Report of the Primary Care Health Inequalities Short-Life Working Group

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Foreword from Primary Care Health Inequalities Short-Life Working Group Chair

It has been a real privilege to chair the Primary Care Health Inequalities Short-Life Working Group.

The recommendations in this report are the result of successful collaboration across different professions, sectors, and interests. Group members from a wide variety of backgrounds have brought evidence, challenge and experience to the group. Participation by those with lived experience of health inequalities and access to primary care was also essential. I would like to offer my thanks to members for their hard work and active participation to the Group, as this report would not have been possible without their contributions.

I would also like to thank the Chance 2 Change Group, including Leanne McBride, their facilitator, and Dr. Peter Cawston, who was the link between the Working Group and Chance 2 Change. Their powerful report offers an important and realistic view into how health inequalities impact upon some of our most vulnerable communities in Scotland, and challenges us to ensure that action is meaningful.

The Group built on a huge amount of existing work and reports, and sought to identify clear actions which were informed by existing evidence. The recommendations are clear that while tackling health inequalities requires broad action on social determinants well beyond health services, primary care has a key role to play. The recommendations combine practical actions which are achievable in the short term, with others which are undoubtedly aspirational reflecting the Group's philosophy that without ambition there is no change.

There is much to be done and this report aims to creates a framework for long term sustainable change. The reports into health inequalities led by Professor Sir Michael Marmot have informed and influenced the work of the group, and we are encouraged to "do something, do more, do better".

Lorna Kelly, Interim Director of Primary Care NHS Greater Glasgow & Clyde and Professional Adviser to Scottish Government Primary Care Directorate

Foreword from Chance 2 Change Facilitator

C2C would like to thank the Primary Care Health Inequalities Short Life Working Group (SLWG) for the rare chance to have their voices/views heard in a platform that has the power to generate real change.

Working with the SLWG has been challenging but equally empowering for the individuals that have had the courage to share their experiences. The group hope the report highlights that the success of any service or system is reliant on listening to and working with the people that should benefit from them.

The outstanding collaborative work achieved between C2C and the SLWG should not be rare or unique but normal practice. Encouraging collaborative working to become normal practice necessitates action; engagement is key and encouraged when people feel heard and see beneficial change. C2C ask the Scottish Government and all relevant professionals to recognise their power, use it for positive change and create a fairer, more just Scotland.

Leanne McBride, C2C Facilitator

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Introduction

Health inequalities are unjust and avoidable differences in people's health across the population and between different groups.[1] Scotland compares poorly on health inequalities compared to most of Western Europe,[2] which means that the right of everyone to the highest attainable standard of physical and mental health is not being enjoyed equally (Scottish Parliament Health and Sport Committee 2015). This longstanding injustice has been brought into sharper focus by the COVID-19 pandemic (Bambra et al 2020).

The root causes of health inequalities largely lie outside of health services. Inequalities in society are caused by inequity in the distribution of money, resources and power, which impact on opportunities for good-quality work, education, income, and housing. In turn, these determinants shape individual experiences of health.[3] A wide range of commercial determinants also impact on health.[4] [5]

Health inequalities and climate injustice are also closely interconnected and share common root causes. To give two examples: unsustainable food production and marketing of low nutrient food lead to obesity, malnutrition, liver disease and cancer (WHO 2021). Car-based transport systems, air pollution (Pye et al 2007), poorly insulated housing and reliance on carbon fuels for energy (Oxfam 2020) lead to respiratory and cardiovascular disease, fuel poverty and lack of community access to green and health spaces. All of these impact most heavily on the most vulnerable. Many actions to address health and climate injustice have co-benefits for both achieving carbon net zero and creating health sustaining communities (Deep End Group 2021).

Recognition that the causes of poor health largely lie outside the health system is reflected throughout public policy in Scotland. Some longer-standing examples have been the Christie Commission on the future delivery of public services (Public Services Commission 2014), the six Public Health Priorities (Scottish Government 2018a) and national policies on early years, alongside more recent documents, such as the "Housing to 2040" vision (Scottish Government 2021a), and the national COVID-19 Recovery Strategy (Scottish Government 2021b).

Modern health care does, however, have enormous potential to prevent the onset of illness and to delay its progression. Access to health care is itself a social determinant of health. As a result, inequitable access to effective health care is an inadvertent yet powerful driver of health inequalities.[6]

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[1] Public Health Scotland 'What are health inequalities?' http://www.healthscotland.scot/health-inequalities/what-are-health-inequalities
[2] Public Health Scotland 'Measuring health inequalities' http://www.healthscotland.scot/health-inequalities/measuring-health-inequalities
[3] Public Health Scotland 'Fundamental causes of health inequalities' http://www.healthscotland.scot/health-inequalities/fundamental-causes
[4] World Health Organization 'Commercial determinants of health' https://www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health
[5] Examples of research into commercial determinants (including the availability of alcohol, tobacco and unhealthy foods) in Scotland include work by members of the SPECTRUM consortium: https://www.ed.ac.uk/spectrum
[6] The Lancet '50 years of the inverse care law' https://doi.org/10.1016/S0140-6736(21)00505-5

Primary Care in Scotland: a definition from clinical professionals

"Most of the time, people use their own personal and community assets to manage their health and wellbeing and achieve the outcomes that matter to them. Primary care professionals enhance this by providing accessible health care and support to individuals and families in the community, when it is needed, at whatever stage of life.

"Primary care is provided by generalist health professionals, working together in multidisciplinary and multiagency networks across sectors, with access to the expertise of specialist colleagues. All primary care professionals work flexibly using local knowledge, clinical expertise and a continuously supportive and enabling relationship with the person to make shared decisions about their care and help them to manage their own health and wellbeing. Primary care is delivered 24 hours a day, 7 days a week. When people need urgent care out of core service hours, generalist primary care professionals provide support and advice which connects people to the services they need, in a crisis, in a timely way."

From "The Future of Primary Care: a view from the professions" (2017) - https://www.rcn.org.uk/About-us/Our-Influencing-work/Policy-briefings/sco-pol-future-of-primary-care-1-sept

This short report sets out recommendations for actions to be taken by primary care health services to help reduce health inequalities and improve health equity in Scotland. Primary care is provided by a wide range of health care workers (such as nurses, GPs, optometrists, pharmacists, allied health professionals) and other key staff (such as practice receptionists and community link workers), who are usually based in the community and offer the first point of contact when people need support to maintain their own health. Primary care services focus on the needs of individuals and defined populations, rather than on specific diseases, usually offer care over a long period of time, and provide coordination of care for people with complex health problems.

The 2013 Scottish Ministerial Task Force on Health Inequalities (Scottish Government 2015) recommended that tacking health inequalities required work to mitigate (make less harmful) the negative impact on individuals, as well as undoing the root causes and harmful environments. By virtue of being embedded across all our communities, and operating at the 'frontline' of the NHS, primary care can play a pivotal role in mitigating the effects of health inequalities at a number of levels (Scottish Parliament Health and Sport Committee 2021): through preventative and anticipatory clinical care; wider patient advocacy; community engagement; and influencing the wider health and social care agenda, as well as responding directly to complex clinical needs (Watt 2019). However, existing commitments to reform primary care will not be sufficient to meet the challenges of health inequality.

