GENERAL PRACTITIONERS AT THE DEEP END
INTERNATIONAL BULLETIN NO 14
DECEMBER 2025

Introduction

Welcome to the 14th Deep End International Bulletin, with reports from 12 Deep End Projects from 8 countries on 4 continents.

Be impressed by the range of activity, often described under the headings of Workforce, Education, Advocacy and Research.

Some projects such as Denmark, Canada, Ireland and Scotland cover whole countries and engage with national political and other institutions. Others cover local regions, areas or cities. Their situations and possibilities differ but they are all expressions of front-line practitioners' commitment to address inequities and injustices in health and health care.

Austin O'Carroll (page 4) introduces the third *Medicine on the Margins* Conference to be held in Dublin on 30th January 2026, specifically for young doctors in training and health inequality fellowship schemes.

And on page 24, the Deep End Ireland team give advance notice of a Deep End International Conference in Dublin on 15-16th May 2026. What further encouragement do you need to visit Dublin in 2026?

On page 7, the Scottish Deep End Project gives generic advice on how to criticise the political enthusiasm for walk-in centres in primary care.

Throughout the Bulletin, starting on page 17, there are snapshots of the Health Inequalities Exhibition at the RCGP Headquarters at Euston Square in London.

Catch up on previous Deep End International Bulletins (page 27) on the Scottish Deep End website, which had 4473 views in 2025, and 423 for the international page.

Graham Watt **graham.watt@glasgow.ac.uk** **December 2025**

The raw material is the consultation. With continuity and coverage, a pattern can be wrought. For individual patients, the serial encounter builds knowledge, experience, confidence and trust, to cope better with life's problems. For the population, audit and the measurement of omission are the keys to equitable care. For the future good of humanity, practitioners take long and painful labours. The effectiveness of primary care depends on the "harmonious order of its parts". Primary care is a social construction, made of ordinary materials, mostly men and women, and beautiful in its own way.

From The Exceptional Potential of General Practice. Making a Difference in Primary Care

Contents

I have gathered a poesy of other men's flowers, and only the string that binds them is mine own.
Montaigne

MEDICINE ON THE MARGINS CONFERENCE IN DUBLIN, 30TH JANUARY 2026

Austin O'Carroll

Over the past decade, a new movement has emerged across Ireland, Scotland, and England/Wales: GP training programmes and Fellowships designed specifically for doctors working in the Deep End. These include the North Dublin City GP Training Programme, Scotland's GP Pioneer Programme, and in England/Wales the Trailblazer Scheme, Health Equity Focused Training, and the Greater Manchester Deprivation Programme. Their mission is clear: to address the *Inverse Training Law* i.e. the reality that the areas most in need of GP training practices are the least likely to have them.

These initiatives do more than teach good general practice. They equip GPs with the skills, insight, and motivation to tackle health inequalities and to work with marginalized populations—people experiencing homelessness, migrants, travellers, people who use drugs, and others whose needs are often overlooked in mainstream training.

Evidence now shows that training GPs in Deep End settings improves recruitment into these areas. Clinical exposure during training is a decisive factor in shaping young doctors' choice to continue working in deprived communities. Follow-up data from the NDCGP Programme in Dublin show this effect clearly: 59% of graduates are working in areas of concentrated deprivation; 22% care for significant populations from deprived backgrounds; and 40% are working part-time with 11% full-time, in clinics dedicated to marginalized groups. Graduates report increased commitment, confidence, knowledge, and practical skills for working in Deep End practices. Crucially, they also describe reduced prejudice and greater empathy for patients from disadvantaged backgrounds.

While it is still too early to fully evaluate retention, early success in recruitment—and the growing number of young GPs training in this way—is likely to support the morale of older GPs and encourage them to remain in Deep End practices.

The Third *Medicine on the Margins* Conference – 30th January 2026

On 30th January 2026, we will host our third *Medicine on the Margins* Conference, bringing together GP trainees and Fellows from these programmes. This year, our focus is poverty:

- How poverty creates the conditions for childhood trauma, and how that trauma shapes later health and life outcomes
- The political drivers of poverty and why GPs must understand them
- The ways in which poverty generates marginalization across the life course

Alongside clinical and policy discussion, we will explore poverty through the arts—with a photographic exercise examining the built environment, and a spoken-word session. Spoken word poetry has long been a vehicle for working-class voices to express life in deprivation; we hope to draw on that tradition.

Inspiration literally means "to breathe life into." This conference aims to breathe life into the growing movement that trains doctors to work in the Deep End. But this momentum is fragile. The Scottish GP Pioneer Programme, despite its documented success, was defunded. We cannot allow the same to happen elsewhere. These programmes need support, renewal, and expansion. Because patients in the Deep End need doctors who are trained to understand their lives.

To register, email Caroline.keating@icgp.ie. Cost 60 Euro.

CONFERENCE PROGRAMME ON 30TH JANUARY, DUBLIN

09.10-09.30	Social Inclusion How to approach and tackle	Brian Kirwan HSE Social Inclusion Lead
09.30-10.30	Let's Get Political A political approach to addressing the Social Determinants of Health	Senator Lynee Ruane
11.00-11.30	Spoken Word Poetry Performance in Action	Emmet Kirwan Actor, Playwright, Poet
11.30-12.30	Impact of Childhood Trauma How the Past Shapes the Future	Dr Sharon Lambert Clinical Psychologist, UCC
12.30-13.00	Put Yourself in the Picture Photographic Art Project inspired By local artist Dorothy Smith	Dr Paul Doyle ASD, NDC GPTS
14.00-15.00	Workshop Choice 1	NDC GP training Scheme
15.00-16.00	Workshop Choice 2	NDC GP training Scheme
16.00-16.30	Spoken Word Poetry Performance Performance in Action	Co-ordinated by Cormac MacGearailt Artist and Poet
16.30-17-15	Love and Power Leadership for Health Equity	Prof Andy Knox MBE Academic GP
17.15-17.30	Closing Address	Prof Graham Watt Founder, Deep End

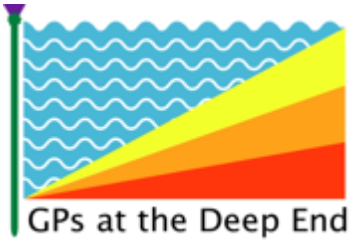
WORKSHOPS

The choice will be between sessions on Theatre of the Oppressed (Alana Lawlor and Paul Doyle), Drug Addiction (Mark Murphy), Homelessness (Austin O'Carroll), Sex Working (Lisa Lawless), Prison Health (Therese Boyle), Migrant Health (Fiona O'Reilly and CrossCare), Narrative-Based Medicine (Anna Beug) and Spoken Word Poetry (Cormac Mac Gearailt)

NOTE

Reproduced below is the response of the Scottish Deep End Project to the Scottish Government's suddenly announced (like pulling a rabbit out of a hat) policy of establishing Walk-in Centres in Scottish primary care. The arguments in response are well made and may be helpful in other contexts.

WALK-IN CENTRES



17th October 2025

Dear Cabinet Secretary

We were surprised, disappointed and distressed to hear the recent announcement from the First Minister that 15 new GP 'walk-in' centres are to be opened in Scotland in the coming months. We believe that an unintended consequence of this approach will be to worsen health inequalities. We have explained our reasons for this below.

Erosion of continuity of care

A walk-in service, that is purely driven by convenience and speed of access will further undermine our ability to deliver continuity of care. As we've discussed with you previously, continuity of care is so important as a driver of improved safety, improved quality, improved efficiency, improved treatment adherence and prevention uptake, improved health outcomes (morbidity and mortality), reduced emergency admissions, improved patient experience, and improved clinician experience. The evidence base, especially for relational continuity of care between a GP and their patient over a long period of time, is overwhelming. It is the reason many doctors choose to become GPs. It is especially important for patients who are experiencing poverty, social adversity, mental health issues, addictions, complex long term conditions, frailty, and much more (if of interest, our recent roundtable discussion and report explains this in more detail). Without joined up IT systems, walk-in centres will also negatively impact on informational continuity of care, with lack of access to a person's medical and social history and context; this in turn drives inefficiency and can have serious safety implications (for example around prescribing of complex medications, lack of awareness of social circumstances such as vulnerable adults or children, gender-based violence, and much more). We are also concerned as to how robust and reliable lines of communication will

be achieved between walk-in centres and the patient's registered general practice, or indeed our existing out-of-hours general practice service (which seems to have been forgotten in all of this despite the excellent coverage they provide to ensure a 24/7 service), given our poor experiences of IT inter-operability to date.

