's placement included a Deep End practice.

If it's like, oh I would love to work there but I don't know enough about childhood trauma or I don't feel I have enough experience in psychiatry. Or is it? Is it worth doing some research to find out what those learning needs are that aren't being met, that are stopping staff from going to work in Deep End practices?

Whether you can get that research and say, look, Welsh Government, if you want GPs to work in this area, they said this research shows that they're not going to unless they have this, this and this. So we need funding to provide this, this and this.

Looking at the topic in more detail, a few thought it would be beneficial to know what matters to the workforce around **wellbeing** that would encourage them to stay in a Deep End practice instead of leaving. Additionally, better understanding what they felt would be beneficial for their **development** and what support they needed. One participant gave the example of how limited maternity leave pay caused financial issues for staff. This was in contrast to

another practice that had put in place the same maternity policy for other staff as for GPs.

[The member of staff] really made inroads with some of our most, entrenched vulnerable families. And when [they] left, [they were] heartbroken to leave, but couldn't [stay] for [their] own mental health.

A further issue identified relating to wellbeing was to understand how '**burnout**', attrition, losing staff, sickness and absences compared between Deep End and non-Deep End staff. Linked to this, it would be useful to know what **motivates clinicians** to continue to deliver good care despite all the challenges they face – and how can this be made **sustainable** including what good practice looks like.

Focusing on other staff roles, one participant wanted to know how to recruit and retain **community based health staff** / allied health professionals (e.g. health visitors) who are supporting such vulnerable families and what causes them to leave.

The turnover of health visitors and the number of health visitors that are off on the sick long term and end up just taking a better paid job in a nicer area. And it's devastating when they leave. . . . What would it take to get people to come and stay and, and stay in these roles for a long time and have continuity with these families?

A final query was to understand to what extent the Deep End practice workforce **reflected the populations** they served.

3.4 Funding related questions

Funding as a theme emerged in both focus groups even though it was not prompted prominently. Issues concerning perceived **underfunding** were raised: how the extent of perceived underfunding in Deep End practices can be quantified; and how Deep End practices compare with those with more typical UK demographics, considering patient complexity, comorbidities, and deprivation. Within this there was also reference to having suitable data to assess whether the Carr-Hill funding formula is **fit for purpose** for Deep End practices.

It would be amazing if there would be a metric that could adjust deprivation by postcode or geography.

This is all about changing the funding allocation to areas where it's needed more. But the only way that's going to happen is if research shows that the demand and the need is so much more in those areas.

Further funding related queries included:

- Should cluster funding for Deep End practices **reflect the deprivation** and challenges as opposed to a blanket generic funding per capita
- How Deep End can influence government and policymakers to invest in improving care for deprived populations and **ensure equitable funding**
- To better understand and identify **where funding is needed**.

We all know that the work is more in Deep End, but can we do some research that nails it down so that you can say to the government 'this is a formula, this is better than the Cahill formula or whatever'? . . . This is based on deprivation. This is the need. You need to fund practices according to that need and it be fair and equitable rather than equal.

I think research into how you can allocate that funding because I think there was talk before about a supplementary service for doing reviews of deprived patients. Well, I mean, that's like 80% of my patients. I guess it is research into how you can do that equitably. . . . Research into where the funding is actually needed.

Some participants also felt it was important to try to **measure the additional effort** that Deep End practices have to make to try to change patient behaviours, rather than just targets being met. This would mean that funding allocation could be fairer.

What are practices doing that's above and beyond what they're not being paid for. . . . Is there a way of capturing what's done on goodwill in order to show that that needs to be financed properly if you want practices, not just to close because they can't afford to stay open?

Safeguarding procedures . . . These aren't funded specifically. And when the workload involved in those is huge, it takes a GP away from clinics.

There's lots of unfunded work. And I think some research into what that work is exactly and whether that can be addressed and how you allocate money to Deep End areas would be probably critical in being able to attract and retain staff and build services for patients rather than them just seeping away.

It was believed that robust data on this theme would enable clusters and health boards to develop **targeted local solutions** tailored to patient populations. Additionally, evidence of underfunding would support advocacy for fairer resource allocation.

These research areas are critical, as Deep End practices face unique and heightened challenges compared to standard GP practices, necessitating dedicated funding and strategic planning.

3.5 Clinical research questions

Participants were asked what **clinical topics** or areas in Deep End practices they felt lacked sufficient evidence or clarity.

Some participants wanted to better understand what was happening with children's behavioural issues, and parents wanting an **ADHD** or **autism diagnosis** versus the issue being related to parenting practices. Such consultations were lengthy and could distract from systemic problems, for example linked to education, parenting, and poverty. One participant echoed this need but with older teens and adults seeking a diagnosis. Was it linked to certain characteristics of Deep End patients like deprivation?

What percentage of children presenting looking for a diagnosis actually have one that's treatable and whether you can actually control for all the variations in other factors to find out whether drugs for ADHD actually help these children in any meaningful way. . . . Ten years ago, we weren't making 28 ADHD referrals a week. Where has this come from? Is it real? . . . My partners tear their hair out with the volume of work that's involved with that.

Unless it comes with a pill, most of our patients are not interested - a pill or a sick note.

A lot of patients have come to us recently in the last year or so wanting ADHD and autism diagnosis as adults.

In a similar vein, a participant wanted to better understand the extent to which adults were presenting with **attachment disorder** but were expecting an ADHD diagnosis.

You do wonder whether a lot, you know, in children we talk about ADHD presenting very similar to attachment disorder. And I wonder which is, you know, attachment disorder is obviously something that's, well, I don't know, I'd say obviously to me [attachment disorder] is much more common in these kind of populations. And whether there's something about the impact of that on adults who then feel they have ADHD or present with similar symptoms. . . . I just need to find that research and read it.

