Workforce Voices

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

GPs at the Deep End

Report 1:
Connecting, sharing and celebrating: a landmark celebration of the London Deep End community coming together in-person, for the first time, in partnership with Workforce Voices.

Report on a meeting held on Wednesday 4th February 2026 at the UCL Institute of Child Health- Wolfson Centre, Mecklenburgh Square, London

On behalf of Workforce Voices:
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Dr Bryan Burford, University of Newcastle
Professor Sophie Park, University of Oxford
Professor Tim Rapley, University of Northumbria
Dr Eleanor Hoverd, University of Oxford

London Deep End co-producers:
Dr Kavita Gaur, GP, Northeast London
Dr Jenny Blythe, GP, Northeast London
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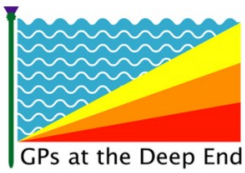


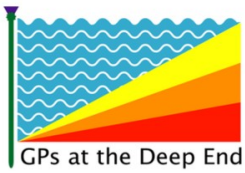
Workforce Voices is funded by the National Institute for Health and Care Research (NIHR) HSDR grant number 160772. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

Summary

A meeting was held on 4th February 2026 at the UCL Institute of Child Health- Wolfson Centre, Mecklenburgh Square, London, hosted by Workforce Voices. Workforce Voices is a National Institute for Health and Care Research (NIHR) and Delivery Research (HSDR) workforce research partnership. The partnership works between universities and healthcare organisations to find ways to improve the working experience of different staff groups in the NHS – anyone working in any role in general practice or maternity services, in under-served areas.

The event was one of a number of UK Deep End-based conversations being held with the Workforce Voices research partnership, creating space for London Deep End colleagues to connect and share thoughts about future neighbourhood working. The Deep End London group was formed in September 2020, virtually, by a several GPs as a way of sharing information and building solidarity through a London Deep End Equity community. The group has continued to grow to include a range of health and care professionals who are passionate about reducing the impact of "*longstanding health inequity, racism, and social exclusion, to address climate change and to promote fairer systems and healthier places to live and work*. [1]"

The agenda for the event was co-produced with members of both the Workforce Voices research partnership and some of the members of the London Deep End group.



Lunch and refreshments were provided by Workforce Voices research partnership.

Professor Gill Vance (Newcastle), co-lead of Workforce Voices opened the event welcoming the group and introducing Workforce Voices to those in attendance. Speakers from Workforce Voices including Professor Sophie Park (Oxford - realist review workstream lead) and Dr Eleanor Hoverd, Research Fellow (Oxford) presented an introduction to the event and a brief overview of the realist reviews currently in progress. This was followed by a creative activity in break-out groups that provided space for building, drawing, writing and discussing what they thought a “good” workforce looks like in neighbourhood health for the communities they serve in the Deep End. A discussion and agreement of key recommendations was facilitated by Professor Caroline Mitchell (Keele), Dr Kavita Gaur (GP – Northeast London) and Dr Jenny Blythe (GP, Northeast London). Professor Sophie Park and Professor Tim Rapley then facilitated discussion of ways to draw together identified problems as well as available and potential solutions to inform next steps. The discussions have been summarised below into nine, descriptive themes. A set of draft recommendations follows with a concluding summary of the event.

Summary of speakers talks:

• Professor Gill Vance presented an overview of the Workforce Voices research partnership, outlining the five, Health Services Design Research (HSDR)R Workforce Research Partnerships around the country. She described the focus of Workforce Voices on workforce sustainability, particularly on recruitment, retention and ensuring the right people are in

the right roles. Professor Vance explained that the research partnership focusses specifically on under-served areas which include those that are economically deprived, rural/remote and coastal. She provided an overview of the Core partners and workstreams that encompass a diverse range of expertise. An overview of the aims and philosophy of Workforce voices as well as the projects underway. Professor Vance highlighted that the London Deep End are a key partner with relationships established with Deep End partnership in the Newcastle and Northumbria regions with a view to learning from, working with and complementing past, present and planned work to produce workforce benefits.