Cost-effectiveness, and overconsumption of healthcare

Being seen, assessed, investigated and referred by a clinician who does not know the patient, or the wider context of their ongoing health issues, who does not have access to their records, and who is unable to use time as a diagnostic tool because they are not seeing them for follow-up, is likely to drive overconsumption of health care. This is because the ability to safely manage risk and complexity (in the absence of a long-term care relationship) is greatly reduced. This is likely to drive up costs for the NHS in terms of diagnostics and in terms of waiting times for specialist treatment. Walk-in centres in NHS England were not found to be cost-effective. Previous analysis by the Nuffield Trust, which considered whether these models met need or simply fuelled demand demonstrated that they generated additional demand at high cost. They noted that "16% of people attending walk-in clinics reported that they would have done nothing if that service had not been available". This development is also completely at-odds with the principles of Realistic Medicine, 20-minute neighbourhoods, and our desire to move to more low-carbon approaches.

Impact on core general practice – workload and workforces

The creation of parallel systems of care, where there is no ongoing relationship with, or responsibility for, patients, is also likely to generate additional workload for the person's registered general practice, as unrealistic expectations can be created, and work can be 'passed back', which is often inappropriate and demand (rather than need) driven. It is unclear where the additional GP and nursing workforces will be found to staff these new centres, but there is also a concern that it could destabilise existing workforces, which are already working under extreme pressure, especially in more deprived areas.

Impact on ability to address the Inverse Care Law

We have previously had positive conversations with you about how we can tackle the persisting Inverse Care Law in Scottish general practice, recognising that access to care is poorest for those who need it the most, driven by factors including smaller workforces and higher levels of need in our poorest communities. A commitment to invest in a new parallel service undermines the ability to fundamentally address the inverse care law in Scotland which requires increased overall investment in core general practice, with allocation of additional resource proportionate to levels of need.

Cost, and opportunity cost

There is an urgent need to invest in premises, IT and workforce capacity in core general practice if we are to realise the ambition of moving more care into the community and enabling a greater focus on prevention. We are concerned that investing in a parallel

walk-in service will not only be costly and inefficient compared to core general practice, but it will also mean significant opportunity cost, especially at a time of economic crisis.

Two-tier systems of access

We are concerned that the creation of 15 walk-in centres will create two-tier systems of speedy access, depending on where these centres are located. They are likely to widen the urban/rural divide. In addition, regardless of location, access to these centres is unlikely to be 'equally easy' for all. We know that patients from more disadvantaged areas, who often experience lower levels of health literacy, lower confidence in navigating complex systems, and who often have additional language needs, and much more, will be less able to make use of this additional service, thus propagating a two-tier system of access. If instead, the investment was in core general practice to improve access, this would ensure a less fragmented, and more equitable approach that invests in its future sustainability. Strong primary care systems are globally recognised to correlate with improved population health outcomes, and improved health equity.

Impact on ability to meet the needs of our population demographics

Our population is ageing and living with multiple long-term conditions. The Scottish Burden of Disease data predicts a 21% increase in disease burden over the next 20 years. These projections will generate unsustainable costs unless we grow our generalist workforces in core general practice, who are trained and best-able to deliver holistic, person-centred care, including anticipatory care planning. Walk-in centre models are unlikely to offer patients with more complex medical and social issues access to the vital skills of a wider team, including community link workers and financial inclusion workers. While we continue to prioritise models that are orientated to speed for access and reactive healthcare to meet demand rather than need, we will fail to rise to the population challenges that we face.

Given the lack of detail around these walk-in centres, including in terms of staffing models, intended type of clinical work, location, IT systems, governance structures, guidelines around appropriate prescribing, diagnostics, and referrals, we would be interested to know what mitigations will be put in place to understand and manage these risks.

We do appreciate the challenges that currently exist around access to general practice, especially for working people who appreciate flexibility. But we don't believe that this is the right, or the fair, way to solve the problem. As always, we would welcome the opportunity to discuss these challenges from a health inequality perspective. We look forward to hearing from you.

Best wishes,

The Scottish Deep End Project

BRISTOL

As we move through 2025, the Bristol Deep End network continues to grow in reach, impact and ambition, bringing together frontline primary care teams, community organisations and researchers to tackle health inequalities in our most deprived communities.

Since launching in 2023, we have built a thriving and committed community with representation from all 17 Deep End surgeries across Bristol and Weston-Super-Mare, alongside Homeless Health and The Haven refugee and asylum seeker services. Participation remains strong across our meetings, events and projects with a strong sense of collaboration and shared purpose guiding our work.

Fellowships and Workforce Activities

Our fellowship programmes continue to expand and make a real difference. Over the last two years, 13 Health Inequality Fellows have been supported through BNSSG Training Hub funding. They have worked on projects covering continuity of care, reducing cardiovascular risk, mental health support for minoritised groups, food education, and supporting staff recruitment and retention in Deep End practices. Plans are already in the pipeline for the next group of 5-10 Fellows, starting in January 2026 following interviews in November 2025.

In October 2025, our 5 Research Delivery Fellows began work, funded through the RDN. They are helping practices take part in research and ensuring that patients from our communities are represented in national studies. Alongside them, 4 Health Equity Focused Training (HEFT) Fellows, who started in August 2025, continue to bring health equity learning into GP training.

Our Power Up Passion Projects continue to support clinicians to develop their own projects aimed at reducing health inequalities. Across 2024-25, 13 projects were funded, helping clinicians pursue professional development, improve services and share learning across the network. In addition, our ICB-funded Deep End Research Nurse, working

across Pioneer and Shirehampton practices in Bristol, provides practical support for research and improvement projects in local practices.

Education and Training

Our education programmes continue to grow. The Deep End Student Selected Component (SSC) at the University of Bristol welcomed 4 students in June to July 2025, giving them hands-on experience of primary care in areas of high deprivation. The next cohort is planned for July 2026. We also continue to host University of the West of England Insight Programme students, providing opportunities to learn about research in diverse and underserved communities.

Work is also underway to develop a Deep End conference for GP registrars, planned for Spring 2026, to help early career doctors learn more about health inequalities and the unique challenges of working in Deep End practices.

Face-to-Face Events

We host three major Deep End events each year, alternating between sessions for community members and clinician-only events. All 17 Deep End practices are represented at each gathering, ensuring a strong network of engagement and collaboration.

Our most recent clinicians only event on 14th November 2025 in Bristol brought together GPs and colleagues from across all practices. The day included updates on network projects and upcoming opportunities, a practical session on how to deliver research in Deep End settings, an overview of the ICB's Impact Acceleration Unit and how it supports innovation, discussions on funding and strategy for group consultations in deprived areas, and a hands-on workshop titled Housing Matters! which explored the link between housing and health. The event was practical, engaging and strengthened the sense of shared purpose across the network.

Community Partnerships and Advocacy

Our Deep End PPI Group has grown to include 15 community organisations, bringing a wide range of perspectives from north and south Bristol and the ICE Locality Partnerships. Members provide important insight into patient experiences, including challenges with booking appointments, digital access and language barriers. Their feedback has informed service development and continues to shape our priorities.

Plans are also underway for our first Deep End patient education session on child health, led by a GP, practice nurse and a health visitor, with further sessions planned. In addition, we are exploring the use of group consultations in Deep End practices to improve patient care and engagement.

Research: Delivery and Development

Research is a central part of our work. Our Research Delivery Fellows, Research Nurse and practice-based hubs help ensure Deep End communities are included in national studies. At the same time, grassroots ideas from our clinicians continue to flourish with projects funded through Research Capability Funding. Current projects focus on continuity of care, community health and wellbeing, and the impact of deprivation on menopause care. Collaboration with academics at the University of Bristol, University of the West of England and community partners is helping turn these ideas into meaningful research.

CANADA

PRIMARY HEALTH CARE AT THE DEEP END CANADA REPORT

Ellah San Antonio,[1] Joseph O'Rourke,[1] Shankavi Nandakumar,[1] Kimberly Manalili,[2,3] Stephanie Garies,[2,3] Wendy Blunt,[2,3] Janet Reynolds,[4] Amy Ferris,[2,3] Jazmin Marlinga,[2] Kerry McBrien,[2,3]

1. Upstream Lab, St Michael's Hospital, Unity Health Toronto
2. Department of Family Medicine, University of Calgary
3. Southern Alberta Primary Care Research Network
4. Calgary Foothills Primary Care Network

Primary Health Care at the Deep End Canada had a busy start in its first year, since our first coalition meeting in June 26, 2024. We have grown to approximately 10 organizations and 5 patient partners, representing over 30 individual clinics, from 7 provinces out of 13 provinces and territories. Our members include clinicians, researchers, and staff working in diverse primary health care settings, including family health teams, hospitals, community health centres, community pharmacies, provincial health authorities, and research teams.