There were instances in both focus groups of participants wanting a clearer understanding of how fit for purpose 'fit notes' are. A few commented that GPs did not necessarily know the job descriptions of patients requiring the notes. They felt that the patient would probably have a better outcome if they were referred for an occupational health assessment.

We get a lot of requests for sick notes when they're on Universal Credit and what actually that means. Because I always write, if they've been on it for six months, they would benefit from a assessment and to get more help. But what actually happens? And is there a different way of doing that and things like that? I just don't really know.

Mental health and **14-20 year olds** was a topic of interest on occasion. Participants wanted to know what is best for these patients and what exactly lies behind the issues they present with. 'What could make a significant change in the lives of that population?' as they were thought to often end up on antidepressants and a 'sick note'.

If there was a kind of pattern, . . . like an algorithm. What's the best thing or what works well in this age group? What do we try first so that then the answer isn't just OK, yeah, great, don't work, try this medication. We don't want to medicate this age group. It's not good for them. What other options are there? What's the pathway?

Some participants discussed better understanding what diseases are **more likely to occur** among patients living in **deprived** areas. This could mean that a lower threshold for referral could be accepted for patients in these areas.

Our threshold for investigation, sometimes we feel like we need to be lower because it feels like the deprivation creates a lot more pathology. . . . It would be really interesting to know if there is any evidence as to what your thresholds . . . We all learn how to look for cancer, what threshold this is, what probability this symptom is. not just cancer, but all sorts of different diseases. To have a bit more of an understanding as to where deprivation is a

risk factor . . . so we can understand it and know what we're looking for in a bit more detail.

With our patient population, you would investigate a bit sooner. And maybe that they don't necessarily fit into the tick boxes of the symptoms that they would need to meet the USC criteria. But you have that feeling because of where you are, and you know your patient population. . . . The consultant reads the referral and doesn't think it's a cancer So yeah, they downgrade their referrals.

A further clinical question to arise concerned potential links between **ACEs and chronic pain** conditions: these participants were interested in how research could help to establish what treatment would work best for patients with ACEs and chronic pain like fibromyalgia. They referred to 'struggling with our opiate prescribing because of this kind of historical treatment of chronic pain and trauma with just opioids'. Many patients were now **addicted** to their medication, said one participant, causing more problems for the individual. While guidelines were now said to be focused on weaning patients off these drugs, the alternative was not always deemed to be a 'good solution' given some patients' circumstances.

I wonder if there isn't research already about the impact for ACEs of chronic pain, fibromyalgia, things like that and the ability to be able to treat those things and the treatments that are recommended. . . . If you split out the patients with lots of ACEs away from the kind of other patients, . . . do we need to be doing it slightly differently when it's come from a place of so much trauma and so much deprivation?

I think the chronic pain fibromyalgia is a huge problem for our patient population. And it's not something that can be dealt with quickly either.

Reference was also made to **other health issues** such as diabetes, heart failure/cardiovascular issues, menopause (e.g. understanding staff knowledge and patient expectations), lipid control, weight management (e.g. is there any evidence to suggest that every contact does count), and 'often musculoskeletal, dermatology, acute illnesses but neglecting the maintenance and control/management of chronic diseases'.

[Menopause] is something that's big coming into practice now, isn't it? And I think maybe it wouldn't do any harm to understand maybe staff's knowledge and level of training and also maybe the public's as well, you know, and their expectation. . . . How confident are we all feeling in managing menopause?

We often think, well, our patient's not eating very well, they're eating lots of processed food and all this kind of thing. But it'll be interesting. As a GP I never really know how to start addressing that. It would be maybe useful to know there's some evidence with sort of with smoking and alcohol that like every contact counts.

Further issues and questions relating to this topic that were occasionally mentioned included:

- How to deal with unmanageable **expectations** from patients
- What **insights** public health bodies had gathered to address these needs effectively
- Whether **national clinical guidelines** are sufficiently adapted for **minority ethnic** populations and deprivation levels
- Whether **purchasing weight loss drugs** privately is more of an issue in Deep End communities and could the drugs have harmful side effects that Deep End practices should be aware of / prepare for if it is a significant phenomenon in their communities.

3.6 Patient characteristic questions

Language barriers presented challenges that made delivering care difficult said some participants. These barriers also added a good deal of extra work to the process of supporting patients including double appointments. Written information and guidance or appointments that might be accessed online is reportedly often not much use to a transient population where language is a barrier and for those with low levels of literacy. It was important to better understand the impact on these patients and how best GPs could be supported.

All of the nice things like you can book [an appointment] on an app, for a transient population who don't speak English, it's not very helpful. Or people who are struggling with literacy it's just a not an easy way to access services.

Regarding language, a few examples were given where participants had seen a patient recently and had found it **difficult to know what was best** for the patient. In one such case, the patient required an interpreter and was an asylum seeker. They presented with multiple concerns within a single consultation which, combined with communication barriers, meant that shared decision-making was challenging.

Religious beliefs, stated a few participants, can influence vaccine and screening hesitancy along with **peer groups** generally. An example was given of wanting to know how to **overcome persistent misperceptions** that a vaccine still contained gelatine.

Ethnicity, language, and cultural variations, . . . these challenges are far more frequent in Deep End practices. While a standard GP practice may see such cases sporadically, they are daily occurrences in our setting.

We had a big issue with the shingles vaccines because it did used to contain the gelatine, the Zostavax, but now we've gone over to Shingrix, it doesn't. But obviously getting that message across that this one doesn't contain the gelatine is bit difficult with our language barrier. You've got to get to see them to even get to explain that to them.

It was reported that a **cultural** lens can present further challenges:

- **Gender specific issues** like Hormone Replacement Therapy (HRT) can remain a taboo subject in some cultures
- How to manage differences in **end-of-life expectations** among some minority ethnic patients so that complications with advanced care planning are limited
- How to manage expectations among some communities for all possible interventions to **take place in hospital** even when this may not be in the patient's best interest.