The volume and nature of demand for primary care, and the complexity of the response required, are also influenced by health inequalities and deprivation.

Primary care is partly demand-led and, so, is easier for some groups of people to navigate than others, with various forms of disadvantage (such as power relationships, racism, education, social status) playing a part. Inequity of access, or a mismatch between resources and need, can inadvertently widen health inequalities. Many of the findings and recommendations in landmark reviews, led by Michael Marmot for the Health Foundation, into health inequalities in England apply to Scotland, including the need for policies and delivery broadly founded on 'proportionate universalism' (Marmot 2010; Marmot et al. 2020a, 2020b). In the context of this report, this mean that primary care needs to be best where it is needed most (Ashwell et al. 2020).

Reflections from a GP

A hospital discharge letter recently documented that the patient concerned had missed five renal clinic appointments in the preceding two years. Their kidney function had dropped so sharply in this time that the specialist advised the window of opportunity for intervention had been missed, and they would need life-long renal dialysis within the year.

For the person and their family this will mean life-changing illness, premature disability, burdensome treatment, loss of income and reduced life expectancy, all of which could have been prevented. For society it will mean the enormous cost of high tech downstream medical treatments, loss of economic activity and future dependence on social support. There might be many reasons why someone struggles to access health care.

For this individual, possible factors might have been the cost of bus fares (£4.60); the length and complexity of travel by public transport (a three-hour round trip involving four buses); an employer who will not allow time away from work; literacy issues or poor communication on the part of the NHS; not understanding or denying the potential consequences of their kidney problem; or having to deal with competing challenges, such as other physical or mental health conditions, caring responsibilities or other personal circumstances.

Barriers to health care such as these fall most heavily on those who are already most at risk of illness and disability. This personal tragedy is one snapshot from the hundreds of thousands of individual stories that lie behind health inequalities in Scotland. For a nation to be truly modern, prosperous and progressive, it must be able to ensure that access to effective health care is available to all on an equal basis of human dignity alone, and not influenced by factors such as bank balance, postcode and birthplace.

Dr Peter Cawston, Member of the SLWG and GP in a Deep End practice in Glasgow

The Primary Care Health Inequalities Short Life Working Group

This report and its recommendations are the product of a Short Life Working Group (SLWG) on Primary Care Health Inequalities who met over a period of twelve months. The Scottish Government established the SLWG in October 2020 as an action from the Primary & Community Health Care Mobilisation Sub Group of the Scottish Government's Mobilisation Recovery Group,[7] in acknowledgement of the key role of primary care in relation to tackling and mitigating the impacts of inequalities.

The purpose of the group was not to conduct an academic or systematic review of the literature. Instead, it focussed on the professional expertise and insights of a wide range of stakeholders with extensive experience of delivering, planning and designing primary care across Scotland. The SLWG's terms of reference and membership (Annex C) reflected geographical areas and specialisms, with a focus on including members with the ability to implement change in their organisation or system.

The SLWG has also worked closely with an expert reference group of people, called Chance 2 Change, who have first-hand experience of the impact of health inequality as individuals and within their community.[8] Their remit has been to identify specific service improvements and actions for primary care to help reduce health inequalities and improve health equity.

The SLWG strongly recognise that health inequalities cannot be addressed by one sector in isolation. All services provided by the NHS in Scotland, including mental health, specialist and hospital based services, need to take deliberate practical action to ensure that the health care they provide is equally accessible to all and is not discriminatory in its impact on individuals and groups. Social care also has a powerful part to play. The root causes of health inequality cannot be solved from within the health and social care system. The group's recommendations should be seen in the wider health and social care system, where there is a responsibility for all services, as well as government, the wider public sector and society at large to take effective action to ensure that individuals and communities no longer experience the injustice of health inequality.

The SLWG's focus has been to build on existing learning and evidence to identify and recommend clear actions that can be implemented and sustained with a long term impact. The SLWG's remit was intended to maximise primary care's unique potential in the patient journey to deliver meaningful improvements in health outcomes. The group took evidence from recent initiatives and programmes, such as

[7] Scottish Government 'Mobilisation Recovery Group 7: Note of Meeting' https://www.gov.scot/binaries/content/documents/govscot/publications/minutes/2020/11/mobilisation-recovery-group-minutes-9-october-2020/documents/mobilisation-recovery-group-minutes-9-october-2020/mobilisation-recovery-group-minutes-9-october-2020/govscot%3Adocument/Mobilisation%2BRecovery%2BGroup%2B-%2B%2BNote%2Bof%2BMeeting%2B7%2B-%2B9%2BOctober%2B2020%2B-%2BFinal.pdf

[8] YouTube 'Chance 2 Change': https://www.youtube.com/watch?v=bVy6T7CXXjY

the Govan SHIP,[9] the Deep End Pioneer Scheme,[10] the Community Links Worker programme (Mercer et al. 2019), and the Queen's Nursing Institute Scotland.[11] They drew on sources, such as the Marmot reviews, the evidence gathered by the GPs at the Deep End group,[12] and a small number of recent publications and policy papers.[13] Their priority was to identify practical actions and programmes that could be implemented within primary and community care, yet still reflect powerful ambition for change.

The SLWG took the view that health inequalities and health inequity have complex and entrenched roots within the health service, and recognised that there can be systemic resistance to change. Mechanisms for allocating health resources are based on historical data which tend to reflect demand for health services rather than unmet need. This favours those already able to take advantage of the systems in place. At a time, however, when all services are under strain, simply changing how resources are distributed would be counter-productive if existing services were destabilised.

The unequal geographical distribution of poverty results in concentrated areas where whole communities face barriers to health care and experience poor health, high prevalence of long term conditions and premature mortality (NRS 2020). However, reliance on area-based indices of 'deprivation' such as SIMD can divert attention from individuals and households who face profound barriers despite living in less disadvantaged and even affluent areas or in rural data-zones (Scottish Government 2021e). Barriers can include institutional discrimination and stigma due to many characteristics, such as disability, ethnicity and sexual orientation, body weight,[14] as well as poverty and social exclusion. Initiatives to address health inequity need therefore to both address the challenges experienced by geographical communities identified as experiencing 'deprivation' and the less visible but, nevertheless important, health inequity impacting on many other individuals and families throughout Scotland.

Since April 2018, public bodies in Scotland have been legally responsible for 'the Fairer Scotland Duty'. This requires them to identify and address barriers and inequalities of outcome that arise from socio-economic disadvantage whenever they make significant decisions, and they are publicly accountable for how they have carried out this duty (Scottish Government 2018b). The Fairer Scotland Duty is additional and complementary to statutory duties under the Public Sector Equality Duty and the Human Rights Act.

