INSTITUTE of HEALTH EQUITY

TRAILBLAZERS: PRIMARY CARE AND HEALTH INEQUALITIES

INTRODUCTION

Primary care plays a vital role in improving population health and reducing health inequalities. GPs, as the first point of contact for many patients, witness first-hand, the health and social issues experienced by the communities living in areas of high deprivation. Beyond delivering healthcare, general practice is at the heart of our communities so is uniquely positioned to bear witness and play a part in addressing the broader social determinants of health, including education, employment, housing, and social isolation. It is essential that healthcare organisations and systems take deliberate action to address the social determinants of health and actively contribute to tackling health inequalities. Meaningful progress cannot be achieved through healthcare alone; it requires coordinated action on the broader social conditions that shape health, including early years development, education and training, employment, housing, social isolation, poverty, and other related factors. (1) The Royal College of General Practitioners has emphasised that ***"a strong, properly resourced general practice service is essential if the UK is to reduce and eventually end health inequalities."*** (2)

Recognising the need to support GPs working in areas of higher deprivation, Health Education England (now NHS England) introduced the **Trailblazer Deprivation Fellowship Scheme**. This initiative, which began in 2018 in Yorkshire and the Humber, was **inspired by the Deep End Pioneer scheme** in Scotland (see Box 1). Following positive evaluations in Yorkshire and Humber, the programme expanded in 2020 to other parts of England and one in Wales.

The Trailblazer programme provides structured fellowships for GPs in high-need areas and a national educational programme to support their personal and professional development. By investing in primary care leadership in underserved communities, the scheme represents a proactive approach to reducing health inequalities and strengthening healthcare delivery where it is needed most.

BOX 1: DEEP END GPS

The Trailblazer scheme was inspired by Scotland's ***Deep End Pioneer scheme,*** an initiative addressing the challenges of primary care in deprived areas.

In 2009, Professor Graham Watt of Glasgow University introduced the Deep End concept, using the metaphor of a swimming pool to illustrate the social gradient and the heavier workload faced by GPs in more deprived areas. In response, he founded the Scottish *Deep End* group, uniting GPs serving communities with socioeconomic deprivation. (3)

D*eep End* networks have expanded across the UK and internationally, supporting GPs through four key principles: support, learning, improvement, and advocacy. These networks enhance workforce resilience, strengthen links with community services, and provide tailored learning opportunities to tackle deprivation-specific healthcare challenges.

WHY TRAILBLAZERS WAS NEEDED: BEING A GP IN AREAS OF HIGH DEPRIVATION

General Practice in areas of high socio-economic deprivation faces many of the same challenges as general practice elsewhere, but with greater intensity and some additional unique pressures. One of the biggest challenges in healthcare is ensuring increased volume, quality, and consistency of care in areas of high deprivation. The Trailblazer scheme was designed to address this issue by supporting GPs working in these high-need communities. (4)

THE INVERSE CARE LAW AND THE GP WORKFORCE CRISIS

In 1971, Dr Julian Tudor Hart described the Inverse Care Law, stating that ***"the availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced."*** This remains evident today, with deprived areas of the UK significantly under-doctored—meaning there are fewer GPs relative to health needs. (5)

Tudor Hart's *Inverse Care Law* remains as relevant today as it was 50 years ago. Without urgent action to address the inequitable distribution of funding, training, and workforce, the most deprived communities—where health needs are greatest—will continue to be underserved.

GP shortages are particularly acute in areas of high deprivation, where practices have, on average, **300 more patients per fully qualified GP** than those in the least deprived areas. (5) The GP workforce crisis is worsening, with numbers falling as demand rises. This decline is occurring fastest in socioeconomically deprived areas, where recruitment remains a challenge.