Serving a **transient population** posed challenges as well, with patients only being in the area for a few months and having no medical history on record.

3.7 Service organisation research questions

Service organisation was prompted as a topic with participants as concerning areas such as improving access for patients, improving quality of service, and managing workload.

In terms of **improving access** for patients, participants' asked:

- Are Deep End communities at a disadvantage in accessing health services? And how can access be made more equitable for deprived patients who often need to work during the day or those who lack transport?

The geography of the area I think is sometimes overlooked. And yeah, public services like transport are absolutely critical for people to access anywhere

you're going to refer them, really. So it's not just distance to the GP surgery, it's distance to secondary care and other primary care services.

- Does evidence show that patients benefit from double appointments?
Is more appointments helpful for these patients? Probably. But actually is that the answer or is there a different answer?
- How can access be improved for patients with high chronic disease burden?
- How can access be made equitable for those with challenging health needs and language barriers?
- By not providing e-consult for patients as it was decided it was not feasible for the patient population to use it, is this step preventing some patients from accessing services?

From a **quality** perspective for patients, the following issues were raised:

- How to solve the difficulties they complain of with getting an appointment and trying to discuss all their issues in one appointment
- How to educate patients so they understand that other health professionals may be better placed to help them rather than the GP

I struggle with the way we say about patients wanting to see a nurse compared to a doctor. They don't understand my role and what I do. But then if you would go to another surgery, the ANP, they might do very different to what I do.

- Dealing with long waiting lists for secondary care
- Healthcare professional aims or priorities may differ from patients'
- Whether any initiatives targeting Deep End practices could be more sustainable and practices kept up to date on what is available?

If there are going to be initiatives for the Deep End practices, is there a way to make them sustainable for more than just six months or a year? Because the practicalities are that, you know, it's tokenistic.

From a **leadership** perspective:

- What are the leadership traits required to run a Deep End practice smoothly and sustainably?
- What can be learned regarding teamwork and the most effective skill mix?

In terms of **workload**:

- What data is available on Deep End practices' workload compared with non-Deep End practices? As described in section 3.4, this could include how much unpaid work or extra work staff do without being fairly remunerated. 3

3.8 Advocacy

Where there was time, participants were briefly asked what research they thought Deep End Cymru needs to do to support its advocacy messages. Several suggestions were made, including research in a number of the areas mentioned above.

What actually are the barriers to providing these patients with the care, good quality care that they need? Is it pay? Is it waiting times? Is it that they're not health educated? Is it unhealthy behaviours that they personally have? And how does that stop? And what actually is the root cause, . . . what part of deprivation does lead to poor health outcomes and what can then we do to help that?

- Understanding how the voice of Deep End practices and patients can be better heard at a higher policy-making level. To illustrate this point, a participant explained how practices were offered a supplementary service activity on frailty, but their practice did not have the capacity to do the additional work

We're already under the cosh, we can't then just say, right, we'll do that and get that extra money. Whereas practices that are already doing very well, probably have capacity to say, oh well, we've got these free appointments, we'll use that and then they get even more money while we don't get that money.

- Use research data to
 - Inform suitable public communications campaigns
 - Lobby the Welsh Government / The Senedd so the data becomes a 'talking point of policy making'
 - Publicise patient stories in the media and therefore gain public and political traction
- Share data with Public Health Wales, NHS local health boards, the Welsh Government and other stakeholders like GMC / BMA
- Actively ensure data is used to keep decision makers accountable.

3.9 Attitudes to research

There was little time to cover this topic area. Regarding **motivations** for practices to get involved with research, there were references to the following:

- Time has to be fairly resourced and funded. Remunerating time for this research project (with Beaufort) is an 'excellent example of good practice' according to one participant. Another commented that they were only able to take part in research because they were able to access additional resource
- Allowing opportunities for publishing
- Allowing opportunities to raise the profile of practices on the positive steps they are making to improve healthcare equality
- Ensuring regular updates and that data is contextualised so that it remains relevant and relatable to practices
- Ensuring the practice has co-ownership of data to take forwards especially in cluster working
- Needing to improve practice targets on certain measures that affected funding.

Reported **barriers** to getting (more) involved in research centred on the time, cost and resource pressures of doing so. Time for research had to be reasonable and proportional to the working week and pressures, summed up one participant.

Clinical pressures, if time to help in research is unfunded or un-resourced, there is a 100% guarantee practices in the Deep End that are already struggling would be unable to take part.

Possibly why we haven't sort of gone into the research side of it because we just have kind of filled up our time and resource and physical space.

We would be happy to do research, but it would have to be resourced basically.

Some commented that **patients** might be reluctant to participate owing to a general mistrust of institutions and authorities. Also, they might be less likely to participate if it means having to travel to the practice. A concern was also voiced that the sample achieved was likely to be skewed towards non-Deep End patients. These patients would fully understand the purpose of the research, for example, and trust more in the process.

Patients may be averse as these are populations facing high degrees of mistrust of institutions. Delivery needs to be carefully done with practices or teams they trust to enable better delivery and completion.

You wouldn't necessarily get the sort of deep dive into actually what the Deep End patients want or feel like because obviously no practices are 100% Deep end, are they? So you'd get the small percentage of our patients who are living in the more affluent areas.

4. Patients' views on priority research areas

This chapter presents the findings from the quantitative online survey with 378 members of the public aged 16+ living in WIMD quintiles 1 and 2 in Wales.

A set of background questions were asked to provide some context about the survey participants. The results from these questions are covered first, followed by survey participants' opinions on what research topics should be prioritised.