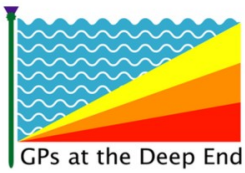
• Professor Sophie Park chaired an introduction of all present, inviting people to share their roles and interests. She outlined the planned activities and co-produced learning outcomes, demonstrating how these addressed the identified needs of both the *Workforce Voices* research partnership and the Deep End group, informed by preliminary discussions with the wider group and facilitators via WhatsApp and email.

Learning Outcomes

Intended learning outcomes for the Deep End group were:

1. To provide a space for face-to-face connection between London Deep End group members.
2. To facilitate conversations about some of the upcoming opportunities and challenges of neighbourhood working for Deep End communities and workforce.
3. To explore appetite for further events.

Intended outcomes for the Workforce Voices research partnership were:



1. To build on a range of conversations with Deep End communities and groups across the UK, to ensure our work is rooted in Deep End priorities.
2. Share updates and listen to feedback about our research so far (particularly looking at insights and gaps identified from the existing literature).
3. To explore opportunities to help develop and evaluate relevant interventions to serve the needs of Deep End communities and workforce.

• Eleanor Hoverd presented emerging findings on two realist reviews, a theory driven, interpretative approach for synthesising evidence about complex systems and problems. Plans to develop a third review around Deep End learning was also shared.:

1. Understanding the contextual and causal factors shaping the work of receptionists in general practice: A realist review
2. Understanding how the primary-secondary care interface works, for whom, how, why and under what circumstances, in under-served areas: a realist review protocol
3. Understanding how learning is facilitated and supported within Deep End groups, for whom, and under what circumstances: a realist review

Summary of key themes

Nine descriptive themes were identified through the discussions and creative activity with attendees:

1. ***Neighbourhoods as relational, not just structural***

Across the discussions and creative activity, “neighbourhood” was understood less as a fixed structure and more as a relational and conversational space. Participants questioned who defines neighbourhoods, who holds power, and how solutions are shaped. Participants expressed strong resistance to top-down configurations, favouring locally defined, community-owned approaches that enable “one conversation” across services rather than fragmented interfaces. A key contribution of this work was to clarify what “neighbourhood health” means, a concept that remained unclear to many and to ensure that the needs of deprived patient populations and the workforce supporting them were central to its development.

From deficit to strengths-based narratives

A shared concern was the dominance of deficit-focused narratives about deprivation, practices, and communities. Instead, attendees emphasised recognising existing strengths, informal labour, and relational work that already sustain care but remain invisible to funding and metrics. This hidden work underpins the system yet contributes to burnout and moral injury when unacknowledged or unfunded.

2. ***Workforce capacity, agency, and moral injury***

Attendees highlighted a range of pressures on the primary care workforce:

Capacity constraints are pushing clinicians away from frontline care.

This aligns with evidence from a recent realist review published in 2025 on GP workforce sustainability [3] , which found that when practices operate at, or beyond functional capacity , additional demands do not translate into increased output but instead trigger adaptive responses such as role withdrawal, reduced availability, or exit from frontline work

[3]. The review conceptualised workforce capacity as an elastic and dynamic system with sustainability undermined when responsibility for excess demand is implicitly shifted onto individuals who are already operating at full capacity. The review demonstrated how capacity is not fixed but can be modified e.g. through strong (and continuous) relationships between staff and patients, to maximise the effective use, potential needs and planning of interactions. Discussions highlighted the need for system-level collective pressure adaptations to enable equity (supporting those staff and patients who need it most in order to engage) rather than placing additional burden on those who are struggling most.

Agency matters: staff need permission, expertise, and protected time to advocate, innovate, and respond to social complexity.

There is a lack of “space” to do better, with GPs feeling that they are working at maximum capacity. Much essential work (advocacy, emotional labour, interface management) is formally unpaid, creating chronic moral injury. Examples of ‘protected time’ for GPs to engage with local communities or invite community members into the practice were shared as valuable elements of neighbourhood work. There was discussion of whether shared accountability through collective action that is aligned with collective responsibilities and outcomes, rather than individual resilience, might be needed to challenge unfunded expectations embedded in the system. This may support improved job satisfaction and patient experience.

3. ***Relationships and continuity as core infrastructure***

Relationships emerged as the core “infrastructure” of neighbourhood health:

• Relational continuity between staff, patients, and communities was valued more than introducing new or alternative services.