To compensate for the shortfall in GPs, primary care teams in these areas have diversified, incorporating additional roles such as advanced clinical practitioners, paramedics, and physiotherapists. While this expansion is beneficial, it has placed significant training and supervision burdens on existing GPs. Additionally, those working in high-deprivation areas experience **higher levels of stress and burnout**, making retention even more difficult. (6) (7) **GPs working in areas of higher deprivation are twice as likely to burn out than GPs working in less deprived areas.** (6) (7) Research shows this burnout can occur in newly trained GPs, as well as more experienced GPs. A 2024 study of 13 trainee GPs in North England found heavy workloads leading to burnout and fatigue were concerns when considering working in areas of deprivation. (8)

GP training opportunities tends to be concentrated away from inner-city and areas of high-deprivation, further exacerbating workforce shortages. Research conducted in Scotland and Northern Ireland indicates that general practices situated in less deprived areas are more likely to engage in training activities outside of the most socioeconomically disadvantaged regions. (8) (9) In Scotland, this trend appears to be driven primarily by larger practice list sizes rather than deprivation levels. This pattern represents a missed opportunity: it limits the exposure of trainee GPs to the realities of health inequalities and the wider social determinants of health. As a result, they may be less prepared when working in high-deprivation areas. (9) (10) Both studies recommend that training bodies actively target and support smaller practices, particularly those in socioeconomically deprived areas, to create more equitable training opportunities and ensure GP trainees gain the necessary experience to serve all communities effectively.

INCREASED DEMAND AND PATIENTS BUT LESS FUNDING

There is an increasing demand on GPs practicing in areas of high deprivation, with practices in the most disadvantaged neighbourhoods caring for significantly more patients on average than those in more affluent areas. (11) Analysis of GP appointments between 2007 and 2014 estimated demand for GPs to be **15% higher** in the most deprived quintile compared to patients in the least deprived quintile. (12) This affects patient experience and makes it more challenging to diagnose and manage patients and primary care funding mechanisms do not adequately reflect these increased pressures. (13)

Further challenges in deprived areas include **high patient list turnover** due to more transient populations, which, combined with **fewer GPs, higher demand, and a more diverse workforce**, results in reduced continuity of care.

Although deprivation is considered in England's primary care funding formula, it has long been criticised for failing to account for the additional burdens imposed by socioeconomic deprivation. A proportionate universalist approach states that universal policies should provide increasing support proportionate to level of deprivation. However, there are **no clear guidelines** on how to operationalise it within healthcare funding policies.

Funding levels fail to reflect the greater demands of primary care in deprived areas, where multimorbidity and complex psychological and social issues increase in direct proportion to deprivation. GP practices serving these populations often receive **less** funding per patient, despite the higher complexity of care required.

After adjusting for workload, GPs in England's most deprived areas receive **7% less funding per patient**, despite managing **10% more patients** than those in affluent areas. (5)

This funding shortfall has significant consequences. GPs working in high-deprivation areas report **higher levels of stress and burnout**, exacerbating workforce retention issues and further limiting access to care. The financial inequality also undermines efforts to tackle health inequalities, as underfunded practices struggle to meet the needs of their communities. (14)

More broadly, primary care remains underfunded in the UK's healthcare system. Despite delivering **90% of all patient contacts**, general practice receives **less than 10% of the total NHS budget**. (15) Addressing this imbalance is crucial to ensuring that general practice can play its full role in reducing health inequalities and improving population health.

The Trailblazer programme seeks to address some of the inequalities and improve the ability of primary care to reduce health inequalities.

BACKGROUND

The **Trailblazer Deprivation GP Fellowship Scheme**, part of the **post-CCT fellowship programme**, supports newly qualified GPs (within their first five years) working in areas of high socioeconomic deprivation. Designed to improve GP **recruitment and retention** in the most disadvantaged communities, the scheme is offered to practices ranking in the **top 20% by deprivation score and/or working with inclusion health groups**. (16) Inclusion health groups describe people who are socially excluded and "typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma". (17)

The aim is to equip early-career GPs with the **skills, knowledge, and experience** needed to work effectively in these challenging but rewarding environments, fostering long-term commitment to reducing health inequalities.

Trailblazer GP Dr Donal Farrell presenting at the National Conference in 2025.

STRUCTURE OF THE FELLOWSHIP

Over a **one-year placement**, Trailblazer GPs combine clinical work with **one day per week of funded professional development**, which includes:

- **Teaching sessions** on relevant topics delivered online as part of a monthly national programme.
- Carrying out an **in-practice or community quality improvement project/approach**. All fellows joining the national programme are expected to complete this. This project/approach gives GPs an opportunity to strengthen their connections with the communities they are working in and develop a deeper understanding of the social determinants of health.
- An in-person annual national conference for shared learning and collaboration inviting all the fellows past and present.