4.1 Attitudes towards health and health services

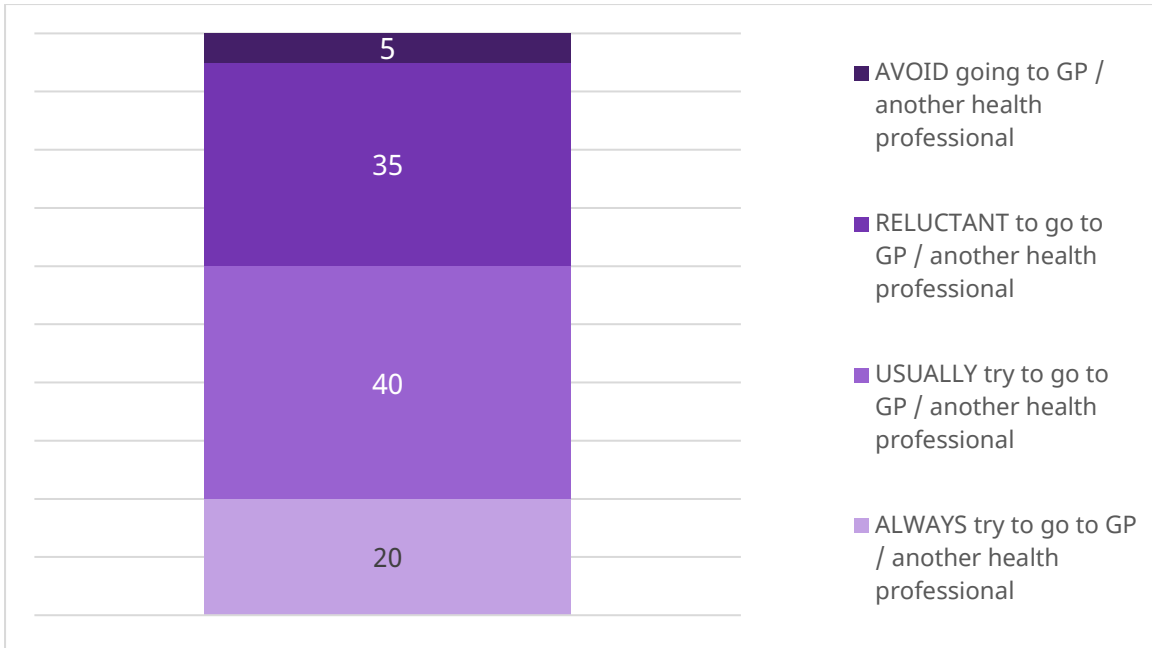
Adults aged 16+ living in areas classified as WIMD quintile 1 or 2 reported mixed opinions when asked to describe their current health in general. Whilst only a minority (13%) described their health as *bad* or *very bad*, only around a half (49%) reported it as *good* or *very good*. The remainder described it *fair* (38%).

Indications are that these levels of self-reported health are lower in these areas than those that exist in the population as a whole across Wales. Whilst the two surveys are not directly comparable due to differing methodologies², the National Survey for Wales (2022-23) reports that 69% of the population across Wales describe their health as *good* or *very good*.

Similarly, there are mixed results (Figure 1) when respondents were asked their attitude to seeing a GP or other health professional. Whilst 60% reported that they *always* or *usually* try to go the GP / another health professional if they have a health concern, a significant minority said they were *reluctant* (35%) or *avoided* (5%) seeing a GP or health professional in these circumstances.

Figure 1: Attitudes to seeing health professional if have health concern(%)

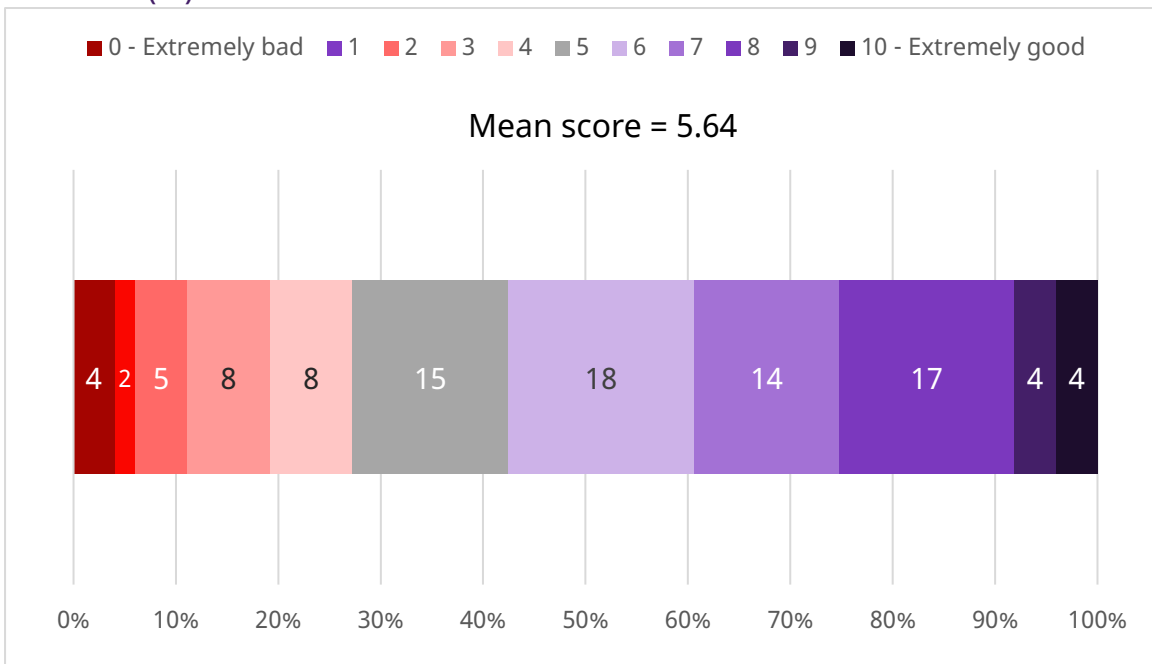
² National Survey for Wales 2022-23 was a random probability telephone interview. The Beaufort Omnibus Survey is a quota-based online self-completion interview.