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[9] University of Glasgow 'Deep End Report 29' https://www.gla.ac.uk/media/Media_463781_smxx.pdf
[10] University of Glasgow 'Deep End Pioneer Scheme' https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/deependpioneer/
[11] Queen's Nursing Institute Scotland 'Catalysts for Change': https://www.qnis.org.uk/catalysts-home/catalysts-complete/
[12] University of Glasgow 'The Scottish Deep End Project': https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/
[13] See, for example, Scottish Government 2021c Social Renewal Advisory Board Report https://www.gov.scot/publications/not-now-social-renewal-advisory-board-report-january-2021/, The Scottish Government (2021d) Annual Report of the Chief Medical Officer https://www.gov.scot/publications/cmo-annual-report-2020-21/ and Thomas et al 2020 'GPs with an extended role in population health' https://bjgp.org/content/70/697/378
[14] World Health Organization Europe 'Weight bias and obesity stigma: considerations for the WHO European Region (2017)': https://apps.who.int/iris/bitstream/handle/10665/353613/WHO-EURO-2022-5369-45134-64401-eng.pdf?sequence=1&isAllowed=y

The Fairer Scotland Duty

This statutory duty came into force in Scotland from April 2018. It places a legal responsibility on public bodies in Scotland to actively consider ('pay due regard' to) how they can reduce inequalities of outcome caused by socio-economic disadvantage, when making strategic decisions. This Duty is an opportunity to put tackling inequality genuinely at the heart of key decision-making. Over a million Scots are living in poverty, including one in four children; and health inequalities and educational attainment gaps are far too wide. This unfairness isn't inevitable. The purpose of the duty is to reduce poverty and inequalities of outcome, helping to realise the rights of the people who have experienced them. To fulfil their obligations under the Duty, public bodies must be able to meet what are called 'the key requirements': (1) to actively consider how they could reduce inequalities of outcome in any major strategic decision they make (2) to publish a written assessment, showing how they've done this.

As noted above, current commitments to reshaping and reforming primary care will not alone be sufficient to meet the challenges of health inequality. Additionally, as the unpredictable economic and social impacts of COVID-19 cause health needs to change and shift across our communities, primary care will also need to be able to respond flexibly as new forms of health inequality arise.

The twenty-three recommendations from the SLWG, which are included at Annex A, are built, therefore, on both a realistic understanding of the scale of the problem and a careful consideration of what might be possible in this context. They are aspirational, courageous and wide-reaching, and include a call for new, dedicated national leadership to ensure a cross-sectoral approach. However, they will only have their full impact if they become part of a much wider commitment to health inequalities and addressing the social determinants of health which sit beyond the direct remit of primary care.

Community Voice - An Expert Reference Group with Direct Experience

The SLWG included a wide range of professional voices and experiences, including those of the third sector and health care professionals working at the 'front line'. The group were clear however that the voices involved in this discussion should not simply be those of professionals and policymakers but of people who might be directly impacted by the recommendations. Health policies that are well justified by other forms of evidence may be disempowering to people who live with discrimination or exclusion if those policies are not shaped by the evidence of their own lives and experiences. How the recommendations were to be developed would therefore be as important as the recommendations themselves. The voices of those with direct lived experience of the issues being discussed needed to be integral.[15]

[15] 'Lived experience' is a widely used term in current policy discourse. With its origins in phenomenology, it has many interpretations, and can risk being tokenistic or creating an 'other'. What matters is the genuine participation in decision-making of those who are most affected by the issues addressed in this report.

The SLWG therefore decided to engage a small expert reference group from a community which experiences multiple disadvantages and the complex health and well-being consequences of inequalities. Their involvement had to go beyond consultation and enable genuine participation in the process of planning and development of the report and recommendations. Given the short time frame, an established community group, called Chance 2 Change, were approached as they were already at a stage of sufficient development to be able to interact in this way. Dialogue was mediated through their peer-facilitator who helped the group to understand what was being discussed by the SLWG, created opportunities for them to explore the themes in a meaningful way, and then fed this back to the SLWG to be discussed at their meetings. A version of the draft recommendations was provided in plain English to help accessibility, and feedback from Chance 2 Change on the recommendations was taken on board by the SLWG.

The rigorous and in-depth contribution of the community voice is presented in A Chance to Change Scotland: Report of the Chance 2 Change Expert Reference Group with Lived Experience to the Primary Care Health Inequalities Short Life Working Group, with a summary in Annex B of this report. Their close involvement with the SLWG process has directly influenced the recommendations in this report.

"Some of our members have not been seeking medical support because they feel that during the current pandemic, with people dying and the NHS being overwhelmed, that they don't matter. For instance, one of our members who has been clinically diagnosed with poor mental health is currently struggling with impaired hearing, which is having a profound negative impact on their communication. This shows the positive impact of peer-support as it was through discussion with the group that the person realised that they do matter and sought support through their GP. However, following a referral they have now been waiting six months for a consultation, which reinforces the person's original thought of 'I don't matter'. Further to this discussion the group also highlighted concerns that as a result of Covid-19 a range of appointments such as diabetes/stroke check-ups as well as cancer clinics are being deferred and/or cancelled having a massive negative impact not only on those that are 'vulnerable' now but the many that will become our 'future vulnerable'."

Feedback from Chance 2 Change to the SLWG

The commentary from Chance 2 Change is robust and often very critical. All of the members have had negative experience of access to health care, and also negative experiences of interactions with health care workers. They are honest about negative perceptions ("unkind", "uncaring") but also reflect on why these perceptions arise, for example due to the absence of peer or psychological support for health care workers at the frontline of trauma and under severe stress themselves. This analysis from lived experience aligns closely with research evidence that consultations with GPs in areas of socio-economic deprivation are more stressful for patients and professionals alike, with more health and social issues in each consultation, greater pressures on time, and lower perceived empathy than in more affluent areas (Mercer

et al. 2016). This has been considered to be one facet of an 'inverse care law',[16][17] supported by numerous studies and recent additional analysis, commissioned by the Deep End Group, of data from the latest Scottish GP workforce survey.[18]

Chance 2 Change's report describes in detail how the many barriers they have experienced in accessing health care have exacerbated their health conditions and worsened their mental health and that of others in their community. Their report includes a call to action for services, in particular mental health and addiction services, to be reconfigured around the needs of people rather than the structures of the organisation. They give highest priority to the lack of recognition of the effects of trauma in how services are configured and also in a lack of professional acknowledgement of the effects of poverty, stress and trauma. They call for all health professionals to become trauma informed and to have a better understanding of the impact they can have on health inequalities, for good or harm.
Chance 2 Change advice to health care professionals:

SEE ME – I am a person with feelings.
LISTEN – my opinion matters
BE HONEST - even if you don't know because I would appreciate that.
HELP ME UNDERSTAND - please don't tell me what to do, offer me advice and where appropriate alternative solutions.
REMEMBER I AM AN EXPERT in your professional hands - 50:50 partnership, each valuing the other's expertise.
CONSIDER PEER SUPPORT - it is our experience that people build confidence in people far more effectively than medication.