GPs join the national sessions (once per month online) and yearly conference (in person) as part of the national scheme. The rest of their fellowship time is spent locally working on their projects, as part of their local schemes or on their own personal professional development. Local schemes, differ slightly area to area, but may include:

- Peer support and connection with other GPs working in areas of deprivation locally. This may involve formal action learning sets or Balint groups (facilitated and regular discussion groups for clinicians designed to improve their understanding of the doctor-patient relationship).
- Coaching and mentoring
- Structured education sessions and visits
- Personal reflection and development time. (4)

TRAILBLAZER GP EDUCATIONAL PROGRAMME

In addition to individual fellowships, the scheme offers a **monthly online education programme**, connecting Trailblazer GPs across the country for networking, learning, and project-sharing. Since its inception, the programme has continually evolved to meet the needs of its participants.

Each year, a **national in-person conference** brings Trailblazer GPs together for collaboration, support, and shared learning.

EXPANSION OF THE SCHEME

The Trailblazer scheme began in 2018 with seven GPs working in areas of high deprivation in Yorkshire and Humber. It has since **expanded to multiple regions:**

- **Phase 1. 2020-25:** Expansion of programme from Yorkshire and Humber to other areas of the UK including East and West Midlands, Derbyshire, Devon, East of England, Wales, North East of England, North West of England and Lincolnshire. All areas participating in the national education programme since 2020.
- **Phase 2. 2025 and beyond:** As funding allows plans are in place to develop the alumni offer and personal and professional development opportunities within the national programme.

CASE STUDIES

The Trailblazer Programme empowers GPs with the time, support, and flexibility to develop innovative, community-based approaches that address health inequalities and tackle the broader social determinants of health. The following case studies highlight how **individual Trailblazer GPs have used this opportunity to drive meaningful change** in their local communities.

Dr. Joseph Whitney, a Trailblazer GP in Hull, **set up a drop-in GP clinic at a local family hub** in a socio-economically deprived area of the city. Recognising gaps in healthcare access that aligned with his values as a compassionate GP—prioritising holistic, patient-centered care, flexibility, and creating a trusted care delivery site—**he reached out to stakeholders at every level**. These included families, Family Hub staff, public health professionals, local authority workers, early years academic researchers, and fellow GPs. Through ongoing conversations and collaboration, they developed the project's structure, rooted in these core values. They actively sought feedback, buy-in, and evaluation at each stage of development. The service has been running for 18 months and secured funding for an additional two years.

> *'I feel I have more insight. I feel like I have more understanding. I hope that comes across to my patients.'*
>
> **Dr Saira Khan, Trailblazer GP 2018/2019**

Dr Sasha Darwazeh, a Trailblazer GP in Coventry and Warwickshire, says participation in the Trailblazer Programme significantly enhances her personal and professional development, deepening her understanding of health inequalities and **equipping her with the skills to provide more holistic, patient-centred care**. She reports the scheme has helped her to:

- Develop knowledge of **barriers to healthcare access** and actively educate other GPs on how to support vulnerable populations.
- Reach out and **build partnerships with key local organisations**, including food banks, youth programmes, crisis support charities, and homelessness services.
- **Increase her knowledge of community resources**, enhancing her ability to better signpost patients beyond medical care.
- Strengthen collaboration with social prescribers, recognising the importance of **addressing both medical and social determinants of health**.
- Develop a more holistic approach to patient care, ensuring patients receive support that extends beyond the GP practice.

> *'I genuinely feel it is the most worthwhile, well-structured and enjoyable educational experience I have ever had. I have never felt more "invested-in".'*
>
> **Dr Jennifer Baylis, Trailblazer GP 2022/23**

Dr Darwazeh continues to share her knowledge with the aim of inspiring future GPs, she:

- Delivers teaching sessions on health inequalities to Coventry and Warwickshire Vocational Training Scheme trainees, challenging misconceptions about working in areas of high deprivation.
- Encourages ST3s (trainee GPs) to embrace the challenges of primary care in high-need areas, demonstrating its rewards and impact.