• Many patients continue to want to see a GP, reflecting distrust or limited utility of fragmented or unfamiliar services where most problems are interconnected, undifferentiated and complex.

• Reception staff and non-clinical roles were repeatedly highlighted as central to trust, access, and patient experience, not peripheral. Discussion around “doing” relationships differently [4], developing job descriptions that have space for innovation and change could make the difference between creating a new role versus encouraging everyone to do something differently in the way in which they relate to each other. For example, having space to reflect after changes are introduced.

4. ***Feeling valued: roles, recognition, and investment***

Feeling valued was consistently linked to workforce wellbeing and innovation. This included:

• Clear role definition and recognition across clinical and non-clinical staff with job descriptions reviewed regularly to adapt to new needs of the population and service.

• Investment in reception teams (training, debriefs, aggression management, time-out permissions) leading to improved retention, confidence, and service quality. This was felt to require innovative Practice Managers who are forward-thinking and created protected time to innovate.

• Practices that supported reflection and staff development were often those with the flexibility to experiment and adapt. Participants highlighted the importance of a learning-oriented culture in enabling this approach. At the same time, there was recognition that practices operating under significant financial and workload pressures may struggle to create the time, headspace, and stability required to begin, let alone sustain such work

• A need to articulate clear values and vision underpinning general practice was desired.

5. ***Space for thinking, connection, and shared learning***

A major cross-cutting theme was the absence of funded space:

• Space to think, reflect, and share was seen as essential, not a luxury.

• Participants valued protected time for all staff (including clinicians, receptionist etc.) to reflect upon and discuss “moral moments” encountered under pressure during everyday ethical decisions. For example, a receptionist might experience moral injury absorbing anger and frustration from patients leading to compassion fatigue. Having the space to discuss these situations with other practice staff may be beneficial to receptionists, patients and practice colleagues.

• Informal mechanisms (story exchange, WhatsApp groups, books of “good practice”) were viewed as powerful ways to surface learning, making invisible work visible, and building collective confidence.

There was a strong desire to connect with the local community e.g. four hours per month for communities to talk with general practice staff, building relationships and mutual understanding.

• Create spaces for mutual learning between practices and communities.

6. ***Experimentation, small wins, and learning together***

There was clear rejection of searching for a single solution.

Instead:

• Emphasis on trying small, creative interventions, learning iteratively, and sharing what works.

• “Trojan mouse” approaches and marginal gains (Olympic cycling analogy) were used to describe how small changes can shift power, relationships, and outcomes.

Examples included housing drop-ins, Primary Care Networks (PCN) going out to communities, social-legal welfare advisors, crisis funds, and practical fixes that make an immediate difference. The importance of the GP as expert generalist was highlighted. This role supports patients (often with undifferentiated and multiple issues) to problem-set and identify problems prior to identification of relevant supportive resources.

7. ***Metrics, funding, and speaking the system's language***

Participants expressed frustration that metrics and coding often fail to capture meaningful work and can generate "failure demand" (e.g. inappropriate interventions). However, there was also realism:

• Numbers and metrics remain the dominant language of funders.

• Stories, moral moments, and relational work need translation into evidence without losing their meaning and are important to share. They provide ways to improve and sustain practice.

The discussions at this event present an important opportunity for the collaboration between Workforce Voices and the Deep End London group to potentially translate some of these stories and moral moments into evidence, retaining their meaning.

There was interest in evaluation, narrative capture, and shared learning to help practices evidence value and advocate for examples where something does work locally but the evidence is required to legitimise, sustain and ensure interventions or activities that are suitably resourced.

8. ***Solidarity, hope, and shared struggle***

The Deep End London group itself was described as a source of solidarity and belonging, a community of practice, where struggles are

shared, acknowledged and supported, hope is balanced with realism, and **ideas grow through shared stories rather than competition**. Sharing learning across regions made visible the widespread nature of deprivation and service pressures, reducing isolation and shifting the focus away from blame at practice or local level.

By broadening perspectives, the London Deep End group allows a range of healthcare professionals (including GPs) to connect and share ways to make-meaning, acknowledge and develop positive strategies to address the burden and trauma experienced by patients and staff.

