Aberdeen City Health & Social Care Partnership
A caring partnership

INTEGRATION JOINT BOARD

Date of Meeting	29th November 2022
Report Title	Marywell Service Review
Report Number	HSCP.22.102
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Consultation Checklist Completed	Yes
Directions Required	No
Appendices	None

1. Purpose of the Report

1.1. The purpose of this report is to provide an update to the Integration Joint Board on the Marywell Service Redesign.

2. Recommendations

2.1. It is recommended that the Integration Joint Board:

a) Note the progress made with the redesign of the Marywell Service

ABERDEEN CITY COUNCIL NHS Grampian

b) Agree that a triage clinic is established in partnership with Aberdeen City Council at West North Street
c) Agree that Marywell practice is funded for 24 months via the Alcohol and Drugs Partnership as a response to the public health challenge of drug related deaths from funds agreed by the Alcohol and Drugs Partnership and Integration Joint Board of 7th June 2022
d) Instruct the Chief Officer, in consultation with the Public Health team, to develop and deliver a health and inequalities plan to support mainstream Primary Care; and
e) Instruct the Chief Officer to report to a meeting of the Integrated Joint Board on the next phase of the redesign of the Marywell Service, with a Business Case to outline the future provision of services within 18 months.

3. Summary of Key Information

3.1. Within the recent redesign of 2c practices in Marywell Practice was not bid for and as a result the IJB requested an update on the redesign of Marywell and plans going forward, which are now set out in the report below.

3.2. Health and Inequality are routinely cited in reports such as Long-term Monitoring of Health Inequalities and Hard Edges Scotland which highlight the links between deprivation and the needs of people with multiple complex needs. On all indicators health outcomes are poorer for people who live in areas of deprivation and who have multiple complex needs. Services are often delivered on a "single specialist" basis and can be harder for people to engage with. Public Health Scotland A Scotland where everybody thrives: Public Health Scotland's Strategic Plan 2020 to 2023 illustrates that "Life expectancy is relatively poor and has not improved since 2012" and "Health inequalities are wide and have worsened over the last ten years".

3.3. The Scottish Government Primary Care Health Inequalities Short Life Working Group published a report on the 14th March 2022 which contained 23 recommendations in relation to reducing health inequalities. These are summarised at **Annexe A.**

3.4. The impact of poorer health outcomes is seen in the demand on primary and secondary care services. This report seeks to set out a vision and actions for

ensuring that the most vulnerable are supported to engage with health and social care services with a longer term aspiration towards prevention and early intervention. Work that has been undertaken reviewing the provision of Marywell Medical Practice which was established in 2001 as a practice for people who are homeless.

3.5. This report proposes to address a number of interlinked issues:

- The changing demographic of homelessness
- The increased requirement on drug services to meet the complex needs of those at risk of drug related harm
- The increasing need to support people facing health inequalities in areas of deprivation and with multiple complex needs
- Recognise the increased pressure on primary care services and seeks to wrap additional support around those with patients in the deepest end of the health inequality spectrum
- Recognise the increasing demand that health inequalities place on secondary care services and seeks to prevent, reduce and provide early intervention to reduce demand in the longer term
- Recognise other service developments in line with the Community Planning Partnership, the Family Support Model and the work of Early Intervention and Community Empowerment Dept.
- Support the development of locality based care and support
- Recognise current resource constraints in terms of staffing, funding etc and the need to ensure services are integrated and supported to be resilient with an aspiration to support the population to access mainstream services where possible.
- Recognises the strategic direction the Scottish Government has set out in relation to Homelessness, Public Health and Health Inequality, Drug Treatment, and Primary Care Health Inequality

3.6. The report is based on a draws together information from:

- Marywell Homeless Practice
- Aberdeen City Council housing and homelessness services
- The Alcohol and Drug Partnership and drug treatment services
- The Healthy Hoose
- Deepend GP practice model

3.7. **MARYWELL PRACTICE**: Within the recent redesign of 2c practices Marywell Practice was not bid for. A Marywell Service Review project team was established in May 2022 to develop future sustainable plans for the service. Service leads, practice team, representatives from Aberdeen City Council and representatives of patients, people with lived experiences came together in an initial discovery phase. A further series of workshops to discuss with staff a vison and improved model of service delivery have also been held. This report updates on progress to date and presents a series of recommendations.