The focus of the group is not all on health services: they use video reporting and photography to tell their stories of the transformative effect of having been members of a peer support group. Community networks, local organisations, family and friends are essential to health and wellbeing. They describe the distress and anxiety that results from financial insecurity for groups such as theirs, and call for long term security and commitment to communities and community groups such as theirs.

The reference group are also scathing about how vulnerable communities are excluded by language and the structures of governance from decision making and strategic planning. They challenge what might even be described as a neo-colonial mindset:

"You wouldn't go to Switzerland and change their systems without first learning their language and consulting with their people – so why would you think this approach would produce a positive outcome in our communities?"

Chance 2 Change member

[16] The term 'inverse care law' has been used since the 1970s to describe how the availability of good health care tends to vary inversely in relation to population health needs.
[17] The Lancet '50 years of the inverse care law' https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00505-5/fulltext#articleInformation
[18] See the Deep End website for postcode analysis undertaken by Public Health Scotland (PHS) in addition to the analysis in the main PHS report (Public Health Scotland 2021): https://www.gla.ac.uk/media/Media_829448_smxx.pdf and https://www.gla.ac.uk/media/Media_829455_smxx.pdf

Recommendations of the Primary Care Health Inequalities Short Life Working Group

Health care systems that are undergirded by strong and effective primary care services achieve better health outcomes and greater health equity at lower costs than health care systems that are unbalanced towards specialist and technological health services (Starfield 2009). The Short Life Working Group's fundamental position is that a strategic national commitment to support and build primary care services and to enable sustainable, well-being communities is a necessary pre-requisite to reduce the harmful impact of health inequalities in Scotland.

The SLWG agreed the twenty-three recommendations in Annex A as the result of in-depth discussions over more than a year.

Initially, the SLWG identified nine themes to investigate how primary care and communities could be strengthened and supported to more effectively mitigate health inequalities:

- Structural Inequality
- Community Voice
- Sustainability & Leadership
- Long Term Health Conditions
- Mental Health
- Inter-sectoral Collaboration
- Digital Health Care
- Access to Health Care
- Unmet Need and Missing Communities

Small sub-groups discussed individual themes in detail to consider: existing opportunities and barriers; priority areas; levers and resources; and how to deliver the recommendations. It was considered whether some of these might be actionable directly by the SLWG, what input would be required from the Scottish Government and who would be necessary stakeholders within health, social care, the third sector and at a community or local level to ensure that the priorities would be delivered.

These thematic discussions generated ideas which fed into the development of the recommendations. The recommendations cover a range of short-term and long-term actions to tackle health inequalities and inequity head-on in primary care settings and wider communities. They are organised under four broad headings:

- Empower and Developing the Primary Care Workforce
- Leadership, Structures and Systems
- Empower and Enable People and Communities
- Data, Evidence and Knowledge

Practical steps taken so far in tandem with the work of the SLWG:

• Funding of £600k to NHS Greater Glasgow and Clyde ring-fenced for additional link worker posts.
• A national network and community of practice[19] for community link workers.
• Welfare Advice & Health Partnerships extended and given core status
• A community led digital inclusion learning project commissioned.
• The Scottish Government commitment[20] to create a network of 1,000 additional dedicated staff who can help grow community mental health resilience and help direct social prescribing, by 2026 through the implementation of Mental Health and Wellbeing in Primary Care Services.
• Since 2007, the Scottish Government's Population Health Directorate have identified and prioritised practical actions to reduce the most significant and widening health inequalities in Scotland. This includes a report series[21] monitoring a range of health indicators over time.
• The Scottish Government have been working with key stakeholders to provide a wider place-based approach to health improvement which will focus on how health and social care institutions can help to benefit their communities economically and socially.
• The £15 million Adult Communities Mental Health and Wellbeing Fund was announced on 15 October 2021. The Fund will focus on several areas including addressing the mental health inequalities exacerbated by the pandemic and the needs of a range of 'at risk' groups.

The SLWG formulated its recommendations against a backdrop of very significant challenges for health and social care services at this time. The NHS Recovery Plan for Scotland recognises that the COVID-19 pandemic has created a serious backlog of health care and had a significant detrimental impact on workforce wellbeing and morale in health and social care (Scottish Government 2021f). Even prior to the pandemic many believed there was an evolving crisis of workforce and skills shortages across many professions working in primary care, including nurses, pharmacists and GPs [22],[23]. The Health Foundation's recent "Build Back Fairer" review for England (Marmot et al 2020b) found that the pandemic has disproportionately affected the UK's poorest areas and worsened existing health inequalities. In addition to these challenges, the climate emergency only adds to social inequity.

It will be vital that these recommendations are aligned with wider policies reshaping primary care if they are to be translated into actions and programmes of work. Alongside efforts on 'recovery' from the pandemic, there are ongoing commitments to reform primary care (including the 2018 Scottish GP General Medical Services

[19] VHS, 'The Scottish Community Link Worker Network' https://vhscotland.org.uk/what-we-do/scottish-community-link-worker-network/
[20] The Scottish Government 'Increasing mental health support in GP practices' https://www.gov.scot/news/increasing-mental-health-support-in-gp-practices/
[21]The Scottish Government 'Long term monitoring of health inequalities' https://www.gov.scot/collections/long-term-monitoring-of-health-inequalities/
[22] RCN, 'Results of new survey reveal extreme pressure nursing staff are feeling' https://www.rcn.org.uk/news-and-events/news/rcn-employment-survey-scotland-2019-28-nov-2019
[23] BMA, 'BMA Scotland: Spiralling demand pushing GPs to the brink' https://www.bma.org.uk/bma-media-centre/bma-scotland-spiraling-demand-pushing-gps-to-the-brink

contract[24] and the two related Memoranda of Understanding,[25] [26] the Scottish Government's Primary Care Improvement Fund, and Health and Social Care Partnerships' Primary Care Improvement Plans). In addition, the Scottish Government is also developing four new cross-cutting Care and Wellbeing Programmes; there is the ongoing redesign of urgent care; and work to design and legislate for a National Care Service. While these are being supported with additional funding commitments, there is a huge amount that needs to be done. Difficult decisions will need to be made, both centrally and locally. Core to these will be choices about the extent to which actions to address excess deaths (including drug deaths), premature disability and long-term health inequalities are prioritised alongside many other competing demands on health and social care services. This will require concerted national leadership supported by a strong and inclusive commitment from a range of partners.

Many of the recommendations therefore involve adding a specific and explicit consideration of inequalities to existing programmes of work, rather than being new or standalone initiatives. The majority of these relate directly to primary care, such as a Scottish programme of multidisciplinary postgraduate training similar to the Fairhealth programme in England,[27] equipping and empowering multi-disciplinary teams; actions to improve the collection and use of equalities data in general practice; threading inequalities through the Scottish GP contract and Memoranda of Understanding delivery mechanisms; or a new Enhanced Service.