What is Deep End Canada?

Deep End Canada is a network of primary health care teams, including health professionals, researchers, patient partners, and decision-makers, working with patients who may face social and/or economic disadvantages. We advocate for addressing health inequities in primary health care at individual, organizational, and policy levels

through the collection and use of social determinants of health data and the sharing of ideas and projects. Currently coordinated by Upstream Lab, our goal is to ensure the sustainability of this network after the end of its current funding.

What have we done recently?

We've built the internal portal within our website for members to access meeting minutes and share resources across the network, as well as the public-facing page to showcase our members and the work they are doing.

We've updated the members' page to include information about Advocacy Trainings, a social determinants of health Resource Bank and added profiles of Patient Advisors. We launched the follow-up survey regarding the Reach and Adoption of the SPARK Tool, to understand any changes in how organizations are collecting and using social data to address social determinants of health.

We hosted two quarterly network meetings and, as part of our evaluation of DEC, hosted several focus groups with members about the collection and use of demographic and social needs data in primary health care.

Members attended the annual Family Medicine Forum by the College of Family Physicians of Canada in Winnipeg, MB in early November and presented a poster about Deep End Canada and our evaluation plan.

The protocol for the publication of Deep End Canada was published in JMIR Research Protocols.

Pharmacy researchers in Newfoundland and Labrador have completed and presented findings from their SPARK RPh Public Engagement project asking about patients' views on collection of social data in pharmacies. These led to a number of other connections to inform provincial activities on social data collection. This work was included in the latest edition of the College of Pharmacy of NL Newsletter, called "The Apothecary".

The University of Calgary is working in partnership with Primary Care Networks and ten primary care clinics serving diverse populations to pilot and study the implementation of the SPARK Tool in urban and rural settings in Alberta. Three of the ten clinics are now implementing the SPARK tool, and we are continuing to work with our partners to prepare for implementation and tailor implementation strategies to their settings, patient populations, and clinic capacity. These strategies include patient and provider engagement, exploration of integration options of SPARK data into different Electronic Medical Records, and partnerships with data and quality improvement supports. We are also engaging community organizations and conducting an environmental scan of

community resources that help to address the Social Determinants of Health in Alberta, which primary care providers can connect their patients.

EVENT SPOTLIGHT

We held an event on July 24 entitled, One year of Deep End Canada: International lessons for tackling health inequities. We heard from health General Practitioners in Ireland (Susan Smith), Scotland (David Blane) and England (Caroline Mitchell) about their experiences establishing and growing their respective Deep End networks: Deep End Ireland, Deep End Scotland, and Deep End Yorkshire and Humber, followed by a Q&A. Members expressed gratitude for being able to learn about other Deep End networks across the pond!

What are we working on right now?

We continue to meet with and recruit new members across Canada as people reach out to the Upstream Lab or Deep End Canada with interest in the SPARK Tool, sociodemographic data collection and/or health equity.

We have been engaging with Electronic Medical Record (EMR) vendors to build the SPARK Tool into diverse EMR systems.
We are adding a new section to the Members portal to showcase and highlight each member and their organization. This will provide updates on how each site is progressing and will aid in connecting members when they have questions about specific areas of work.

What are our goals for the rest of 2025?

We will finalize our evaluation of the network and continue seeking funding opportunities to support future coordination of the network.

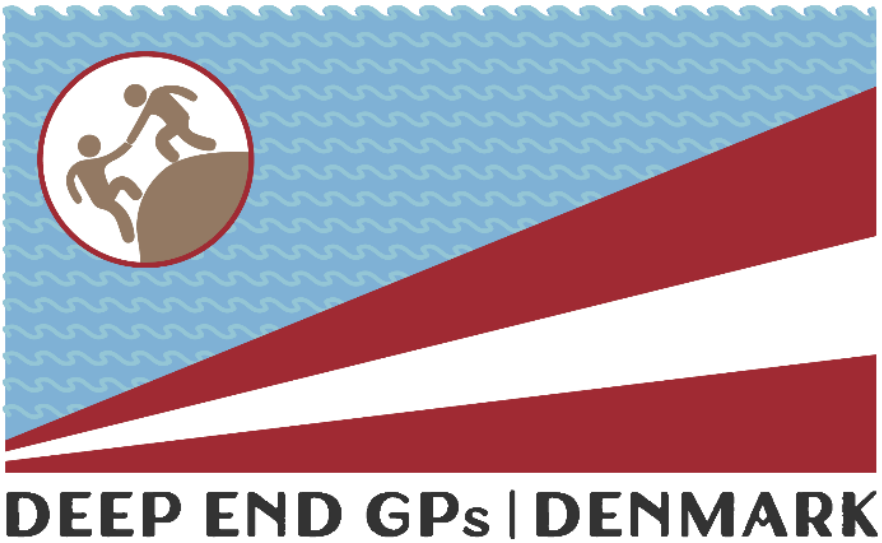
RCGP EXHIBITION ON HEALTH INEQUALITIES

This small and apparently permanent exhibition near the entrance to the RCGP Head Offices at 30 Euston Square, London, comprises several display cases, mostly describing pioneering general practitioners working in deprived areas, especially Dr Julian Tudor Hart, whose INVERSE CARE LAW is quoted in full on a glass panel.

See selected quotes from the displays on Pages 20, 34 and 42.

Display stands at the Health Inequalities Exhibition at the RCGP, Euston Square, London

DENMARK



The Danish Deep End project continues to grow, and currently 56 practices with 80 GPs have joined. They come from different parts of the country, united by a shared passion for supporting patients with more complex health needs than average. They are a group of dedicated 'ildsjæle' – literally translated as 'fire souls' – which means individuals who go above and beyond because they truly believe in what they are doing.

Healthcare Reform in Denmark: Opportunities, Challenges, and Impact

Denmark's healthcare system is undergoing major changes with a new reform that gives general practice an even greater role, creating both opportunities and challenges for Deep End GPs. The reform marks a historic step towards allocating resources according to patients' needs and reducing the inverse care law. The report was formed by the Health Structure Commission and signed by the government. It states: "*The reform also aims to reduce health inequalities. Resources should be distributed more evenly across the country, and the ability to prioritize initiatives and resources for those with the greatest need should be strengthened financially, professionally, and geographically.*"

From the very first Deep End meeting, GPs contributed their views on the challenges they face and potential solutions to the Health Structure Commission, helping to shape elements of the new reform. With the reform now formulated, standing together as a unified group is more important than ever. The Deep End GPs serve as a vital voice for patients whom the system often fails to support, and it is essential to ensure that the reform is implemented as intended, so that resources reach those with the greatest needs and health inequalities are genuinely reduced.

Believing in Incremental Gain: The Story of Deep End

At the very beginning, when we established the Deep End-project, Graham Watt told us, '*You have to believe in incremental gain*.' We have to say he was right. We started with a small group of Deep End GPs who were getting to know each other and discovering how the project could be used to its full potential. Three years later, our meetings are characterized by a strong sense of community, emerging initiatives, high energy, and mutual support. At the most recent national meeting, Deep End GPs were asked to describe the two days in one word, as shown in the figure below. The word 'Fællesskab' was mentioned repeatedly meaning community (see picture below) and the feeling of togetherness and connection within a group. It was a clear example of the spirit and solidarity that increasingly define the Danish Deep End-group.

It is an exciting period for the Danish Deep End project, as the healthcare reform unfolds and the project continues to grow. We are enthusiastic about continuing our journey in 2026.

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

EAST OF ENGLAND DEEP END: EOE

We remain grassroots and connect over 400 professionals across our 6 ICSs (soon to be 3 ICS clusters) and with several of our academic institutions, including Cambridge University, UCL, QMUL, UEA and ARU. If any academic institutions or networks are keen to partner more formally, please reach out! jessica.randall-carrick1@nhs.net, emily.clark2@nhs.net.