3.8. The Marywell Service Review project team which comprises of the following key personnel:

- Primary Care Lead – General Practice Services
- Substance Use Operational & Planning Manager/ADP Team Lead
- Primary Care Development Manager
- Clinical Lead Substance Use & Mental Health
- Primary Care Support Manager
- Staff Side Representative
- Human Resources
- Deputy Lead Nurse
- Marywell Team: (GP's/Advanced Nurse Practitioner /Community Specialist Nurse/Practice Manager/Medical Receptionists)
- Aberdeen City Council Housing Access and Support Manager

3.9. Information has been collated from various project and service planning meetings, patient surveys and facilitated workshops with key stakeholders. Findings have been fully incorporated into this report.

In the past a significant barrier for people who were homeless was being able to register with a Medical Practice when they didn't have an address or were sleeping rough which led to the establishment of a specific practice for people who are homeless. It should be noted that Marywell Practice is not currently integrated into statutory housing / homeless provision in the City i.e. it is not currently incorporated into the work of Aberdeen City Early Intervention and Community Empowerment statutory responsibility to reduce homelessness and the harm caused by homelessness.

3.10. At October 2022 Marywell currently had 169 patients registered with them, of which:

- 1 person is of no fixed abode
- 30 have permanent housing
- 138 in some form of temporary accommodation

3.11. There are currently 56 patients open to Marywell and also receiving drug treatment from specialist drug treatment services.

3.12. It should also be noted that not everyone who is having housing difficulties or is homeless necessarily deregisters from their existing GP Practice

3.13. Since September 2021 the Marywell Practice have taken on registrations of the Afghanistan Asylum Seekers of which there are currently 103 housed in temporary accommodation in Aberdeen. Plans to transfer these patients to other practices across the city in May 2022 were delayed due to concerns regarding General Practice sustainability. In the longer term this number will decrease as people are supported to resister with mainstream GP care

3.14. Households with children under the age of 16 are referred to mainstream practices for care, no one under 16 years of age is registered and the practice does not carry out any home visits. Part of the practice remit is to stabilise patients sufficiently so that they may be transferred into mainstream primary care.

3.15. From 2006 the Marywell Practice operated from purpose built premises at the Marywell Healthcare Centre on College Street. This is a multi-storey mixed use premises owned by Grampian Housing Association. The ground floor unit in which the practice occupied is owned by NHS Grampian. On the 13th December 2019 there was a flood in the upper floor of this building which caused severe damage to the ground floor unit occupied by the practice. The damage was relocated to the Timmermarket Drug Service building from the 14th of December 2019 initially on a temporary basis. However subsequent redesign of services during the covid-19 pandemic resulted in the Marywell HealthCare Centre, College Street premises being repurposed as a Community Treatment and Care Services (CTAC) hub.

3.16. The Marywell Practice now operates from within the Timmermarket Drug Service since December 2019, 1 East North Street, Aberdeen however they both currently work as separate services. The opening hours aligned to those of the Timmermarket from August 2022, Monday to Friday 9am – 5pm. To ensure compliance with contractual obligations requiring access to GMS provision between core hours of 8am – 6pm, Monday to Friday a Service Level Agreement (SLA) is in place with a neighbouring practice, Whinhill Medical Practice. The current SLA with the Whinhill Medical Practice is due for review by the 1st of March 2023 and will be aligned to the ongoing work as part of the service review.

3.17. **HOMELESSNSESS**: Aberdeen City Council has made significant innovative progress in reducing rough-sleeping and homelessness in the City. Whilst numbers of people presenting as homeless / rough sleeping will fluctuate, importantly there has been a shift in strategy to focus on early intervention to prevent homelessness from occurring or getting that person back into secure accommodation as soon as possible and providing wraparound support to help them sustain the tenancy. The Alcohol and Drug Partnership is funding a Housing Support Officer in partnership with Aberdeen City Council to provide early intervention and prevention of housing related issues. There is a significant range of help provided to support people via Housing Support Services.