Other recommendations relate to the wider health and social care system, such as ensuring health and social care staff have the digital skills, understanding and resources they need; the challenging idea of an investigation into how barriers to healthcare and services contribute to premature morbidity and mortality; reviewing how transport and health services interface; or developing a better understanding of 'missingness' in health care (i.e. the needs of those marginalised populations who for complex reasons do not seek out health care or who repeatedly miss healthcare appointments) (Williamson et al. 2021).

A small number look beyond and across government policy, such as a possible new Commissioner for Health Inequalities in Scotland; investing in wellbeing communities; or recognising digital (access, literacy, confidence) as a determinant of health in its own right alongside other socio-economic factors.

We envisage the SLWG will evolve into: a development group function to formulate proposals for implementing specific recommendations; and a reference group function to provide a perspective on inequalities for wider policy developments. Both of these functions will entail significant commitment and planning with partners and consideration of different options for delivering the recommendations.
Some of the recommendations in this report will require funding in their own right, for example the postgraduate training fellowship, the establishment of an Enhanced

[24] The Scottish Government 'GMS Contract: 2018' https://www.gov.scot/publications/gms-contract-scotland/
[25] The Scottish Government 'Delivering the new GMS contract in Scotland' https://www.gov.scot/publications/delivering-the-new-gms-contract-in-scotland-memorandum-of-understanding/
[26] The Scottish Government 'Memorandum of Understanding 2' https://www.sehd.scot.nhs.uk/publications/Memorandum_of_Understanding%202-GMS_Contract_Implementation_for_PC_Improvement%2030_July_2021.pdf
[27] Fairhealth: Health Equity Action and Learning https://www.fairhealth.org.uk/home

Service for health inequalities, or the potential setting up of a Commissioner for Health Inequalities or similar. Many will require investment through existing programmes of work, in particular to develop capacity within health, social care and communities. The most important resources needed are human, to develop leadership, create better ways of working, and to enable an infrastructure of people, professionals, volunteers and communities, who are inspired to dedicate their energy, expertise and enthusiasm where it is needed most. This will only be developed gradually and will require long term vision, commitment and sustained support from the national leadership.

A key recommendation of the SLWG is that the voices of those individuals, groups or communities who have experienced health inequalities first-hand in their own lives should be foremost in all planning and policy developments which might have an impact on them. The principle of 'nothing about us without us' should hold especially true. As role modelled in the SLWG process, this should go beyond consultation to direct participation in the planning and development of policy and programmes.

The SLWG are conscious of the challenges of this ambitious portfolio. Phasing and a degree of prioritisation are certainly needed, but the scale of ambition matches the scale of the challenge.

Implementation and Impact

The SLWG has brought together an extensive range of experience, expertise and evidence. This includes frontline professionals, academics, leaders of statutory, professional and third sector organisations, civil servants, and - most importantly - people with expertise derived from their own experiences of the issues being discussed. Implementation of the SLWG's recommendations will enable primary care and community-based health and wellbeing services to have the greatest possible impact on mitigating the long-standing injustice of structural health inequalities in Scotland at this time. The scope of the recommendations is therefore substantial.

To enable this work to proceed with the concerted momentum and energy it requires, the SLWG identified five foundational recommendations as priorities. These five should be prioritised as they will lay a strong bedrock on which to build the full range of ambitious and far-reaching recommendations in Annex A of this report.

The proposed five foundational recommendations to be immediately prioritised are:

1. **Strengthen national leadership for health inequalities.**

   Options for bolstering national leadership should include consideration of a potential Health Inequalities Commissioner or similar role, and annual reporting on progress. Health inequalities are complex and multifaceted: no single department or organisation has been able to bring about sustained change on their own. Coordinated working across organisational divisions with cross-portfolio leadership and transparent accountability is a necessary prerequisite for transformative change and for the recommendations in this report to have a meaningful impact. Excess deaths and disability due to

inequalities must be a national priority and require a coordinated national response.

2. **Implement a national programme of multi-disciplinary postgraduate training fellowships in health inequalities.**

   Health and social care systems and the behaviours of frontline professionals are drivers of health inequalities. Evidence has demonstrated that postgraduate health inequalities programmes have a significant impact on, not only the awareness, attitudes and skills of professionals, but also practitioner retention and reduction of stress and burnout. The introduction of such a programme at scale will create a foundation for strengthening services where they are needed most and for building services that are informed about discrimination and trauma and are oriented to working alongside people and their communities. Primary care should also make best use of existing programmes and resources, including the National Trauma Training Programme to address a widespread lack of trauma-informed practice and care.[28] Leaders at the frontline are faced with many competing priorities, amongst which health inequalities are often lost. Frontline workers face stress, burnout and overwhelm arising from daily encounters with trauma, discrimination and inequality. This can lead to harmful coping behaviours and systems that exclude those most in need.

3. **Create an Inclusion Enhanced Service that invests in the management of patients who experience multiple and intersecting socio-economic inequalities.**

   The current distribution of health care resources in Scotland does not reflect the needs of those at greatest risk of premature death and disability. A lack of systematic data about unmet need has resulted in resource allocation formulae that do not match need. This is most clearly the case in the distribution and allocation of resources to GP practices through the GP contract. In the long term, better data will allow for more equitable resource allocation. In the immediate term however a mechanism is required that will allow investment to be targeted to the frontline and unlock the potential for other changes. A similar enhanced service exists in England.

   An Inclusion Enhanced Service would help to address elements of the inverse care law by providing time for primary health care professionals to undertake co-ordinated care planning alongside people with complex and long term conditions - a key determinant of better health and wellbeing outcomes.

[28] NES 'National trauma training programme' https://www.nes.scot.nhs.uk/our-work/trauma-national-trauma-training-programme/

4. **Develop a strategy to invest in wellbeing communities through local, place-based action to reduce inequalities.**

   Health and social care services are most be effective if they rest on a foundation of strong community networks and organisation. These encourage support from family, friends and peers; build self-confidence and belief in entitlement to services; enable access to information about health and wellbeing, including digital resources; give support to assert rights and articulate needs; and nurture skills to create and sustain health and wellbeing. Financial obstacles, discrimination and many other barriers prevent individuals and communities from realising their strengths and potential. A long term strategy, led by communities themselves with the support of locally embedded organisations, will allow community infrastructures to protect and promote physical and mental health, wellbeing and resilience, and will create an environment in which health and social care can begin to function more effectively as partners alongside the communities they serve.

5. **Commission an investigation into how barriers to healthcare can themselves inadvertently contribute to excess deaths and premature disability related to socio-economic inequalities.**

   There is widespread experience and evidence that health and social care systems are themselves drivers of health inequalities. A thorough investigation would enquire into the mechanisms and processes by which this occurs, not only in primary care but also in mental health, addictions, hospital based services and social care.