Key learning and next steps for workforce sustainability in Deep End areas

Attendees were divided into three break-out groups each facilitated by GPs working at the Deep End (CM, KG, JB). Professor Sophie Park facilitated a discussion of key learning raised in each of the groups. These included:

1. Fund protected “thinking and connection space” at neighbourhood level

Create explicitly funded, protected time for practices and neighbourhood teams to think, reflect, and connect. This should include space for:

- Sharing “moral moments” and ethical dilemmas across all staff groups (clinical and non-clinical)
- Reflecting on what works, what doesn’t, and why
- Building relationships with community partners and local services e.g. staff going into communities or protected time for communities to come into practices.

This space should be recognised as core infrastructure, not an optional extra, given its role in workforce wellbeing, innovation, and continuity of care.

2. Invest in the whole practice workforce, not just clinicians

Funding and support should explicitly include receptionists, practice managers, and non-clinical staff, recognising their central role in access, trust, and continuity. This includes:

- Training (e.g. aggression management, trauma-informed care)
- Structured debriefs and peer support
- Permission for staff to pause, reflect, and recover

Evidence from practice that investment in reception teams showed improved morale, retention, and service quality, suggesting this is a high-impact, scalable intervention.

3. Shift from "finding the solution" to supporting innovation, implementation and shared learning

Move away from seeking single, system-wide solutions. Instead:

- Support small-scale innovation and implementation ("trojan mouse" approaches)
- Encourage incremental change and rapid learning
- Create mechanisms (e.g. story exchange, shared repositories, informal networks) to spread ideas across practices
- Create flexible space in job descriptions to enable innovation and use approaches to focus on relationships rather than specific roles

This approach recognises the complexity of deprivation and allows locally appropriate solutions to emerge and adapt over time.

4. Make invisible visible and address it collectively

Trauma-informed work with patients requires time and short-term investment to support system-wide and longer-term benefits. There needs to be longitudinal vision where longer appointments are required in the short term. Investing in this way would create a positive ripple effect across the system.

Commissioners and system leaders should acknowledge the essential role of informal and relational work sustaining primary care (e.g. advocacy, interface work, emotional labour). Actions could include:

- Capturing this work through narrative and qualitative evidence
- Aligning funding with what practices actually do and related outcomes, not just what is coded at one point in time

Without this, moral injury and workforce attrition will continue.

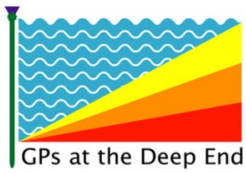
5. Balance stories and metrics to "speak the language of funders"

Develop approaches that combine qualitative stories with quantitative evidence, ensuring meaningful work is not lost in coding systems. This could involve:

- Evaluating small interventions and relational work
- Translating patient and staff stories into funder-relevant outcomes
- Supporting practices to evidence impact without adding excessive administrative burden

This enables advocacy for funding while retaining the values and intent of neighbourhood working.

6. Strengthen Deep End as a community of practice and solidarity



Resource and grow Deep End as a space for solidarity, shared identity, and collective learning recognising its role in:

- Reducing isolation
-Acknowledging and supporting struggle

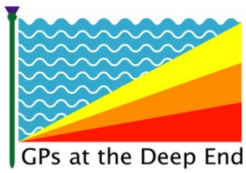
Sharing hope grounded in realism was repeatedly identified as critical to sustaining workforce morale and enabling change in highly pressured contexts.

Ways Workforce Voices and the Deep End can work together

Suggested ways in which Workforce Voices and the Deep End could work together were discussed. The Deep End were keen for Workforce Voices to support rigorous production of evidence about innovation and implementation in Deep End communities. A number of suggestions were made. For example, Dr Tamsin Ellis, Former Director of Greener Practice, Salaried GP in London and an Associate at the Centre for Sustainable Healthcare shared existing and potential opportunities where generation of evidence can support practice.:

1. COPD proactive winter care reviews.

Addressing high avoidable admissions and fuel poverty in Islington, this multi-agency project proactively "cold-called" high-risk COPD patients to provide vaccinations, clinical reviews, and referrals to social prescribing and fuel poverty services. The initiative used co-production with nurses and EMIS data tracking to evaluate impact, successfully demonstrating a "worthwhile" model that is now being scaled to lower-risk groups. This



serves as a prime example of a "trojan mouse" intervention that targets social complexity through collaborative, relational care.