3.18. Aberdeen City Council temporary accommodation facility at West North Street is developing towards being a "hub" of support for people who are experiencing significant housing and homelessness issues.

3.19. In October 2021 the Scottish Government published Ending Homelessness Together. A key strand of Ending Homelessness Together is to move to a system of rapid rehousing by default with the aim of preventing homelessness by prioritising settled housing, including the use of the Housing First model for those with more complex needs.

3.20. The Scottish Government are also currently consulting on legislation that will place a statutory duty on all public services to prevent homelessness.

3.21. Since 2016 SHORE standards (Sustainable Housing on Release for Everyone) have been in place to offer people sustainable housing on release

from prison. The aspiration is that everyone who is released from prison goes straight into secure accommodation (without the need for temporary accommodation).

3.22. ALCOHOL AND DRUG PARTNERSHIP / DRUG TREATMENT: Marywell Practice is currently co-located within the Timmermarket "front-door" of the integrated drug treatment services, however the two services are working separately. People in drug treatment are with the Timmermarket for circa 16 weeks and then move on to specialist locality teams operating from GP Practices.

3.23. The Scottish Government have established national Medication Assisted Treatment (MAT) Standards, which place a greater emphasis on people getting direct access, same day if required, to prescribed treatment. Drug treatment services in the City continue to have a constant demand whilst coping with vacancies and recruitment challenges. People with drug problems have multiple co-morbid health problems.

3.24. Drug services are working towards a new Target Operating Model (TOM) that will see a number of "front-door services" merge to provide easier access in the community, at the Timmermarket, and at Alcohol & Drugs Action.

3.25. On the 7th of June 2022 Aberdeen City Alcohol and Drug Partnership (ADP) presented a report to the IJB on the ADP Investment Programme, following available funding from the Scottish Government's national mission to reduce drug related harm, Medication Assisted Treatment Standards (MAT Standards). The recommendation was to align £480,000 of ADP funding to support the implementation of the MAT Standards and specifically take forward Direct Access to prescribed drug treatment: "to *contribute funding to a service redesign, in partnership with primary care management to deliver Medication Assisted Treatment Standards" Further detail is provided below".*

3.26. The Alcohol and Drug Partnership has established a Rapid Implementation Plan to fast track actions and funding to tackle the issue. The Rapid Implementation Plan has been agreed at a senior level and is being led by Gale Beattie, Director of Commissioning Aberdeen City Council, Sandra MacLeod Chief Officer of the Aberdeen City Health and Social Care

Partnership and Susan Webb the NHS Grampian Director of Public Health and is meeting fortnightly.

3.27. THE HEALTHY HOOSE MODEL: The Healthy Hoose redesign of service provision is progressing and will link to the Marywell Service Redesign. Recommendations for a refreshed Healthy Hoose service have been proposed and will support the health needs of populations in each of the localities by increasing access across the city with a range of professionals and services including Advanced Nurse Practitioners, Alcohol and Drugs Action, Public Health and Sexual Health.

3.28. DEEPEND GP MODEL: Other areas of Scotland have engaged in the development of the Deep End GP model to address the higher health needs of people in areas of deprivation and people with multiple complex needs. This model recognises the extra burden on staff and seeks to remove barriers to people accessing care. The scheme started with the top 100 practices in areas of deprivation to reduce health inequality. Practices in Aberdeen, at that time did not fall into this category, however it is now recognised that whilst a whole practice might not fall into this category, there will be a percentage of patients who do. Whilst further work needs to be done locally to analyse patient lists and identify the distribution of deprivation and complex needs across primary care this model offers support to GPs and other primary care staff working in the "deep end" of patient care. This can then allow additional resources and support to be aligned longer term to support these practices.

3.29. Initial discussions with the Deep End GP team have indicated that they would collaborate with Aberdeen in developing a model that saw a "pro-rata" definition of deep end based on the analysis of patient lists. For example Practice A may have 25% of patients living in area of deprivation whereas Practice B may have 95%.

3.30. CONTEXT SUMMARY: Since the Marywell Practice was established around 21 years ago there have been many changes to the operating environment both locally and nationally, these are outlined below and highlight the need for change.