The immediate next steps will be to establish an implementation group with clear responsibility for developing programmes of action, making the case for resources and allocating responsibilities. A reference group with wide professional representation, as well as expert reference groups of people with lived experience, should also be established to ensure scrutiny and accountability, with a public report in one year to give an account on progress that has been made.

The national recovery from the current pandemic presents both a challenge and an opportunity. Avoidable differences in people's health and exposure to death or disability based on bank balance, postcode or birthplace are injustices that should have no place in the post COVID-19 world. The recommendations in this report provide a pathway by which primary care can fulfil its duty towards shaping a fairer Scotland. For a nation to be truly modern, prosperous and progressive, it must be able to ensure that access to effective health care is available to all on an equal basis of human dignity alone.

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Abbreviations and Acronyms

AHP – Allied Health Profession
BMA – British Medical Association
C2C – Chance 2 Change
CCT – Certificate of Completion of Training
CLW – Community Links Worker
CMO – Chief Medical Officer
COVID-19 – Coronavirus disease
DEFRA – Department of Environment, Food and Rural Affairs
EMG – Expert Medical Generalist
GMS – General Medical Services
Govan SHIP – Govan Social and Health Integration Partnership
GP – General Practitioner
HIS – Healthcare Improvement Scotland
IAs – Integration Authorities
MOU – Memorandum of Understanding
MRG – Ministerial Recovery Group
NCS – National Care Service
NES – NHS Education for Scotland
NHS – National Health Service (Scotland)
NRS – National Records of Scotland
OOH – Out of Hours
OT – Occupational Therapy
PCIPs – Primary Care Improvement Plans
PHS – Public Health Scotland
QNIS – Queen's Nursing Institute Scotland
RCGP – Royal College of General Practitioners
RCN – Royal College of Nursing
SIMD – Scottish Index of Multiple Deprivation
SLWG – Short Life Working Group
TOR – Terms of Reference
VHS – Voluntary Health Scotland
WHO – World Health Organization

Annex A: Recommendations of the Primary Care Health Inequalities Short Life Working Group

These 23 recommendations of the Primary Care Health Inequalities Short-Life Working Group reflect the scale of the task and the ambition of our vision. All of us involved in primary care have a collective responsibility to make change. Principle responsibility for some recommendations will clearly lie with specific organisations and this will be made more explicit, in 2022, as the successor to the SLWG focuses on how they ideas could be turned into actions. The SLWG are, however, clear that these recommendations, under four broad themes, have relevance to all health and care bodies, leaders, staff and service users in Scotland.

As noted in the main report, we have identified five 'foundational' recommendations as priorities which will provide a bedrock to build on.

Theme: Empower and Develop the Primary Care Workforce

Creating the right conditions; sustaining the workforce and leadership.

- **Implement a national programme of multi-disciplinary postgraduate training fellowships in health inequalities.** This **foundational recommendation** will build a leadership network in primary care to develop skills and generate additional capacity for multi-agency care planning, inter-disciplinary team working, and co-production of health with individuals and at a community level. Communities who are affected by disproportionately poorer health outcomes and high levels of excess deaths due to health inequalities should be identified to benefit from the impact of this additional capacity. The programme will build on the learning from the Deep End Pioneer Scheme and the Fairhealth Trailblazer post-CCT Fellowships, Govan SHIP, Lanarkshire OT and Queen's Nursing Institute in Scotland programmes. It should develop capacity in professional practice based on deep understanding of overlapping causes and dimensions of health inequalities, including the intersectionality of protected characteristics, socio-economic determinants, place, structural racism, discrimination, impact of racism on health, and privilege.

- **The Scottish Government should create an Enhanced Service for Health inequalities:** This **foundational recommendation** would support the management of patients who experience multiple and intersecting socio-economic inequalities, wherever they are registered, to improve equity of access, patient experience, health literacy, and health and wellbeing outcomes. An evidence-based process for resource allocation would be needed to ensure delivery is targeted as intended. This Enhanced Service would be a key enabler to the delivery of other recommendations.

- **Empower primary health care professionals** to play an expanded role in multi-agency care planning for people who have complex health and social care needs. This will require both sufficient time capacity and adequate

training. Co-ordinated care planning for complex and long term conditions can bring together primary health care workers, including those working OOH in 24/7 provision, with social care, mental health, link workers, education, police, carers, housing, families and individuals themselves as appropriate. The programme of work surrounding Anticipatory Care Planning, and projects such as Govan SHIP provide models from which lessons can be learned. This recommendation would support the Expert Medical Generalist role for GPs, and the implementation and future phases of the MoU and General Medical Services GP contract.

- **Invest in the training and resourcing of health and social care staff for digital inclusion:** All staff in the primary care multi-disciplinary team, for both in-hours and OOH, and including practice administration and community links/welfare workers, should understand the potential and the limitations of digital and remote care, with specific relevance to the demographic characteristics and access requirements of the communities with which they work. They should have the skills, confidence and equipment they need. This includes providing resources, capacity and support for GP and primary care teams to ensure digital access and care are intrinsic to their working practices, patient access and care delivery, and that they can maximise technology's potential to mitigate inequalities, create community and empower self-management (for example, online communities/peer support, home monitoring, YouTube instruction videos). This commitment would require NES and HIS working in partnership.

- **Articulate and embed inequalities as a core concern in the Expert Medical Generalist role:** In parallel to other recommendations related to complexity and dedicating more GP time on patients who need it, there needs to be clearer expression of how inequalities run through the EMG alongside ways to understand whether and how this is being realised.

Theme: Leadership, Structures and Systems

Tackling sources of inequalities and inequity within our systems and communities.

- **Strengthen national leadership:** For this **foundational recommendation** the Scottish Government should consider options, including the potential creation of a new Health Inequalities Commissioner, to strengthen leadership for health inequalities in health and social care and to create momentum, overview and responsibility for measures across all public sectors to reduce inequalities in avoidable/premature mortality, healthy life expectancy, and premature disability. Existing levers, structures and systems (e.g. performance management, statutory requirements, guidance, clusters) should be used to drive change and hold system leaders and managers accountable for tackling health inequalities.

- **Create a national priority of reducing premature disability due to long term physical and mental health conditions:** The NHS, the four new, overarching Care and Wellbeing Programmes being developed by the

Scottish Government, and new National Care Service should have responsibility to deliver this priority. Primary care practitioners need to be able to work together with specialist NHS colleagues, social care, local authorities, community planning, communities and individuals most at risk, the third sector and business sectors to increasingly align resources around empowering individuals to stay well, supported by their families, carers and other assets in their community. This priority should be reflected in both core and enhanced elements of the GP contract offer, with reference to the EMG role, the delivery of realistic medicine, partnership working, and support for wellbeing in the care and management of individuals with long term conditions.

- **Commit to ensuring social and financial inclusion support and advice are available through primary care**: The Scottish Government should reaffirm its policies of promoting in primary care those roles (such as Community Links Worker, Welfare Advisor and Mental Health Worker) which provide non-clinical and social support and advice to individuals experiencing social and financial disadvantage and exclusion.