Dr Donal Farell, a Trailblazer GP in Sheffield, explains that the scheme has encouraged him to:

- Spend more time outside the consulting room. This has given him the **opportunity to meet and learn** from the many enthusiastic, experienced, and knowledgeable members of **organisations allied to health and social care, including those in the voluntary, community, and social enterprise sectors**. He describes this experience as "**eye-opening**".

Dr. Farell recommends that future fellows engage with a range of professionals, including local social prescribers, health coaches, social workers, health visitors, substance misuse workers, mental health workers, and charity workers. He **encourages fellows to learn about what these professionals do, how they do it, and what changes** they believe could enhance the role of GPs, local surgeries, and the broader primary care network in effectively addressing health inequalities.

TRAILBLAZER ALUMNI NETWORK

Participation in the Trailblazer programme extends beyond the fellowship. There is a **network of over 260 GPs**—both current and alumni Trailblazers—working in areas of high deprivation across England and Wales. Alumni fellows are invited back to our annual conference and continue to connect via our national alumni Whatsapp group where we continue to share learning and opportunities.

The first Trailblazer cohort in 2018/19, visiting Bevan Bradford, a social enterprise established in 2011, regarded as being at the forefront of health and wellbeing services for highly vulnerable groups who face social barriers to accessing healthcare.

IMPACT AND FUTURE GROWTH

The Trailblazer programme has proven successful in retaining GPs in areas of high deprivation, fostering professional development and helping GPs address health inequalities. As the programme expands, it continues to evolve to better support GPs in providing high-quality care to the communities that need it most.

The scheme is **currently being externally evaluated**, comparing responses to the GP workforce survey of current fellows on the programme with other GPs across the country. Further analysis and comparisons using the data are continuing but **initial findings** in this evaluation showed that 100% of 50 of the alumni fellows who responded to a survey 'strongly agreed' or 'somewhat agreed' that the knowledge, skills, and experiences gained from the Trailblazer scheme **continue to influence their day-to-day practice**. Fellows highlighted several aspects of the Trailblazer scheme as standout features, reflecting its impact on their personal and professional development when working in areas of high deprivation. **Peer support** emerged as a **central theme**, with many appreciating the camaraderie, mentoring, and the opportunity to connect with like-minded colleagues. A participant on the Yorkshire and Humber scheme described: "Growing a community of learning, buttressed by sharing and hearing experiences from colleagues and experts." Alumni participants had **high praise** for the scheme highlighting its **educational aspects**. Topics mentioned as particularly effective included sessions on trauma informed care and adverse childhood experience. These sessions were described as "inspirational" and "exceptional," providing practical knowledge about health inequalities that participants continued to apply in their practices. (18)

Internal evaluations conducted before and after the scheme (pre- and post-schemes 2020-2025) show significant improvements in confidence, support, and commitment among the Trailblazer fellows working in areas of deprivation (see Table 1).

Table 1. Trailblazer pre-and post-scheme evaluation

Evaluation Metric	Pre-Scheme (%) (n=116)	Post-Scheme (%) (n=50)
Confident about continuing to work in deprived areas	50%	92%
Planning to stay at current practice	56%	78%
Felt supported working in areas of deprivation	42%	84%
Felt part of a peer group of GPs in deprived areas	27%	94%

Peer support, an integral part of the scheme, was especially impactful, with nearly all fellows (94%) in the post-scheme group reporting a sense of belonging to a peer network of GPs working in areas of deprivation, compared to just 27% pre-scheme.

Trailblazer GPs identified **regular meetings with their peers** working in similar settings as one of the **most valuable aspects of the programme**. This finding **aligns with previous research**, which highlights that resilience in challenging environments like the Deep End areas depends heavily on strong support from colleagues. (4)

The scheme's aim is to provide early-career GPs with the support, knowledge and regular opportunities for peer support and personal development, ensuring they not only stay in but thrive while working in areas of high deprivation. These communities need compassionate, dedicated healthcare professionals the most, and it's crucial GPs feel supported, empowered and valued in their roles. As the scheme grows and the alumni network expands **Trailblazer GPs are becoming leaders and role models within primary care teams, driving change and making a real impact on the ground**. By investing in these GPs now, it is not only shaping their futures, it is also investing in the future of primary care in areas of high deprivation – the most underserved areas in the country, where quality healthcare is so needed. The Trailblazer GP programme is **vital in transforming healthcare in these communities**, this programme is providing the support to give them the tools and confidence to make change a lasting reality.