Base: all respondents (378)

The pattern of mixed findings continues when respondents were asked to give their overall opinion of health services in their area on a scale of 0 to 10 where 0=extremely bad and 10=extremely good. The average score out of 10 was 5.64. The distribution of scores below in Figure 2 shows that respondents were most likely to score health services between 5 and 8.

Figure 2: Overall opinion of health services in their area – distribution of scores out of 10 (%)



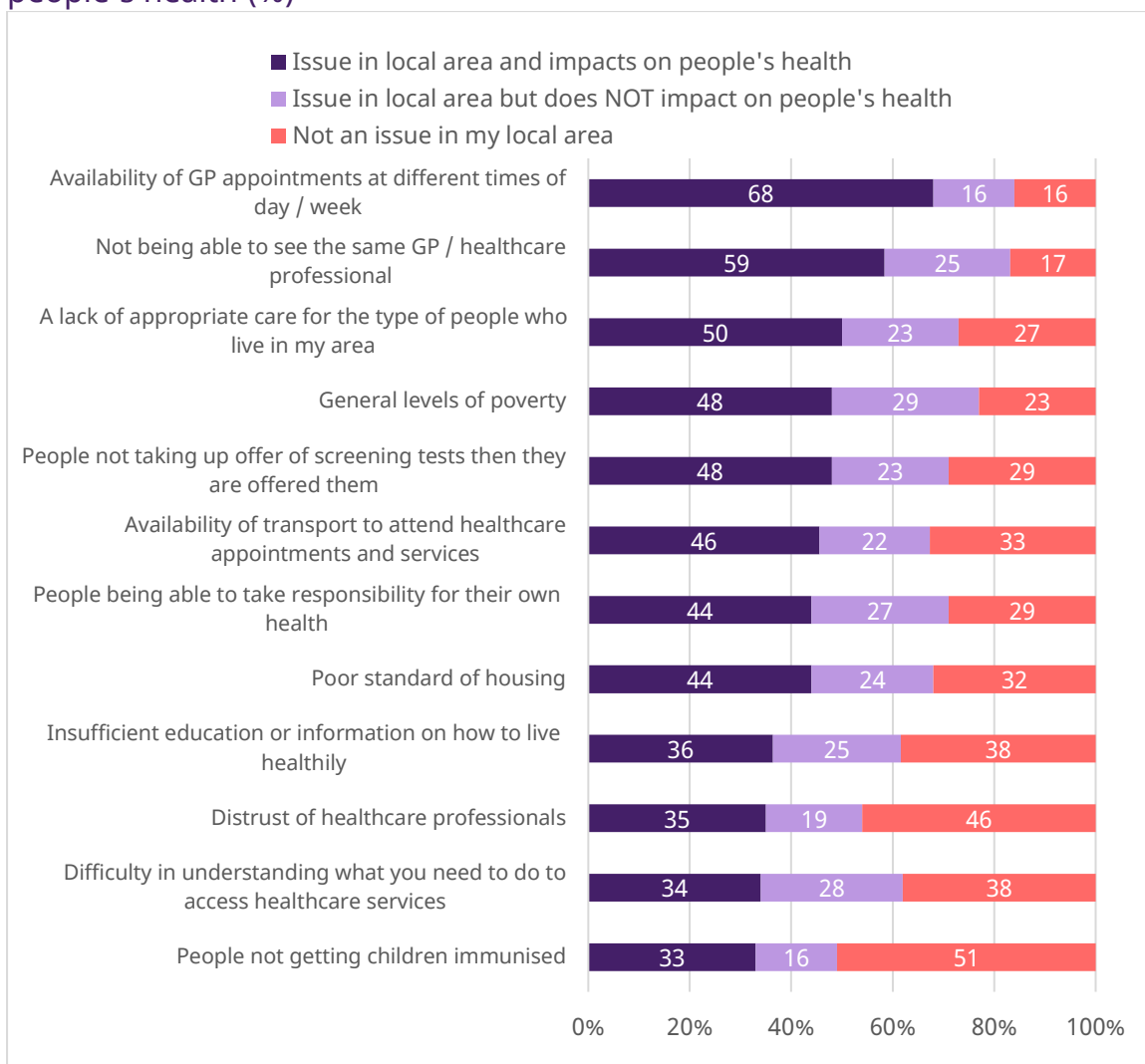
Base: all respondents (378)

4.2 Opinion of different impact on health in local area

Survey participants were presented with a series of potential issues that could impact on people’s health. As mentioned previously, this list was generated from discussion during the GP focus groups and represented the main issues where public opinion could be sought (for example, issues such as funding formulas or complex clinical issues were avoided). The list of factors is shown in figure 3 – for each one, survey participants were asked to choose whether they thought it was:

- An issue in their local area and it impacts on people’s health
- An issue in their local area and it does NOT impact on people’s health
- Not an issue in their local area

Figure 3: Whether each factor is an issue in their local area and impacts on people’s health (%)



Base: all respondents (378)

From list they were presented with, the general public were most likely to regard elements of healthcare resourcing as being issues in their local area which impacted on people's health. Almost 7 in 10 (68%) thought that *availability of GP appointments at different times of the day / week* were an issue in their local area that impacted on people's health. Around 6 in 10 (59%) thought similarly about *not being able to consistently see the same GP / healthcare professional*.

Beyond these top two were a variety of issues where around half of those surveyed thought they that impacted on people's health in their local areas. This included macro infrastructure issues such as *general levels of poverty* (48% thought this was an issue in their local area that impacted on people's health) and availability of transport to attend healthcare appointments and services (46%).

In addition, whilst service level issues such as *a lack of appropriate care for the type of people who live in my area* were perceived as impacting on people's health (50%), the public also acknowledged that individuals also contributed to their own health issues – 48% thought that *people not taking up screening test when they were offered them* was an issue that impacted on people's health in their local area. Similarly, *people being able to take responsibility for their own health* was regarded in the same light by 44% of survey participants.