- **The MoU and the GMS Contract Offer, should be underpinned by a commitment to address inequalities:** Inequalities and equity should, formally and explicitly, run as themes through ongoing implementation of current and future commitments (including the joint December 2020 letter) in the MoU and GMS contract offer and through priority development around Mental Health and Urgent Care, maximising lessons from multi-disciplinary, clusters and partnership working. Decision-making underpinning primary care improvement plans should clearly reflect statutory requirements in relation to equalities. Equality Impact Assessments should be mandatory for Health and Social Care Partnerships, in line with Fairer Scotland Duty statutory guidance for public bodies, which includes socio-economic inequality.

- **Funding allocation:** Any changes to how funding is allocated in primary care should explicitly consider the inclusion of socio-economic inequalities, rurality, equity of access and unmet need. The Scottish Government should also commit to monitoring unintended consequences or risks arising from a future formula or model for funding.

- **Transport and health:** The Scottish Government should create a group which brings together different sectors and stakeholders to review and take action on transport and health and make improvements to how health and transport services interact. This should tackle inequalities and ensure that patients can access health services more easily, when they need them, and in a way that promotes sustainability.

- **Recognise digital as a social determinant of health:** Technology should be understood and recognised as a determinant of health inequalities and outcomes alongside other socio-economic and environmental determinants. The Scottish Government and Public Health Scotland should look at ways to incorporate digital access and skills into their analysis of inequalities.

Theme: Empower and Enable People and Communities

Individuals and communities should have the knowledge needed to use health care and be active participants in problem-solving.

- **Develop a network of expert reference groups with lived experience** to ensure these groups are included from the start of the policy making or service design process and not just at the impact assessment stage. This should take account of socio-economic disadvantage and protected characteristics and the intersections of different characteristics. Practice lists and clusters are key: as mechanisms for delivery of this recommendation and as beneficiaries from it as it would support them to engage more meaningfully with their lists/communities

- **Invest in wellbeing communities:** For this **foundational recommendation** the Scottish Government should support the development of a more coherent and long-term approach to local, place-based action to reduce inequalities. Communities have different starting points in terms of social and material assets they possess. Partnerships between communities, third sector, public sector, and the NHS and social care system as 'anchor institutions', and alignment of policy across government, should prioritise supporting and promoting durable community assets that enable peer-to-peer support, shared community spaces, local groups & activities and other community infrastructure to protect and promote mental health, resilience and wellbeing. Clusters and practices, embedded in their communities, should be intrinsic to this work.

- **Pilot and implement a national programme of digital empowerment for health** through community-based peer-supported learning programmes to enable patients who are digitally excluded to safely use digital networks for peer support, access health resources on-line, and gain hands-on experience in using NHS remote consulting technology.

- **Raise awareness of health care rights and responsibilities:** People who do not use primary care services or are under-represented as health services-users should be informed about their rights and responsibilities in relation to health care. They must be provided with accessible and inclusive information that they understand, through communication channels that work for them. Information would include how to register with a GP and use health care appropriately and cover a range of other services and resources to support their use of primary care. The third sector and community organisations will be key partners.

Theme: Data, Evidence and Knowledge

Securing intelligence on health equity and inequalities to enhance transparency and improve understanding and recognition.

- **Publish high quality, accessible information on health inequality:** National and local bodies should commit to:

  - improve data collection, quality and transparency on inequalities and how they intersect, at national and local levels for protected characteristics, deprivation and other experiences of marginalisation (e.g. homelessness), and address gaps;

  - review how they describe, publish and report on health equity and health inequalities and mortality figures to ensure that information is accessible, easily comprehensible and transparent so that communities and individuals are empowered through knowledge.

- **Develop mechanisms for recording, assessing and reporting on unmet health needs in general practice:** this would respond to observations in a report for the Scottish Government that an alternative allocation model would be needed to address some sources of inequalities, but evidence for this was lacking.[29]

- **Equip communities with data and knowledge to empower them to demand or make changes that matter to them:** Communities should have access to clear and relevant data and analysis, delivered through inclusive communication, that explain the interconnections between health and its social determinants and the reasons for differential outcomes, across communities in Scotland, including excess deaths and the gaps in healthy life expectancy due to socio-economic factors.

- **Commission an investigation into how barriers to healthcare themselves contribute to excess deaths and premature disability** related to socio-economic inequalities. This **foundational recommendation** is for work to examine: barriers to access for different groups; waiting times; delayed presentations with serious conditions; “missingness” from health care; perverse incentives and behaviours created by targets; and negative behaviours/coping strategies people may resort to self-manage or self-medicate when unable to access care and support. Data on missed appointments and ‘missingness’ should be recorded and reported: safe, effective and equitable health care depends on understanding of who misses appointments or does not engage with services. Work should be undertaken to build on previous data linkage analysis (e).[30]

[29] Deloitte (2016) ‘Scottish Allocation Formula – GMS workload model’ Report for the Scottish Government. https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2017/11/2018-gms-contract-scotland/documents/00527541-pdf/00527541-pdf/govscot%3Adocument/00527541.pdf

[30] e.g. AE Williamson at al. (2021) "'Missingness' in health care: Associations between hospital utilization and missed appointments in general practice. A retrospective cohort study." https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0253163

- **Mechanisms to support increased and enhanced collaborative and complementary working between public health and primary care** should be developed to synergistically improve population health at macro and micro levels. This would build on momentum gained from cluster working and during COVID-19 to share intelligence and understanding more effectively and routinely.

- **Improve recording of health data in general practices in marginalised communities**: The Scottish Government should test the impact of providing a sample of volunteer GP practices or GP clusters in deprived areas with dedicated data support to improve the quality and accuracy, the consistency and efficiency of routine data entry and coding. One aim of this would be to identify practical measures to improve and expand data on demand/expressed need.

- **Monitoring and evaluation of primary care reform should more explicitly address health inequalities**. It is essential to track and understand the impacts of reform on inequity and inequality.

Annex B: Summary of Commentary by the Expert Reference Group with Lived Experience

The Primary Care Health Inequalities Short Life Working Group were clear from the outset that the voices involved in agreeing on recommendations should not just be those of professionals and policymakers, but also of individuals with lived experience of the issues being addressed. The SLWG therefore worked alongside a small expert reference group called Chance 2 Change. The group is an established community peer support group with historical ties to Garscadden Burn Medical Practice in Glasgow. It was originally set up by a practice nurse with a QNIS Catalysts for Change grant,[31] but has evolved into an independent community group, hosted and supported by Drumchapel Life and Yoker Community Campus. Participants all have direct experience of both long term health conditions and of facing disadvantages, discrimination or social / economic exclusion. One of the original group gained a qualification in community development and is now the group peer-facilitator, employed on a sessional basis.