- Changing profile of homelessness in the city and proactive strategy to provide people with accommodation or accommodation with support.
- An increasing recognition that deprivation and multiple complex needs are linked to poorer health outcomes including physical, psychological and mental health issues as well as drug and alcohol use, and those with criminal justice involvement.
- A growing demand to provide higher quality and capacity for drug treatment as an emergency response to increasing drug deaths.
- General practice has increasing demand which it does not have the capacity to meet with ongoing recruitment challenges and other sustainability issues.
- Other areas in Scotland have developed networks and models of supporting Primary Care to work with the most deprived / disadvantaged communities with the greatest health inequalities.
- The direction of travel established by the Scottish Government in relation to Homelessness, Health Inequality as a Public Health issue, Health Inequality as a challenge for Primary Care, and Drug Treatment improvements.

3.31. The project team propose to take a phased approach to improving services and reducing health inequalities:

3.32. **PART 1**: This work will seek to consolidate existing services and ensure capacity for undertaking joint working and capacity building. Specifically in response to the increasing number of drug deaths in the City and the MAT Standards requirements. It is proposed that:

1. Marywell continues to be a 2c GP Practice until at least November 2024
2. Marywell will establish a clinically led triage presence at West North Street Homelessness Hub. Immediate health care needs will be treated or escalated for medical attention with either Marywell GP or persons existing GP. If the person falls under statutory definition and duty of care of homelessness and is not registered with a GP they will be register with Marywell Practice. The clinical facility at West North Street will be funded through ADP resources.
3. Marywell will continue to care for their existing patient list and as and when it is possible for people to be supported back to mainstream primary care this will be facilitated.

4. Marywell will have a base at the Timmermarket but will work as part of the drug Treatment Service until at least November 2024 and assist in the delivery of the MAT Standards and specifically support Direct Access prescribing and ensure that all people seeking drug treatment are provided with an enhanced health check and treatment for any underlying associated health issues in discussion with the persons existing GP. The NHS Grampian's Organisational Change process will be followed.
5. The ADP, from its aligned fund of £480,000, will fund the cost of Marywell practice whilst it is working as part of the Drug Treatment Service
6. The ADP funding Marywell Practice means that as a consequence the Marywell budget of £240,000 per year is available to support the developmental work set out in Part 2 of this report over the 24 month testing period (£480,000 in total).

3.33. PART 2: The next 24 months will see the development of a number of Tests of Change to develop longer term sustainable support for mainstream Primary Care and to specifically address recommendations of the Primary Care Health Inequalities Short Life Working Group (annexe A).

3.34. The available funding can be used to supplement/complement the Healthy Hoose budget, any additional Scottish Government funding available for health inequalities work, and any suitable, available, future Primary Care Improvement Programme (PCIP) funding. This work will be in line with "Aberdeen Health Determinants Research Collaborative" which is Aberdeen City Council, working with NHSG and both City Universities, and the successful bid to the National Institute of Healthcare Improvement.

3.35. The programme will specifically:

1. Undertake extensive engagement work with individuals and communities to understand their needs and aspirations

2. Work to examine the range of support services available to support primary care indicates an extensive list of services that are either aligned to practices, localities and communities. It should be noted that Aberdeen City Council has a significant housing support service with the specific aim of working with people to keep their housing and reducing problems.

3. Work with service commissioners and others to align services to GP Practices and Patients and to develop a mechanism to co-ordinate care

4. Develop options for supporting the development of Deepend GP support across Primary Care. Enhanced support could be through a combination of enhanced / multi-disciplinary appointments, outreach clinics at practice or locality/cluster level.

5. Initial thinking would be that patients could opt in and be registered by their GP as eligible for enhanced wrap around care and support. Potential criteria could include:
   - in areas of deprivation,
   - with multiple complex needs, and / or
   - are recent heavy users of specialist services

6. Develop options to support a revised Healthy Hoose model that works as part of a Deepend GP Model and examine other locality-based sites

7. Potential development of enhanced link worker / support worker / care coordinator roles

8. Develop a model for Deep End GP work which potentially provides additional payment for enhanced care; additional sessional staffing, service specifications of commissioned services aligned to health inequality prevention and supporting primary care

3.36. The output from Part 2 of the work programme is proposed:

1. A Citywide Health and Inequalities Plan for the next 10 years

2. Clear patient stepped care pathways both in and out of services, for those who can transition into mainstream general practice when appropriate

3. A business case for the future provision of services aimed at supporting the most disadvantaged in Aberdeen utilising enhanced wraparound support for Primary Care to ensure maximum support for GPs within the available funding of £240,000 per year (plus any potential Marywell General Medical Services income or other income/available funds).