We have continued to reach out to EoE Vocational Training Schemes & Training Hubs and taught their adult learners about trauma-informed care, alcohol & drug dependency, chronic pain etc and how to hold a compassionate approach in their interactions with patients. We had a great attendance at our annual online September Symposium, with particular thanks to Prof Andrea Williamson describing the need to tackle 'missingness' and Prof Dom Patterson describing the RCGP's upcoming accredited Fairer Practice toolkit.

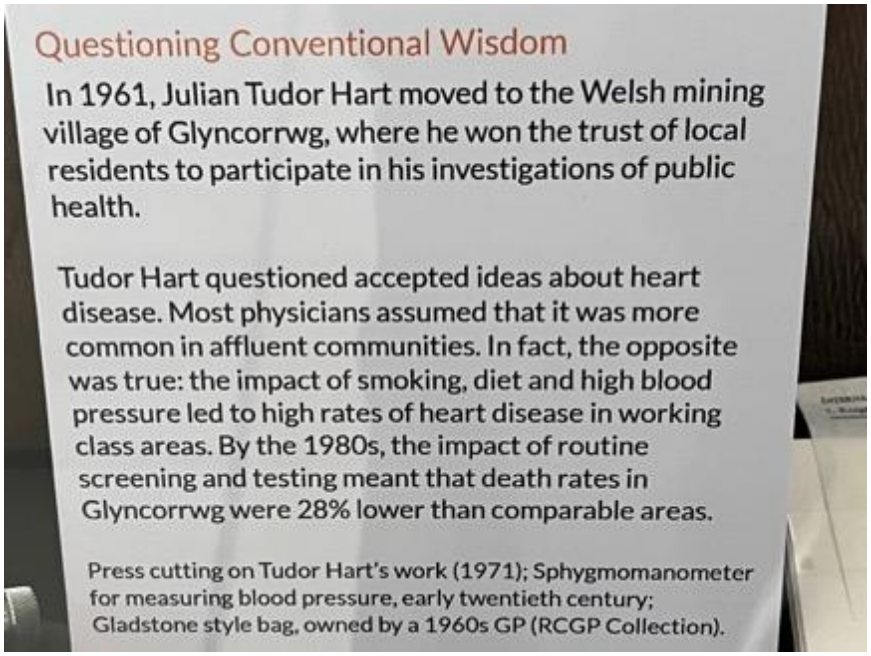
We are thrilled that Dr Jessica Randall-Carrick, co-ordinator and co-founder of Deep End: EoE, is now EoE Medical Director Primary Care and System Improvement at NHSE, and the National Primary Care Medical Directorate Lead for Long Term Conditions. In this role she is positively influencing policy and equity for those in the Deep End by leading on the Modern Service Framework for Cardiovascular Disease (Co-Chair, expected publication Spring 2026), ensuring that there is a Variation & Health Equity workstream across all MSFs. Jessica has ensured that there is health inequality metric on the national GP data dashboard and same metric on the Model Health System, a data-driven improvement tool that enables NHS health systems and trusts to benchmark quality and productivity.

Spotlight on SNEE (Suffolk and North East Essex ICS)…

Thanks to Dr Dean Dorsett and Louise Hardwick from the SNEE ICB Personalised Care team. In SNEE they are integrating Marmot principles, Fuller Stocktake report Core20+5, Joint Forward Plan, NHS 10 year Strategy to develop INT and other guidance by:

- Core Leadership: including membership with all alliance partners, people with lived experience + VCSE members.
- Location, location, location: identifying all 8 INT sites in SNEE based on 5 criteria (Cheap or free, central, transport links, most deprived area of INT, worse health outcomes)
- Integration: Identify 4 lead VCSE for consortia who can deliver core service but also work within other local VCSE
- Connect space at Place: (fluid 'place' definition based on resilience networks) and targeted universalism offer including Social Work, Pharmacy, Nursing, Women's/Children's Services, Education, Healthcare, Prisons, Community Centres, VCSEs etc
- System footprint projects which are all sustainable with scalable outcomes, for example 'Combat 2 Coffee' targeted around Veterans & Men's health and the Football Association as Health Anchor Institution
- Finance Resource Strategy and ICS strategy alignment throughout.

Emily Clark



Excerpt from the RCGP Health Inequalities Exhibition

DEEP END LIVING LAB FRANKSTON, AUSTRALIA

Launched in November 2024, the Deep End Living Lab is based in the Frankston and Mornington Peninsula region of Melbourne, Australia.

A snapshot of the Australian health system

Australia's health system delivers essential health services to 26 million people across a vast geographic area over 8 states and territories. Australia has a universal health care scheme (Medicare) that funds primary care, plus a network of public hospitals that together are designed to provide free or low-cost health services to all Australians. However, significant inequities persist, particularly among people from Aboriginal and Torres Strait Islander backgrounds, people from humanitarian backgrounds and people experiencing complex and multifactorial disadvantage.

Why the Deep End Living Lab?

The Frankston-Mornington Peninsula region of Melbourne is characterised by extreme disadvantage existing alongside extreme advantage. Many people experience intersectional discrimination and marginalisation when trying to access the health, social and community services that they need, placing them at increased risk of poorer health outcomes. This is made worse by a cost-of-living crisis that has seen household expenditure on rent, food and other essentials far outpace wage growth, combined with the lingering effects of the COVID-19 pandemic.

There are an estimated 400-700 people sleeping rough in our region. The number of people living in unstable, unsafe or overcrowded housing is less well documented. About half of the people sleeping rough are in contact with housing or other support services,

and about a third have an active application to receive social housing. The limited availability of social housing stock remains a substantial challenge to addressing homelessness.

Australia does not have the equivalent of Inclusion Health Hubs, therefore, people experiencing homelessness rely on a patchwork of community health, outreach and hospital emergency services for their health needs. Strengthening mainstream health care workers' capacity to respond to people experiencing homelessness is a key area of focus for our team.

Our work to date

- Developed an Australian-first systematic screening algorithm for early identification of housing instability in people accessing healthcare using NCHA's large data.
- Gathered evidence of the systematic barriers hindering healthcare access for this priority population, from the perspective of people with lived experience and clinicians responsible for their care. We have created new knowledge on how these barriers could be overcome.
- Developed a proof-of-concept training module to improve how frontline health professionals respond to patients experiencing homelessness and housing instability.
- Contributed to the Royal Australian College of General Practitioners position statement on homelessness and housing instability.

Australia is full of exotic wildlife, as photographed
by Graham Watt with an iPhone at St Kilda beach, near Melbourne

POSITION OF THE RACGP ON HOMELESSNESS AND HOUSING INSTABILITY

OCTOBER 2024

The RACGP

- Believes that every person requires safe, stable and secure housing to reach and maintain optimal health
- Supports a “housing first” approach where secure, unconditional housing is the first step towards improved heath and social outcomes
- Calls for the recognition of the complexity of the work of general practice, especially when caring for people living in poverty and experiencing homelessness. Access to general practice care, continuity of care and longer consultations should be supported for people experiencing housing instability.
- Advocates for the explicit inclusion of GP expertise in policy spaces where decisions about housing and health are being made, and the increased integration of health and social care functions. General practice expertise needs to be embedded into policymaking and program planning to support people experiencing homelessness and housing instability.
- Believes that adequate funding of general practice is essential to ensure that all Australians can access essential health care, not just those who can afford to pay.

Funding success

In July 2025, our team was successful in a philanthropic funding application to develop, implement and evaluate a new model of care for homelessness. We will be working with a public hospital network in the Frankston and Mornington Peninsula region to co-design this new model of care. Our intervention will focus on enhancing frontline health workers' knowledge, skills and confidence to sensitively discuss housing issues with their patients, and, to offer supported referral to housing and other material aid services available in the local area.

We hope to scale up and disseminate our findings to other Australian jurisdictions down the track.

To learn more about Deep End Living Lab Frankston or explore potential collaborations, please visit us at the Deep End Living Lab/Monash University or contact nilakshi.gunatillaka@monash.edu.

Our team: Suzanne Nielsen, Elizabeth Sturgiss, Nilakshi Gunatillaka, Kimberley Norman, Lin Chai, Helen Skouteris, Terrence Haines, David Blane, Taya Collyer, Philip Mendes, Claire Blewitt, Iain Edwards, Alice Urban.