Further down the list of factors perceived to impact on people's health in their local area were *people not getting their children immunised, difficulty in understanding what they needed to do to access health services, distrust of health professionals* and *insufficient education or information about how to live healthily*. However, even on these factors, a significant minority (around a third) believed they were issues that impacted health in their local area.

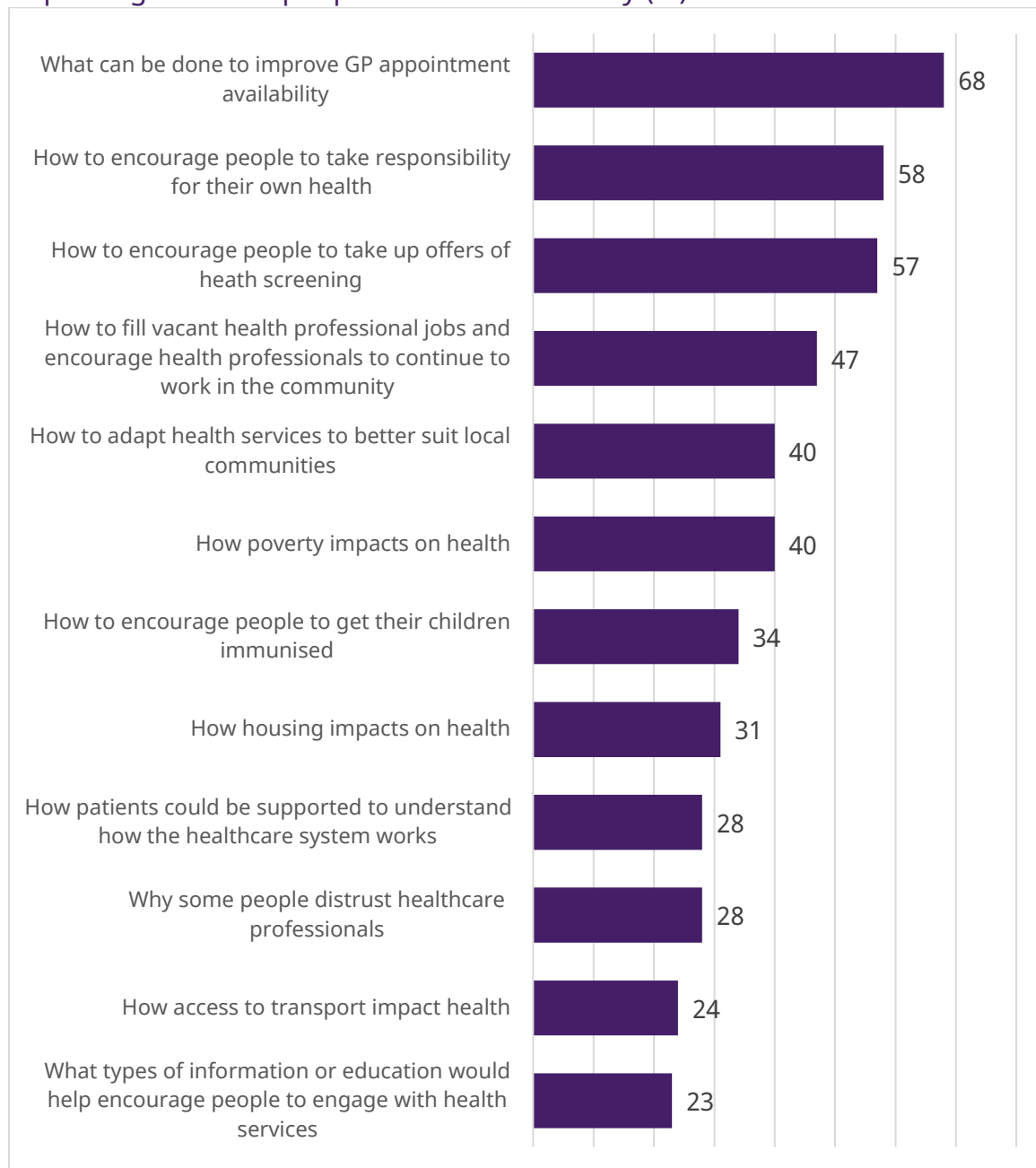
4.3 Priorities for health research

Survey respondents were then presented with different areas of potential health research topics. Each area of research matched the health issues covered in the previous section as detailed below:

| Issue | Area of research |
|---|---|
| Availability of GP appointments at different times of day / week | What can be done to improve GP appointment availability |
| Not being able to see the same GP / healthcare professional | How to fill vacant health professional jobs and encourage health professionals to continue to work in the community |
| A lack of appropriate care for the type of people who live in my area | How to adapt health services to better suit local communities |
| General levels of poverty | How poverty impacts on health |
| People not taking up offer of screening tests then they are offered them | How to encourage people to take up offers of health screening |
| Availability of transport to attend healthcare appointments and services | How access to transport impact health |
| People being able to take responsibility for their own health | How to encourage people to take responsibility for their own health |
| Poor standard of housing | How housing impacts on health |
| Insufficient education or information on how to live healthily | What types of information or education would help encourage people to engage with health services |
| Distrust of healthcare professionals | Why some people distrust healthcare professionals |
| Difficulty in understanding what you need to do to access healthcare services | How patients could be supported to understand how the healthcare system works |
| People not getting children immunised | How to encourage people to get their children immunised |

Respondents were asked to choose up to six areas (from the list of 12) which they thought, if the NHS was able to fund research into them, would have the most impact on improving the health people in their community. Findings are shown below in figure 4.

Figure 4: Perceptions of research topics that would have the most impact on improving health of people in local community (%)



Base: all respondents (378)

The public were most likely to select *what can be done to improve GP appointment availability* as the research area they thought would have the most impact on improving health of people in their local community – almost 7 in 10 (68%) chose this.