Watch Chance 2 Change tell their own story at:
https://www.youtube.com/watch?v=bVy6T7CXXjY

Dialogue between the SLWG and Chance 2 Change was mediated through the peer-facilitator. The group discussions were based on two papers produced by the SLWG, one an overview of the themes being discussed, and the second a draft of the proposed recommendations, written into plainer English. The peer facilitator used these two resources to create source materials to stimulate meaningful conversations and used different techniques to ensure that the group felt comfortable with the topics and able to contribute. Discussions were incorporated naturally into the regular weekly meetings of the group over approximately nine months.

Various methods were used to record and feedback the outcomes of the Chance 2 Change discussions to the SLWG, including reports written by the peer facilitator, photography and a short video featuring the participants speaking in their own words. This expert commentary from people with direct experience was as a standing agenda item at SLWG meetings. One SLWG member met regularly with the peer-facilitator to ensure direct accountability back to Chance 2 Change.

Watch Chance 2 Change talk about their own experiences of unmet need, long term conditions and mental health at: https://www.youtube.com/watch?v=xjl5xJC7dbI

A full report has been published as a supporting document: A Chance to Change Scotland: Report of the Chance 2 Change Expert Reference Group with Lived Experience to the Primary Care Health Inequalities Short Life Working Group

[31] QNIS – Garscadden Burn Medical Practice 'Chance2Change as catalyst for healthier lifestyles' https://www.qnis.org.uk/wp-content/uploads/2016/11/Chance-to-Change-Final-report-Garscadden-Burn-Medical-Practice.pdf

Annex C: Primary Care Health Inequalities Short Life Working Group: Terms of Reference

Introduction

Inequalities in society are caused by a fundamental inequity in the distribution of money, resources and power. This impacts on opportunities for good-quality work, education, housing, life expectancy etc. In turn, these determinants shape individual experiences and health throughout life. Scotland has the widest of health inequalities in Western Europe - a major factor in explaining why overall levels of population health are also among the worst in Western Europe.[32] While the long-term implications of the COVID-19 pandemic on population health and health inequalities are still to be understood, it has brought a sharper focus on the importance of understanding and tackling health inequalities.

Aims of the Group

General practice, and the wider primary care team, by virtue of being embedded within communities and at the 'frontline' of the NHS, can play a pivotal role in mitigating the effects of health inequalities at a number of levels: through clinical care; wider patient advocacy; community engagement; and influencing the wider health agenda. The aim of the Primary Care Health Inequalities Short-life Working Group (SLWG) is therefore to support service improvement activity within primary and community care. In doing so, it will play a role in delivering action that will help to reduce health inequalities, improve health equity, and increase healthy life expectancy in future. The group's focus will be to identify and recommend **clear actions that enable positive change that can be implemented**, building on existing learning and evidence.

Terms of Reference

The group will:

1. Play an influential and leadership role on Health Inequalities within a Primary Care setting
2. Consider how to maximise existing levers within the system to address health inequalities (what does 'good look like' (including for general practice, Clusters, PCIPs)
3. Agree the metrics that are needed to guide change and monitor improvement – thinking beyond health measures where necessary
4. Consider opportunities for closer partnership working between public health and general practice as well as the third and community sectors.
5. Consider the opportunities of shifting to a model of care that has greater emphasis on digital options (such as telephone and video consultations) and consider how to mitigate against digital exclusion

[32] The Scottish Public Health Observatory 'Health inequalities: introduction' https://www.scotpho.org.uk/comparative-health/health-inequalities/introduction/

6. Assess how resource can best be targeted according to the needs of local populations (adjusted for deprivation) to achieve health equity, including the establishment of a new dedicated deprivation fund with clear inclusion criteria and robust governance.

Membership

Group membership will include representation from:

External Stakeholders

Lorna Kelly – Interim Director of Primary Care NHS Greater Glasgow & Clyde and Professional Adviser Scottish Government Primary Care Directorate – **Chair**
Amjad Khan – NHS Education for Scotland
Amy Dalrymple- Royal College of Nursing
Andrew Buist - British Medical Association
Anne Crandles- Edinburgh Community Link Worker Programme, NHS Lothian
Belinda Robertson – Healthcare Improvement Scotland
Catriona Morton – Royal College of General Practitioners
Claire Stevens – Voluntary Health Scotland
Carey Lunan – Royal College of General Practitioners
David Blane – Clinical Research Fellow, University of Glasgow
Elspeth Russell – Head of Health Improvement, NHS Lanarkshire
John O'Dowd – Clinical Director, NHS Greater Glasgow & Clyde
Kate Burton – Public Health Practitioner, NHS Lanarkshire
Paula Spiers – NHS 24
Peter Cawston – General Practitioner, Drumchapel
Rebecca Helliwell – Primary Care Lead with Rural Focus
Roisin Hurst – Voluntary Health Scotland
Sarah Doyle – Queen's Nursing Institute Scotland
Sian Tucker – General Practitioner, Out of Hours Focus
Suzanne Glennie – Glasgow Community Link Worker Programme

Scottish Government

Alex Bowerman – Programme Advisor, Dentistry and Optometry
Jan Beattie – AHP Professional Adviser for Primary Care
Caitlin Byrne – Policy Officer, General Practice Sustainability
Katrina Cowie – Senior Policy Officer, General Practice Sustainability
Morris Fraser – Head of Substance Misuse Unit
Craig Graham – Policy Officer, General Practice Policy and Contract
Natalie Hakeem – Graduate Development Programme Member
Justin Hayes – Policy Officer, Finance, Data and Digital
Khalida Hussain – Challenge Fund Manager
Asif Ishaq – Policy Adviser, Health Improvement
Kathy Kenmuir – Professional Nurse Adviser for Primary Care
Sophie Lawson – Research Officer, Care Research
Fiona MacDonald – Principal Research Officer, Health and Social Care
Lynn MacMillan – Head of Health Inequalities Unit
Karen MacNee – Deputy Director, Head of Health Improvement

David McCaig – Head of General Practice Sustainability
Tim Mcdonnell – Director, Primary Care
Naureen Ahmad – Interim Deputy Director, General Practice Policy Division
Leslie Smith – Senior Administrator, General Practice Sustainability

Members will be expected to actively contribute between and during meetings and should be in a position to recommend and implement actions on behalf of their organisation / the sector they represent. They should also be able and willing to commit resource to develop papers and lead on agenda items either personally or from within their organisations. In this respect, membership should be drawn from senior leaders.

Governance

This group has been established under the auspices of the Ministerial Recovery Group (MRG) on recovery and remobilisation. A Primary Care sub-group chaired by Aidan Grisewood (former Scottish Government Director of Primary Care) agreed that a group was required to take forward a range of actions to tackle existing inequalities.

Frequency of meetings

The frequency of meetings will be agreed at the initial meeting of the group. Meeting agenda and papers will be circulated five days prior to meetings. It is anticipated that the group will meet once a month until the end of the current parliamentary period.

Secretariat

The Scottish Government will provide secretariat support to the group. Minutes and actions will be circulated within one week of the meeting.

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

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