IRELAND

Save the Date: Deep End Ireland Conference 2026

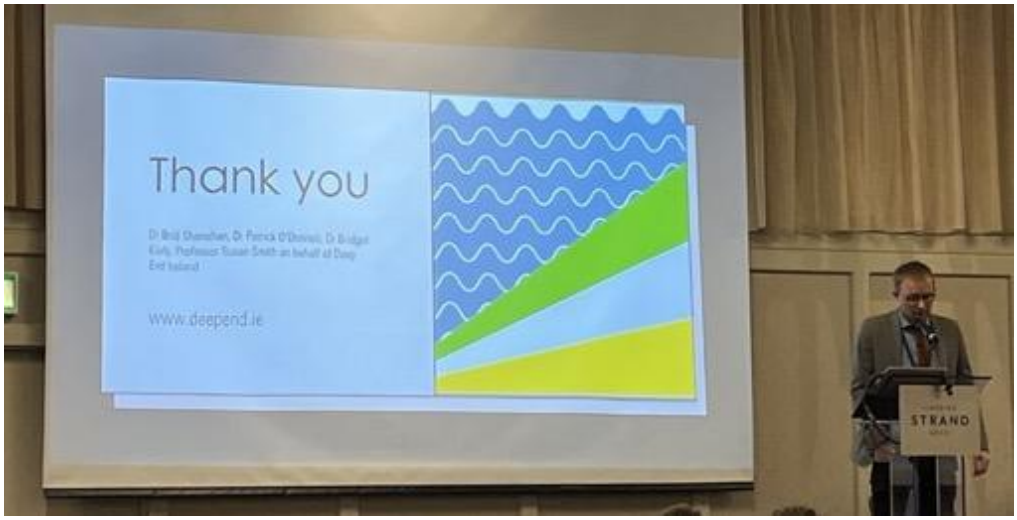
Deep End Ireland is delighted to announce a Deep End International conference that will take place in Trinity College Dublin on Friday, 15th and Saturday, 16th May 2026. Further details, including programme and registration information, will be available in the new year on deepend.ie. We look forward to welcoming colleagues from across the international Deep End community.

"Making Mosaics" – BJGP article

Deep End Ireland member, Dr Anna Beug, contributed to BJGP Life with a reflective and beautifully written piece, "Making Mosaics", which explores the reality and complexity of caring for people living in deprivation.

Presentation at Irish Medical Organisation's 'Health on the Margins' Conference

Dr Patrick O'Donnell represented Deep End Ireland as an invited speaker at the Irish Medical Organisation's Health on the Margins conference. He addressed an audience including GPs, hospital consultants, politicians and health policy leaders, highlighting the urgent need to address structural drivers of health inequity in Ireland.



Deep End Ireland Menopause Project – Summary of Findings

Deep End Ireland recently completed a six-month menopause project funded through the Department of Health's Women's Health Action Plan. Dedicated menopause clinics were delivered across seven Deep End practices in Dublin, Cork and Galway, concluding in September.

Key outcomes from 517 participants (with 85% attendance):

- 8.7% reported literacy difficulties.
- 21% had harmful levels of alcohol use.
- Approximately 20% were not up to date with cervical screening, and 20% were not up to date with breast screening.
- Mental health was addressed in 95% of consultations.
- Only 2.3% required referral to a specialist menopause clinic.
- Newly detected clinical issues included elevated blood pressure in 10% and elevated HbA1c in 7.5% of participants.

The project demonstrated the value of protected menopause consultations in Deep End settings, not only in addressing symptom management and HRT needs but also in identifying hidden cardiovascular risk, supporting mental health, and improving engagement with preventive screening.

Brid Shanahan

DEEP END KAWASAKI/YOKOHAMA

Launch of the Deep End Case Conference (DECC)

At the Annual Conference of the Japan Primary Care Association 2025, we organized a special session introducing the Deep End concept in Japan, together with general practitioners and psychiatrists working in some of the most deprived urban districts — Sanya (Tokyo), Kotobuki (Yokohama), and Nishinari (Osaka). These areas, historically known as the “three major doya-gai” (day-laborer quarters), have long been associated with poverty, social exclusion, and vulnerable communities.

The session attracted exceptional attention — the room was filled to capacity, with many participants standing at the back. The strong response reflected a growing nationwide awareness of health inequalities and a shared desire to learn from the experiences of “Deep End” in Japan.

Following the conference, we launched the Deep End Case Conference (DECC), an online platform connecting clinicians and researchers committed to primary care for socially and economically marginalized populations. The DECC is held every two months and usually gathers 10-20 participants, including general practitioners, psychiatrists, nurses, social workers, and even medical anthropologists, who provide insights into the cultural and structural dimensions of deprivation.

Figure 1. The first session of the Deep End Case Conference

Each session features case presentations and reflective discussions from deprived areas across Japan, highlighting practical strategies, interprofessional collaboration, and self-care among frontline providers. The DECC has become a unique learning community that transcends regional and disciplinary boundaries, fostering solidarity among professionals working at “Deep End.”

Looking forward, we aim for the DECC to grow into a collaborative hub for education, research, and policy development to address social and health inequalities in Japan.

Makoto Kaneko

PREVIOUS DEEP END INTERNATIONAL BULLETINS

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

LONDON

FINDING MEANING IN HEALTHCARE PODCASTS

As Deep End clinicians, most of us understand very well that prevention has roots far deeper than chasing BP targets and lowering cholesterol. Many of us have reflected on what constitutes the essence of our work and considered how we position ourselves as practitioners and as teachers. Inevitably this involves an examination of values. In *Finding Meaning in Healthcare: Looking Through the Hermeneutic Window*, Bob Clarke and I propose a new consultation model that incorporates meaning making. Working in the hermeneutic window encourages us to examine the meaning behind what we do; our conceptualisation of professionalism; how power and inequality affects the consultation; the effect of the hidden curriculum; how we engage with our own emotions; and examine the role that boundaries have for us. With a grant from Della Fish, we have created the Finding Meaning in Healthcare series of podcasts, available on Spotify, Apple music and Amazon; each episode features a story from primary care, where there was a moral dilemma. We hope that these podcasts will be useful in GP training, helping learners to consider their own response to dilemmas posed by Deep End work. We have also planned two conferences- one in December and another in March, both in London – where we will consider the implications of incorporating meaning making into clinical practice and medical education. Please email rupal.shah12@nhs.net for more information.

Rupal Shah

DEEP END OUTER NWL REPORT

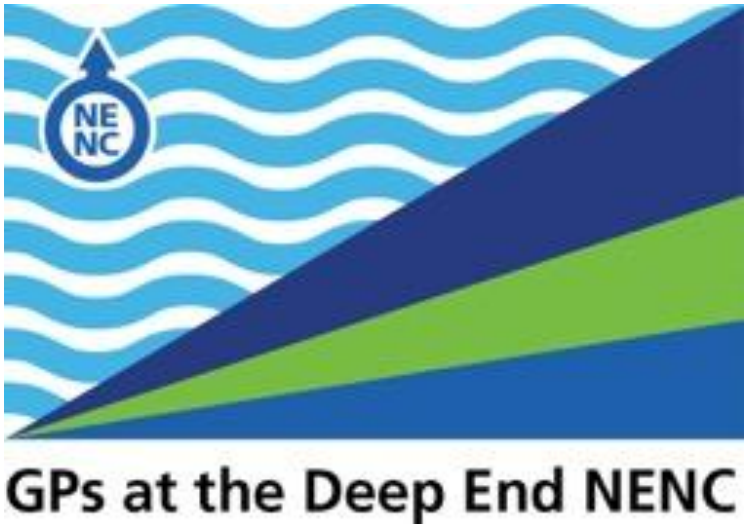
We are working with our local VCSE GP Direct PPG and Roxeth community church, delivering themed workshops and sessions by VCSE partners such as Nisaba, Harrow law centre, and HASVO. We also plan to offer food and clothes banks. We are also working with our team of community health and wellbeing workers to providing tailored support to families with young children. So far, we have had asylum seekers from Iraq, Syria, Gaza, Ethiopia, Eritrea with diverse and complex needs: asylum claim requiring immigration legal advice, mental health, housing, food poverty and early years support around speech and language and behaviour. Attendees have been supported via advocacy support from HASVO, early years support via the community health and wellbeing workers, food bank/hot food via PPG volunteers. There has been liaison with the GP to flag and support mental health needs. We are working to spread the word and plan to translate the flier to key languages.

Some of the PPG group leads who run the session have lived experience of being asylum seekers and also were involved in the design of the session. They are also able to interpret for patients.

Invites were sent via email to all coded as refugee and asylum seekers at the practice. We have been coding these patients by asking this as a question on registration for the last few years to better meet their needs. Following patient feedback, we placed a flag on our computerised records for asylum seeker and refugees to help reception be responsive to their needs.