Whilst GP appointment availability might be regarded as a system issue, the other two research areas that were selected by more than half of respondents were more focussed on addressing individual behaviour – *how to encourage*

people to take responsibility for their own health (58%) and how to encourage people to take up offers of health screening (57%).

Beyond these top three, other potential health research topics most likely to be selected as being helpful to improving the health of the public were *how to fill vacant health professional jobs and encourage health professionals to continue to work in the community* (47%), *how to adapt health services to better suit local communities* (40%) and *how poverty impacts on health* (40%).

To a certain extent, the ranking of research topics that are perceived as helping to impact positively on health mirror the degree to which the public see them as an issue affecting people’s health in their area. For example, 5 out of the top 6 ranked research topics were in the top 6 for issues affecting people’s health – see figure 5 below which compares rankings.


However, in relative terms, research topics that involve individual behaviours tend to outperform their ranking as issues affecting health in the local area. For example, *how to encourage people to take responsibility for their own health* is ranked second in terms of being a research topic that could help to improve the health of people in their community, but only seventh in terms of being an issue that impacts health in their community.


This may reflect that the public regard, in relative terms, other system or infrastructure related issues as requiring more than research to have a genuine impact.

Figure 5: Whether each factor is an issue in their local area and impacts on people’s health / Perceptions of research topics that would have the most impact on improving health of people in local community – comparison of ranking.

| Issue impacting people’s health in their area | Rank | Area of research which would have most impact on improving health of people in their area | Rank |
|---|-------------|---|-------------|
| Availability of GP appointments at different times of day / week | 1 | What can be done to improve GP appointment availability | 1 |
| Not being able to see the same GP / healthcare professional | 2 | How to fill vacant health professional jobs and encourage health professionals to continue to work in the community | 4 |
| A lack of appropriate care for the type of people who live in my area | 3 | How to adapt health services to better suit local communities | 5 |

| | | | |
|---|----|---|----|
| General levels of poverty | 4 | How poverty impacts on health | 6 |
| People not taking up offer of screening tests then they are offered them | 5 | How to encourage people to take up offers of health screening | 3 |
| Availability of transport to attend healthcare appointments and services | 6 | How access to transport impact health | 11 |
| People being able to take responsibility for their own health | 7 | How to encourage people to take responsibility for their own health | 2 |
| Poor standard of housing | 8 | How housing impacts on health | 8 |
| Insufficient education or information on how to live healthily | 9 | What types of information or education would help encourage people to engage with health services | 12 |
| Distrust of healthcare professionals | 10 | Why some people distrust healthcare professionals | 9 |
| Difficulty in understanding what you need to do to access healthcare services | 11 | How patients could be supported to understand how the healthcare system works | 10 |
| People not getting children immunised | 12 | How to encourage people to get their children immunised | 7 |

 = area of research to improve health ranked HIGHER than issue currently impacting on people's health

 = area of research to improve health ranked LOWER than issue currently impacting on people's health

Appendix A – topic guide

Deep End Cymru GP practice research

Focus groups topic guide FINAL

Overall objective:

- *Explore what research and what questions Deep End Cymru clinicians want answered that would have the greatest positive impact on their work and the communities they serve.*

A. Introductions (10 mins)

1. *Thank participants for attending. Introduce self and Beaufort.*
2. *Explain purpose of discussion: As we outlined in the invitation email, Deep End Cymru is keen to better understand what research and what questions Deep End Cymru clinicians want answered that would have the greatest positive impact on their work and the communities they serve.*

The results will be used to inform Deep End Cymru’s ongoing work to support clinicians by advocating for more targeted and relevant research. They’re in the process of building links with Welsh Government and Health and Care Research Wales (HCRW) to influence how they decide what is important to research.
3. *Explain MRS Code of Conduct / GDPR key points:*
 - *Obtain permission to record – purpose of recording is to aid analysis. We will make a transcript of the recording, but Beaufort will not pass it on to the client. The recording / transcript will be securely stored. Any personal information we capture will be kept securely for 3 months after completion of the project and will then be destroyed*
 - *Participation is entirely voluntary*
 - *Check they received the privacy notice*
 - *Adapt as appropriate: The client will know who we’ve approached to take part, but we will not knowingly include anything in our report that could lead to an individual or practice / organisation being identified. Please let us know if you make a point which would identify you.*
4. *Participant introduction:*
 - *First name*
 - *Practice, job title, brief summary of role*
 - *Key characteristics of community practice services (e.g. ethnicity, deprivation levels, urban / Valleys etc.)*

B. Spontaneous needs (15 mins)

Note: where participants spontaneously focus on topic areas covered later in the topic guide, refer to those section prompts / probes as appropriate at this point.

5. Before we discuss the topics in more detail, can we begin with a broad question – what research or questions do each of you want answered that would have the greatest positive impact on your work and the communities you serve? *Probe whatever emerges from a Deep End perspective; ensure each participant can contribute at this point*
 - Are there any questions that you've had in your mind, that you would ask a researcher to go and work on for you?
 - What difference would it make to your practice to have this research need / question addressed?
 - What do others in the group think of these points?
6. Can you think of a patient in the last few weeks where you didn't know what to do, they didn't fit into guidelines or there's little evidence, or you felt that the evidence didn't take into account that person's situation? *If so:*
 - What questions came to your mind that you didn't have the answers to? *Probe*
7. To what extent do you feel these areas of research / questions are more relevant to Deep End type practices versus others?

C. Patient characteristics focus (15 mins)

8. There are a few areas I'd like us to focus (a little more) on. The first is to do with patient characteristics. I'm interested in whether there are any characteristics that can make it more difficult for you to know what to do or how to help an individual?
Share screen – I have some example characteristics here to get us started: 'Ethnicity, age, language, personality, what else?'. *Probe whatever emerges from a Deep End perspective including:*
 - Are there any anonymous examples you can give to illustrate this difficulty?