2. Smear project:

This initiative utilises Somali and Turkish-speaking "cancer champions" to deliver community-led workshops and Q&A sessions, effectively breaking down cultural barriers to cervical screening. By partnering with Healthwatch and practice nurses, the project aims to formalise these ad-hoc outreach efforts into a sustainable, evidence-based model for improving health equity.

3. Greener Practice: This initiative focuses on implementing environmentally friendly Quality Improvement Projects (QIPs) at the local practice level while collaborating with the national "Greener Practice" network. The goal is to rigorously evaluate these interventions to determine their clinical and environmental impact, potentially scaling successful models across the primary care system.

4. Addressing high turnover of receptionists

To address high staff turnover, this practice invested in reception-focused wellbeing by introducing away days, debriefing sessions (“5-minute timeouts"), and aggression management training for reception staff. The project demonstrates how small, low-cost shifts in practice culture can significantly improve staff retention and psychological safety.

Evaluation of the event

Feedback from the event was collected both informally during the event and through an MS Teams form. The overwhelming feedback was positive with attendees reporting feeling “connected” (see word cloud in Figure 1 below):

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Figure 1. Word cloud –description of feelings

Attendees reported valuing meetings with “like-minded colleagues” particularly those from the Deep End group or different sectors. One attendee noted the power of shifting the focus to the workforce and not the patient. There was a clear appetite for understanding and co-creating the reality of neighbourhood working and how it differs from current models. There was a clear desire for sustaining a relationship with *Workforce Voices* through a variety of methods: newsletters and online updates for those who have limited time, face to face events with one attendee noting that they would like to see future involvement costed. Attendees also appreciated learning across the North and South UK experience: appreciating the diversity, but common depth of deprivation and need that all present sought to support in their professional roles.

Photographs

Photographs from the event are shown below. Photography credit: SP, KG (consent was obtained from attendees with permission to share these photographs):

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Alt text: Two workshop attendees smiling and talking while looking at a shared notepad during a breakout session.

Alt text: Two smiling attendees taking a selfie together during a workshop break

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Alt text: Groups of attendees sitting at desks sharing ideas

Alt text: Three workshop attendees standing together and smiling for the camera

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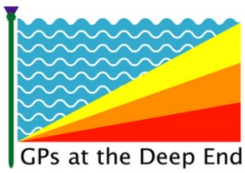
GPs at the Deep End

Alt text: Three GPs smiling for a selfie during a break

Alt text: A Lego model representing 'a good workforce’ built by attendees using various coloured blocks and a window piece.



Conclusion

The collaboration between *Workforce Voices* and the Deep End London group highlights a critical crossroads for primary care. To sustain a workforce operating at its absolute limit the system should view sustainability as being found in collective accountability, not individual resilience as well as formally recognising the often invisible relations work that occurs, preventing the system from collapsing. The conversation reinforced that any next steps must be realistic, properly resourced, and collectively owned, given existing workload pressures.

Success in neighbourhood health requires a shift in funding to enable protected spaces for thinking and connecting, investment in the non-clinical workforce such as receptionists and adopt “trojan mouse” approaches to innovation that values small, local wins, over rigid, top-down implementation. Ultimately, the Deep End group functions as a critical community of practice, providing the solidarity and hope necessary to balance the harsh realisms of frontline practice with the possibility of meaningful change.

In conclusion, the workshop forms part of a wider series taking place across communities in the UK aimed at gathering shared insight to support and evaluate the local implementation of innovation.

Acknowledgements

We would like to thank all speakers and attendees. Thank also to Professor Caroline Mitchell, Dr Kavita Gaur and Dr Jenny Blythe for capturing key discussion points in the break-out groups and feeding this back to the whole group. Thank you to Professor Kath Woolf for helping us to arrange a room to hold the event in.

Disclaimer

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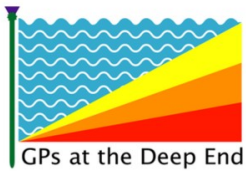

The views in this report from the break-out group discussions were analysed and collated by the authors of this report, and do not necessarily reflect the views of all discussants.

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