Jamila.sherif@nhs.net

NORTH EAST AND NORTH CUMBRIA (NENC)



Network Engagement

The Deep End North East & North Cumbria Network (NENC) has continued to strengthen throughout 2024-25. In November, we hosted a major Neighbourhood Health & Deep End Communities Round Table Event attended by over 90 colleagues from across our Integrated Health System (ICS) including Deep End practices, Public Health in local authorities and the Office for Health Improvement and Disparities, NHS Integrated Care Board (ICB) workstreams, NHS hospital trusts, National Institute for Health and Care Research (NIHR) NENC Research Delivery Network(RDN) and Applied Research Collaboration (ARC), Newcastle University researchers, VCSE partners, and representatives from other UK Deep End networks.

Discussions focused on access, trauma, system fragmentation, the importance of local leadership, and ensuring Deep End communities have meaningful influence within the emerging Neighbourhood Health Framework.

Practices also continue to engage through our regular webinars and learning sessions. Our most recent webinar brought together multiple Deep End practices to discuss early learning from the CAREDEEP pilots, cancer screening recovery, and the development of local Social Determinants of Health roles.

Pilot Projects

Three key pilot areas are currently being delivered or expanded across the network:

Training Practice Development (TRAINDEEP Expansion)

We have successfully supported practices to become training practices by funding an experienced GP trainer to work within the practice, releasing a GP to complete the required training. This model has been positively received and we plan to expand this offer to further Deep End practices to support long-term workforce sustainability.

Social Determinants of Health (SDOH) Link Worker Pilot (CAREDEEP)

A major focus across the network has been the delivery of the CAREDEEP programme, supporting Social Determinants of Health (SDOH) activity in primary care settings now engaging 48 Deep End practices. Practices continue to highlight the value of SDOH link workers and care coordinators in supporting housing issues, financial stress, domestic abuse, food insecurity and complex family needs. Early evidence suggests these roles help identify hidden needs earlier and reduce pressure on clinical teams. Across more than 25 practices, interventions to address barriers to accessing screening have been delivered, including extensive cervical, bowel and breast screening outreach. Several practices report substantial improvements in uptake.

Workforce

Our fellowship programme has expanded again this year, providing protected time and support for GPs to lead targeted improvement work in Deep End practices. The latest cohort is delivering a range of health-inequality projects shaped by local population needs. Current themes include improving access to women's health services, strengthening health literacy and NHS navigation for newly arrived communities, reducing long-term opioid and gabapentinoid prescribing, developing multidisciplinary approaches to chronic pain, and improving IT safety and efficiency to release clinical and administrative time.

Fellows are working closely with community organisations, specialist services and VCSE partners, with early outcomes showing improved engagement, clearer pathways and better support for patients facing complex social challenges. Previous fellows continue to build on their projects, contributing valuable learning across the network. Fellowship activity now aligns with Health Equity Focused Trainees, helping to develop a skilled, confident workforce for high-deprivation areas and supporting long-term sustainability across the Deep End Network.

Education

Educational leadership has been strengthened across the network, with a growing focus on workforce education on health inequalities. This includes:

- supporting Health Equity Focused Trainees (HEFT) placed within Deep End practices
- strengthening mentorship from experienced Deep End GPs
- developing new learning sessions focused on trauma-informed care, health literacy, and managing complex social needs
- collaborative teaching with Newcastle University and regional training hubs

These developments aim to build capability, confidence and retention within Deep End general practice.

Advocacy

We continue to work closely with patients and communities to inform what we do and help shape meaningful change. This includes a recent event we co-hosted with community partners to celebrate the achievements of our Deep End Public Advisory Group and further strengthen partnership-working. The event, led by our Advocacy and Engagement Lead, brought together patients, local Deep End practices, social prescribing teams, the NENC Integrated Care Board, and the Deep End Research Team.

Attendees heard powerful patient stories about "life in the Deep End," reflected on the group's work, and explored ways to unite patients and practices facing complex challenges. Feedback was overwhelmingly positive—one patient shared, "*It feels hopeful, getting everyone together in the same room and listening to each other like this."* Plans for early 2026 include trialling multi-practice patient participation groups to further increase patient engagement and outreach.

The Deep End NENC network continues to increase its influence within the Integrated Care Board. We actively contribute to the Prevention and Healthcare Inequalities Programme, workforce discussions, mental health transformation work, and multiple system-level projects centred on reducing inequalities in high-need populations.
Our work remains grounded in the principle that "*if you get it right for the Deep End, you get it right for everyone*."

Research

Working in partnership with NIHR NENC Applied Research Collaboration and Newcastle University, our research programme ensures that out NENC Deep End activity adopt a co-design ethos and initiatives are evaluated to contribute to the international evidence base on action to address health and care inequalities. Current work focuses on:

- Ongoing evaluation of the CareDEEP intervention using a Realist approach
- Qualitative and health economic evaluation of the TrainDEEP intervention
- Evaluation of the NENC Deep End fellowship programme
- NIHR funded research exploring "Deep End" community pharmacy and dentistry
- Scoping adopting community research link working models in NENC, learning from the trailblazing activity in DERA in the Yorkshire and Humber region
- An NIHR NENC Research Delivery Network research nurse focused on promoting Deep End primary care research engagement

Our research has been highlighted as a key success example in the recent national NIHR Applied Research Collaboration renewal communications:

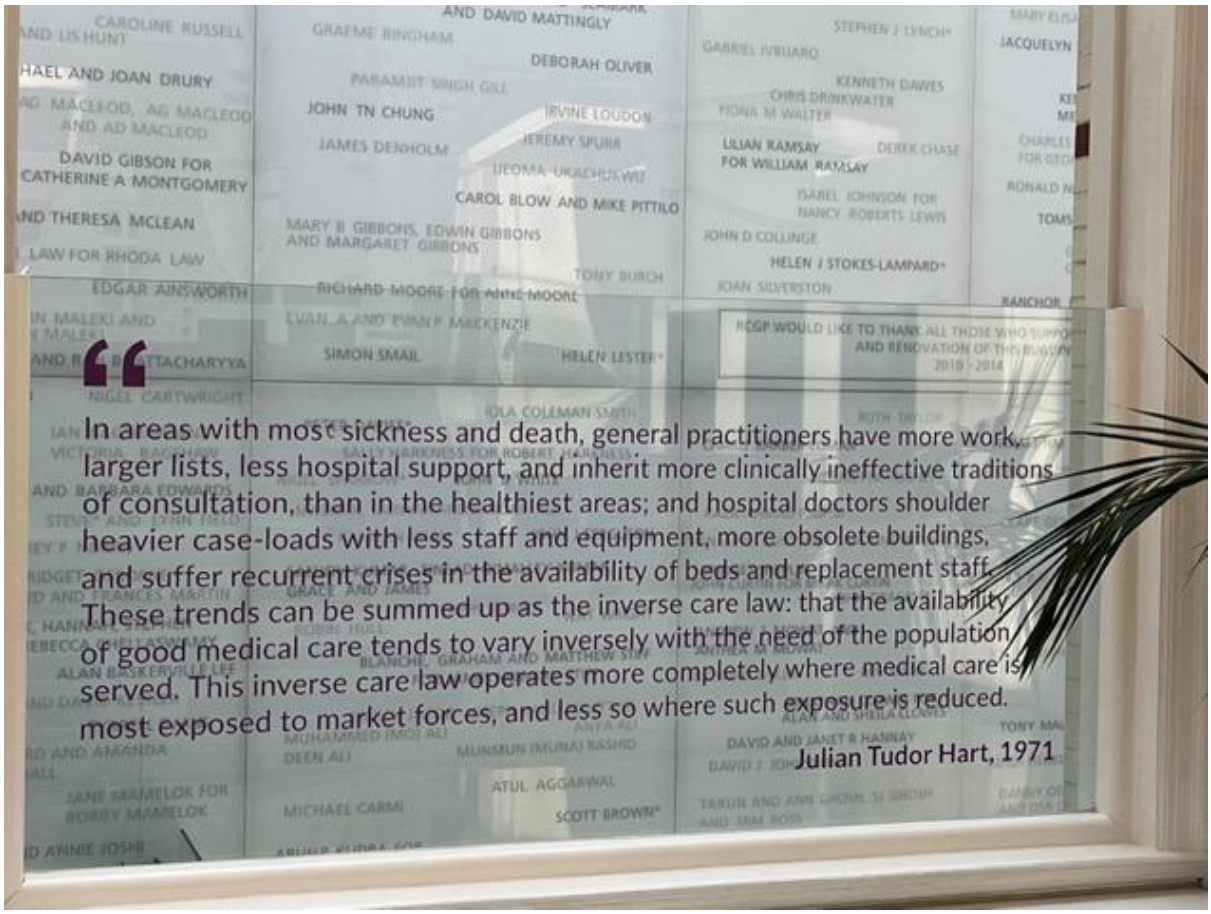
- NIHR awards Applied Research Collaborations £157 million to support transformation of the health and care system | NIHR
- The power of research-practice collaboration: Co-designing a Deep End Network to support primary care in socioeconomically disadvantaged communities - ARC