D. Clinical topics (15 mins)

9. Let's look more at the clinical side of things. What clinical topics or areas in your practice do you feel lack sufficient evidence or clarity? *Probe whatever emerges from a Deep End perspective. If it helps, **share screen** with example areas to explore:*
- Which diseases / conditions?
 - Which problems that patients bring to you?
 - Which combinations of problems?
 - What do you want to know about patient / public health needs?
 - Medicines and therapeutics?
 - Overmedicalisation – overdiagnosis / overtreatment?
 - Underdiagnosis and undertreatment – any unmet needs?

E. Non-clinical topics (15 mins)

10. Can we do the same now for non-clinical topics: which non-clinical problems have unknowns for you? *Probe whatever emerges from a Deep End perspective. If it helps, **share screen** with example areas to explore:*
- Determinants of health – what make people sick or healthy? What do you want to know more about?
 - Is it clear to you how to access help for wider determinants support?
 - What's your experience been like of the quality and availability of that support?
 - If this support was better delivered, what impact do you think it would have on clinical care?
 - What do you want to know about reducing health inequalities?
 - What affects your Deep End patients more than non-Deep End patients?
 - Who else should be researching this? What questions should they be asking?

F. Workforce (10 mins)

11. The next topic I'd like to touch on is to do with understanding the workforce. What questions do you need answered in this respect, or what research would make a difference to your Deep End practice? *Probe whatever emerges from a Deep End perspective. If it helps, **share screen** with example areas to explore:*
- What would be useful to know regarding staff wellbeing?
 - What do we need to know more about in terms of recruitment and retention of all staff when it comes to working in a Deep End practice?

- What would be helpful to know more about when we think of Deep End staff vs non-Deep End staff?
- What would be helpful to know more about regarding clinicians – e.g. motivation/ behaviour/ burn out/ intentions/ attitudes etc?

G. Service organisation (10 mins)

12. Let's move on now to discuss service organisation, so things like improving access for patients, improving quality of service, workload and so on (**Share screen with examples below**). What questions would you like to see answered or what research would make a difference to your Deep End practice? *Probe whatever emerges from a Deep End perspective; example areas to explore:*
- What do you want to know (more) about in terms of:
 - Improving access for patients?
 - Improving quality for patients? What do they complain about the most?
 - Leadership?
 - Workload?
 - Funding and resource allocation?

H. (Ask if time) Advocacy (5 mins)

13. Moving towards the end now, what research do you think Deep End Cymru needs to do to support its advocacy messages? *Could be among Deep End staff, like this project, or patient related research. Probe whatever emerges*

I. (Ask if time) Attitudes to research (5 mins)

14. Very briefly, how do you feel about your practice getting involved in research? *Probe whatever emerges including:*
- What leads to your practice getting involved in research?
 - What prevents your practice from being (more) involved?
 - How do you think your patients feel about being asked to participate in research?

J. Wrap-up (2 mins)

15. Now we've come to the end of the discussion, is there anything else you'd like to add? You can always email Beaufort with anything else that comes to mind.

Thank and close

Appendix B – questionnaire

**March 25 Wales Omnibus
DeepEnd Wales- Questionnaire – FINAL**

Q1. How would you describe your health in general?

- Very good
- Good
- Fair
- Bad
- Very bad

Q2. Which of these statements best describes your attitude to seeing a GP or other health professional?

- I'd always try to go to the GP / another health professional if I have a health concern
- I'd usually try to go the GP or another health professional if I have a health concern
- I tend to be reluctant to go the GP or another health professional if I have a health concern
- I avoid going to the GP or another health professional if I have a health concern

The next question is about health services in your area. Please think about NHS services such as from GPs and hospitals.

Q3 What's your overall opinion of health services in your area? Please answer on a scale of zero to ten, where zero is 'extremely bad' and ten is 'extremely good'.

- 0 – Extremely bad
- 1
- 2
- 3
- 4
- 5
- 6
- 7

8

9

10 - Extremely good

Again thinking about your local area

Q4 To what extent do you think the following impact on the health of people in your local area?

(order of statements will be randomised between respondents)

| | I think it's an issue in my local area and it impacts on people's health | I think it's an issue in my local area but it does NOT impact on people's health | I <u>don't</u> think it's an issue in my local area |
|--|--|--|---|
| Availability of transport to attend healthcare appointments and services | | | |
| Availability of GP appointments at different times of the day / week | | | |
| Insufficient education or information about how to live healthily | | | |
| People being able to take some responsibility for their own health | | | |
| Distrust of healthcare professionals | | | |
| Poor standard of housing | | | |

| | | | |
|---|--|--|--|
| People not taking up offer of screening tests when they are offered them (e.g. cervical screening, bowel screening) | | | |
| People not getting their children immunised | | | |
| Difficulty in understanding what you need to do to access health services | | | |
| General levels of poverty | | | |
| A lack of appropriate care for the type of people who live in my area | | | |
| Not being able to consistently see the same GP / healthcare professional | | | |

Q5 Research plays an important role in helping to improve the health and wellbeing of the population.

Please consider each of the following potential health research topics.

If the NHS were able to fund research into these areas which do you think would have the most impact on improving the health of people in your community.

PLEASE CHOOSE UP TO 6 FROM THE LIST BELOW

(order will be randomised between respondents)

... how to adapt health services to better suit local communities

... what can be done to improve GP appointment availability

... how to encourage people to take up offers of health screening (e.g. cervical screening, bowel screening)

... how to encourage people to get their child immunised

... why some people distrust healthcare professionals

- ... how housing impacts health
- ... how to encourage people to take responsibility for their own health
- ... how patients could be supported to understand how the healthcare system works
- ... which types of information or education would help encourage people to engage with health services
- ... how poverty impacts on health
- ... how to fill vacant health professional jobs and encourage health professionals to continue to work in the community.
- ...how access to transport impacts health