BIBLIOGRAPHY

1. Allen M (2024) The role of primary care in tackling the social determinants of health. London: Institute of Health Equity. Available from: https://www.instituteofhealthequity.org/resources-reports/the-role-of-healthcare-and-the-sdh/primary-care-in-sdoh.pdf
2. Baker M, Mawby R, Ware J (2015) Health Inequalities. Royal College of General Practitioners. Available from: https://www.rcgp.org.uk/getmedia/124b7ba8-ad74-4475-b3e4-6a21e4f2d332/Health-Inequalities.pdf
3. Watt G, Brown G, Budd J et al (2012). General practitioners at the Deep End: the experience and views of general practitioners working in the most severely deprived areas of Scotland. Occasional Paper series Royal College of General Practitioners. 89:i–40.
4. Steen R, Walton E Patterson D (2020) Jumping in at the Deep End: supporting young GPs working in deprivation. British Journal of General Practice. 70 (692): 132-133.
5. Royal College of General Practitioners (2024) Breaking the inverse care law in UK general practice. Available from: https://www.rcgp.org.uk/getmedia/be6b2aba-330f-4993-9d3f-63f09795c9b9/breaking-inverse-care-law-UK-general-practice.pdf.
6. Pedersen AF, Vedsted P (2014) Understanding the inverse care law: a register and survey-based study of patient deprivation and burnout in general practice. International Journal for Equity in Health. 13(1):121.
7. Eley E, Jackson B, Burton C et al (2018) Professional resilience in GPs working in areas of socioeconomic deprivation: a qualitative study in primary care. British Journal of General Practice. Dec;68(677):e819-e825.
8. Armstrong MJ, Wildman JM, Sowden S (2024) How to address the inverse care law and increase GP recruitment in areas of socioeconomic deprivation: a qualitative study of GP trainees' views and experiences in the UK. BJGP Open. Jul 29;8(2).
9. McCallum M, Hanlon P, Mair FS et al (2020) Is there an association between socioeconomic status of General Practice population and postgraduate training practice accreditation? A cross-sectional analysis of Scottish General Practices. Family Practice. Mar 25;37.
10. Butler D, O'Donovan D, Johnston J et al (2023) Are GP training opportunities in Northern Ireland widening or closing the gap on health inequalities? An analysis of Northern Ireland deprivation data. BJGP Open. Sep 19;7(3):BJGPO.2022.0178.
11. Iacobucci G (2021) GPs are at "breaking point" and in need of respite, leaders warn. British Medical Journal. 373:n1139.
12. Hobbs RFD et al. (2016) Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14. The Lancet. 387(10035): 2323 - 2330.
13. Clare S, Grossman D (2022) Poorer areas in England suffer most from GP shortage, study finds. BBC News. Available from: https://www.bbc.co.uk/news/health-63351645
14. Walton L, Ratcliffe T, Jackson BE et al (2017) Mining for Deep End GPs: a group forged with steel in Yorkshire and Humber. British Journal of General Practice. 67(654):36-37.
15. British Medical Association (2020) Investment in general practice. Available from https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/funding/investment-in-general-practice.
16. NHS England (ND) Trailblazer Deprivation Fellowship Scheme. Available from: https://heeoe.hee.nhs.uk/general_practice/fellowships-primary-care/trailblazer-deprivation-fellowships).
17. NHS England (2025) Inclusion health groups. Available from: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/inclusion-health-groups/.
18. Boam E, Claire P, Drinkwater J (2025) Trailblazer Evaluation. Available on request.

ACKNOWLEDGEMENTS

Report writing: Tammy Boyce, Rachel Steen

Suggested citation: Boyce T, Steen R (2025) Trailblazers: Primary Care and Health inequalities. London: Institute of Health Equity

Cover photo: Yorkshire and Humber Scheme 2021/22 cohort attending a session at Project 6, a drug and alcohol service providing support in Doncaster, Keighley and Sheffield.