Recent academic publications

- Sacre A, Todd A, Bambra C, Sowden S. Designing a "Deep End" childhood Open 8 October 2025; BJGPO.2025.0110. https://doi.org/10.3399/BJGPO.2025.0110
- Gupta A, Sirisena M, Armstrong M, Vance G, Sowden S. Professionals' views and experiences of the TrainDEEP (TRaining Assistance INitiative in DEep End Practices) pilot: transforming GP practices into training practices in disadvantaged areas in the North East of England. BJGP Open 17 October 2025; BJGPO.2025.0090. DOI: https://doi.org/10.3399/BJGPO.2025.0090
- Janes A, Riding H, Haining S, Burton M, Allen H, Sowden S. "Socioeconomic inequalities in primary care research: how can we make research more equitable?" BJGP Open 29 October 2025; BJGPO.2025.0082. https://doi.org/10.3399/BJGPO.2025.0082
- Beeson, M., Vernazza, C. & Sowden, S. At the Deep End of dental inequality. Br Dent J 239, 209–213, 2025. https://doi.org/10.1038/s41415-025-8503-z
- Morris R, Schmidt-Renfree N, Joseph W, Reeves D, Morgan C, Stephan B, van Marwijk H, Ford E, Sowden S, Brown L, Tang E. Exploring the Views of Key Stakeholders on Dementia Risk Prediction in Areas of Socioeconomic Deprivation: A Qualitative Study. BJGP 6 October 2025; BJGP.2025.0318. https://doi.org/10.3399/BJGP.2025.0318

Recent conference presentation at Society for Social Medicine and Population Health

- Sirisena M, Gupta A, Hassan S, et al. P66 Addressing wider determinants of health within deep end general practices serving communities experiencing high levels of socioeconomic disadvantage: the CareDEEP initiative J Epidemiol Community Health 2025;79:A69-A70. https://jech.bmj.com/content/79/Suppl_1/A69.2



Excerpt from the RCGP Health Inequalities Exhibition, including the very important last sentence. The quotation is mounted on clear glass which explains the list of RCGP donors in the background.

PLYMOUTH

Here are some facts about our most deprived Deep End area:

The needs of Stonehouse are very real

The newly published multiple deprivation index ranks LSOA Plymouth034A (see map) the 88th most deprived area out of 33,755 across England. In 2019, it as the 163rd most deprived area out of 32,844 areas and in 2015 it was the 154th most deprived areas.

Little has shifted in the past 10 years, except crime increased as a problem relative to other areas between 2019-25.

This kind of data helps us to understand and respond to the needs of our community. Our mission has continued this year under 4 key headings:

Workforce

The GP Fellowship scheme that we helped to start has now expanded across Devon and we have an active group of Health Inequality Fellows who are not only working in areas of highest need but conducting all kinds of practical and innovative projects to improve health and tackle health inequalities.

As well as doctors we have employed four community health workers who have been working in defined areas and to identify problems and issues and act as a bridge between the Community and the practices.

Education

We know that high quality placements in areas of high need are effective in recruiting doctors and other health care workers back into those areas to work. As well as the GP Fellowship scheme, we run a community-based core undergraduate medical school week in complex needs and substance misuse with about 90 students a year coming through. This is their only clinical experience of this vital area of medicine, and we put teach a lot about trauma-focussed care and different methods of history taking more relevant to complex histories. We have also started again providing placements for Clinical Psychology students

Advocacy

This really is a key part of our role, and to do it we work with all kinds of other organisations that work to improve health and wellbeing:

We use and teach the following model of advocacy:

- Respond to individual patient health needs and issues as part of patient care.
- Identify opportunities for advocacy, health promotion and disease prevention, the communities and individuals that they serve, and respond appropriately.
- Identify the determinants of health of the populations and individuals including barriers to access to care and resources and implement a change.
- Identify vulnerable or marginalised populations within those served and respond appropriately

Research

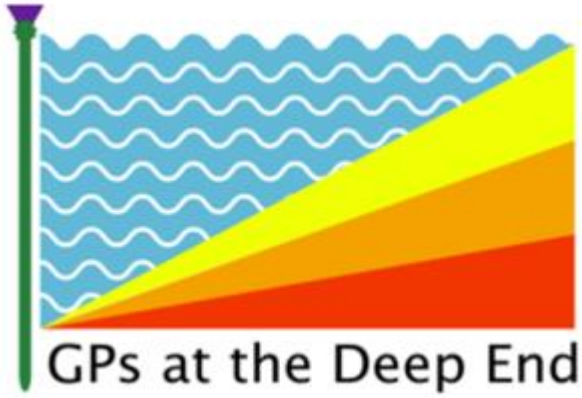
We are really focussing on practical research that makes a difference. This includes implementing and evaluating on ongoing series of outreach events that we call “Feel Good Fridays”, starting and evaluating a trauma-focussed weekly clinic for the most complex patients and working with partners on the effects of the physical environment on health – and what we can do to improve it.

Very good recent news is that we have recently been awarded after a competitive tendering process £150 K to continue and expand our Deep End work and a further £20K for our Feel Good Friday events. In a very difficult financial climate, we are very pleased and excited that our work is still recognised and supported.

We feel confident in moving into 2026 with enthusiasm and with new projects in the pipeline.

Richard Ayres

SCOTLAND



Reflecting on the last 6 months, it has again been a busy time for the Scottish Deep End project! Despite the inevitable 'noise', distractions and unpredictability of an upcoming Scottish election, there have been productive, collaborative and positive conversations about the importance of general practice in shifting the dial on health inequalities, and on NHS sustainability. We are particularly grateful to our friends and colleagues in Deep End Denmark, who have been generous in sharing their time and learning around their plans and processes for their bold healthcare reforms to bolster general practice and address the inverse care law.

Here are a few of our highlights…

Family Wellbeing Workers in General Practice

In June the First Minister John Swinney visited Oakwood Medical Practice in Easterhouse, one of 12 Deep End practices that are involved in the Whole Family Support in General Practice project. The aim of the project is to provide early intervention and wider supports to families living in poverty and at risk of poor health outcomes. Each of the practices involved has a family wellbeing worker (employed by Includem) who have expertise in working with children and young people. Early evaluation findings suggest that families have benefited most from the persistent, relational, and whole-family approach that combines emotional safety and practical support with advocacy and local knowledge, bridging fragmented systems.

Cancer Inequalities roundtable

In August, Cancer Research UK (CRUK), the Scottish Primary Care Cancer Group (SPCCG) and the Scottish Deep End project co-hosted a virtual roundtable discussion on cancer inequalities in Scotland. The statistics make grim reading: around 4,300 cancer deaths in Scotland are associated with socio-economic deprivation, with more late-stage disease and worse survival. General practice has a key role to play across the whole of the cancer journey, from prevention, to equitable access and early disclosure of symptoms, to diagnosis and onward referral. Workload and workforce challenges

hamper our ability to make the difference that we know we could make, and in addition to describing the current situation of significant cancer inequalities, the roundtable included a review of the literature and evidence-base of 'what works', the barriers and opportunities to change, and learning from elsewhere. The report is being finalised and will include a series of recommendations for policy holders and funders. We ran a workshop at the recent Scottish Cancer Conference, and the final report will be published on our website in the next few weeks. We'll use the report to prompt tailored conversations with stakeholders about what we think needs to happen next.

CAMHS roundtable

In September, we hosted a roundtable on Children and Young People's mental health, with a focus on school age children. This roundtable was over a year in the planning as we built up contacts and relationships with frontline colleagues in primary and secondary education and CAMHS to ensure a thoughtful, informed, collaborative and solution-focused discussion rather than perpetuating much of the current silo working. The discussion included frontline Deep End GPs, primary and secondary school depute or head teachers, and CAMHS professionals. It was an impactful and insightful discussion on what is a very emotive subject, summarised by this quote from one of our secondary school colleagues:
"We want a society where our families and young people thrive… and yet so much of our system is about managing risk… and stopping people from being dead. What kind of aspiration is that?"

The report is in draft form but is due to be published soon. Key themes emerged including:

- The importance of preventative and responsive services for families who are often in crisis when they present.
- The key, potentially under-appreciated, role of education and primary care (who know families well) in supporting families through the system. Doing this well is important to practitioners, but can be limited by the system, and takes work. This work has previously been absorbed but is not sustainable.
- The need to commission the "missing middle" services: support for children and young people who do not reach current high CAMHS thresholds for review but need more than current community mental health supports.
- The importance of the primary-secondary care interface, and how to better manage referrals, and 'rejections'.
- The parallels between primary care and education (the two universal services for children) in a Deep End Context. This included discussion of a potential 'Inverse Education Law', with some interest amongst some of the educators in exploring what "Teachers at the Deep End" might look like.

Joint conference

In February 2026, we will be jointly hosting a conference with our friends and colleagues in the Queen's Nursing Institute Scotland (QNIS). Titled *"Just a Generalist?"* The essential role of GPs and GPNs in tackling health inequalities", we want to take the opportunity to celebrate the vital role that generalism plays in improving health equity, the challenges our workforces currently face, and how we can collaborate and learn from each other. The themes of the conference will include the importance of long-term personalised continuity of care in improving patient outcomes; understanding the causes and consequences of 'missingness' in healthcare and how applying a 'missingness lens' can address health equity; how we deliver appropriate, tailored, and evidence-based 'lifestyle advice' for marginalised groups, and the relational support that is needed for workforces to deliver care in socio-economically disadvantaged communities. We will also share some key learning and early thinking around specific projects and research to include green prescribing initiatives, improving cervical cancer screening uptake, HPV self-testing pilots, supporting patients experiencing gender-based violence, managing multiple morbidity in socioeconomically deprived areas, and caring for patients with additional language needs.

Walk-in centres

The unexpected announcement at the SNP conference in October that Scotland is to have fifteen new GP 'walk-in centres' has caused great concern across the profession, and particularly for GPs caring for more disadvantaged populations. We collated our concerns, specifically from a health equity perspective, and shared these in a letter to our Cabinet Secretary for Health and Sport. We have shared on Page of the Bulletin, in case it is also useful for others.

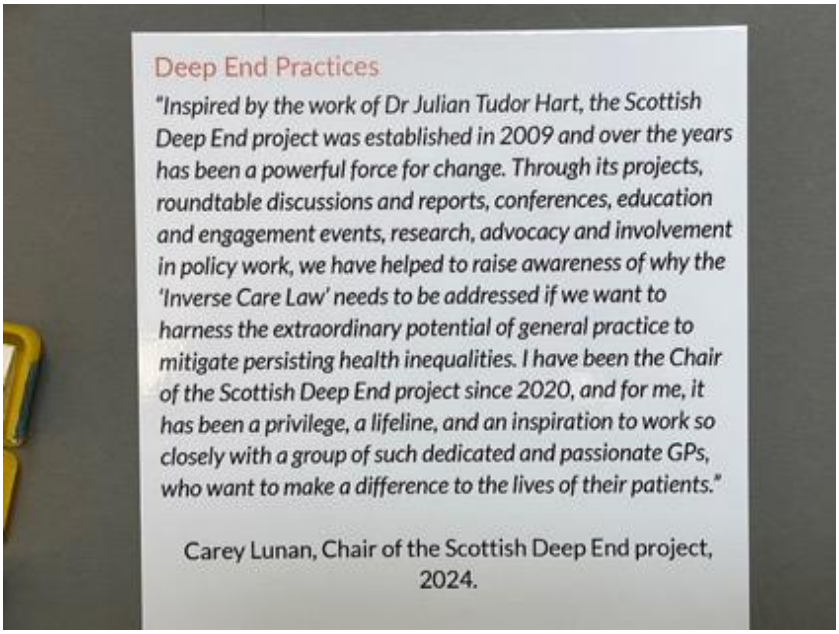
Significant new investment

As we draw to the end of 2025, the recent announcement of significant new and recurring funding into core general practice in Scotland has given the profession a renewed sense of optimism and energy. As the detail is worked through, we hope that all opportunities are taken to distribute this new resource through proportionate universalism approaches, allowing all practices to benefit, but with a scale and intensity proportionate to the levels of need of the populations that they serve. What can we learn from the approaches that are being adopted in Denmark, and from the review of the Carr Hill allocation formula in England? (captured in our recent report from a meeting in September). Could this be our opportunity to meaningfully address the inverse care law in Scotland?

Wishing you all, our inspiring friends and colleagues, a very happy and restful festive break when it comes!

Meeting of the Scottish Deep End Steering Group

Carey Lunan and David Blane



Excerpt from RCGP Health Inequalities Exhibition

WALES

Meddygon Teulu yn y Pen Dwfn
GPs at the Deep End

The Deep End Cymru network of GPs has launched its manifesto ahead of the 2026 Senedd election, calling on all parties to commit to urgent action to tackle health inequalities in Wales.

Formed in 2022, Deep End Cymru represents GPs and practice teams working in some of the country's most deprived areas, providing care for around 400,000 patients. The manifesto sets out clear proposals to end the 'Inverse Care Law': the injustice whereby those who need healthcare most often have the least access to it.

The manifesto priorities include:

1. Fair funding for Deep End GP practices – ending the current funding model that sees practices with more patients from deprived areas receive less support, despite facing higher demand and complexity. Deep End Cymru calls for urgent reform of the Carr-Hill formula and immediate increases to the Additional Capacity Fund.
2. Workforce and training – ensuring Wales recruits, trains, and retains more GPs and healthcare professionals in deprived areas. This includes creating new incentive schemes, expanding health equity training, and prioritising placements in Deep End practices.
3. Investment in staff and services – reducing unsafe workload pressures by lowering patient-to-GP ratios in deprived areas and ensuring wider multidisciplinary teams, including link workers and third sector support, are properly resourced.

Dr Neil James, Chair of Deep End Cymru, said:

> *"The people we serve are sicker, younger, and die earlier than they should. Yet their practices receive less funding and face greater pressure. If we don't fight for our patients, who will? This manifesto shows that with fairer funding and investment, we can transform healthcare in our communities and give people the healthier, longer lives they deserve."*

Joanna Watts-Jane, Deputy Chair of Deep End Cymru, added:

> *"We love our work and the difference it makes, but the system is stacked against our patients and our colleagues. The next Welsh Government has an opportunity and a responsibility to put fairness at the heart of the NHS."*

Deep End Cymru emphasises that the cost of reform is modest but the benefits could be transformational.

Nicola Edmunds
Head of RCGP Wales and Republic of Ireland|Pennaeth RCGP Cymru a RoI

Glyncorrwg Health Centre, the first health centre in Wales,
Where Julian Tudor Hart did his pioneering work

Teg I Bawb (Fair for All):

Deep End Cymru was invited to collaborate with partners from Public Health Wales and representatives from third sector organisations to create a Welsh version of the Doctors of the World Safe surgeries campaign.

Our deputy chair, Joanna, worked as a practice manager in a socially deprived multi-cultural area of Newport, South Wales and has first-hand experience of the issues facing patients and surgeries in areas of severe and multiple disadvantage.

Joanna said

'We know that patients in these areas face more challenges before they even enter a primary care setting. They can face stigma and exclusion attached to their social circumstance. This needs to stop. Primary care is here as a first port of call to help keep patients well, to help them to manage their chronic conditions and guide them to help themselves when they are unwell. We are not here to judge'

Joanna was part of the team that created training for our non-clinical workforce to help them better understand the problems of health inequity and social disadvantage and how that shapes a patient and their health needs.

The training aims to challenge the perception of patients and to reduce the bias and misunderstanding that patients can face. The training was piloted during the late spring of 2025 and quantitative analysis showed it was well received by those teams who attended the initial training.

We are delighted to say that in Autumn 2025 Teg I Bawb has been taken on by Health Education and Improvement Wales with a view to it being rolled out as a nationwide training package.

Public Health Wales has adopted the Teg I Bawb name to use on their strategic action plan to address wider health inequality through Primary Care, with Deep End being acknowledged for our contribution in the development of the framework.