4. Health Inequality Network which includes training and development opportunities

3.37. The above actions are recommended on the basis that they:

1. Don't change current service for existing Marywell patients.

2. Address the public health emergency of the current drug deaths in the city and nationally

3. Provide resources to engage the public and services in test of change to deliver Deep End GP Working and prepare for recommendations of the Primary Care Health Inequalities Short Life Working Group

4. Implications for IJB

4.1. Equalities, Fairer Scotland and Health Inequality

In order to comply with the Equality Act 2010, the Marywell Project Team have been working with the NHS Grampian's Equality and Diversity Team to ensure due regard is given to assess the impact of any proposed changes before, during and after the proposed service redesign. Part 1 of the proposal (3.32) does not change the current service provision for patients at Marywell Practice or the Timmermarket Service. During Part 2 of the service redesign (3.33) an Equality Impact Assessment (EQIA) and a Health Inequalities Impact Assessment (HIIA) will be fully undertaken to align with the recommendations of the Business Case which will outline the future provision of services and the development of establishing a "health and Inequalities" Plan for Primary Care.

4.2. Financial

The proposal is to fund Marywell Practice for 24 months from £480,000 of funding made available from the Alcohol and Drug Partnership and agreed by the Integration Joint Board on the 7 July 2022.

The ADP funding Marywell Practice means that as a consequence the Marywell budget of £240,000 per year is available to support the

developmental work set out in Part 2 of this report over the 24 month testing period (£480,000 in total).

The available funding can be used to supplement and complement the Healthy Hoose budget including any additional Scottish Government funding available for health inequalities work, as well as any suitable and available future Primary Care funding.

The output of the 24-month development period will be a business case for the for the future provision of services aimed at supporting the most disadvantaged in Aberdeen utilising enhanced wraparound support for Primary Care to ensure maximum support for GPs within the available funding of £240,000 per year (plus any potential Marywell General Medical Services income or other income/available funds).

4.3. Workforce

The overall aim is to develop a workforce to meet the needs of the patient population in line with the GMS 2018 Contract and integration agenda being flexible to respond to recruitment challenges and creating sustainability, capacity and new ways of working with an integrated and flexible whole system approach.

4.4. Legal

There are no direct legal implications arising from the recommendations of this report.

5. Links to ACHSCP Strategic Plan

5.1. The Aberdeen City Health and Social Care Partnership Strategic Plan 2022 – 2025 outlines key strategic aims and enabling priorities with a key focus to progress the integration agenda by increasing access to community-based health and social care services, shifting the balance of care from hospital to more homely settings and supporting our most vulnerable residents.

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6. Management of Risk

6.1. Identified risks(s)

Staff retention is good however there is limited succession planning and attracting staff to work within the current model has not proved successful with some key roles within the team due to retire, or who have retired and come back to work within the team recognising the fragility of the staffing situation. There is an opportunity through the development of the deep end GP outreach model that this would be more attractive to staff however there is a risk in terms of the various recruitment challenges which are currently being faced.

There is a potential impact on the timeline for the identified works to the West North Street facility, due to the delays in cost returns and subsequent works being carried out.

There are ongoing recruitment challenges which may have an impact on the workforce plan

6.2. Link to risks on strategic or operational risk register:

Strategic Risk 1: The strategic commissioning of services from third and independent sector providers requires both providers and ACHSCP to work collaboratively (provider with provider and provider and ACHSCP) in order to strategically commission and deliver services to meet the needs of local people.

Strategic Risk 7: Demographic & financial pressures requiring IJB to deliver transformational system change which helps to meet its strategic priorities.

6.3. How might the content of this report impact or mitigate these risks:

The actions in this report will help mitigate the risk of the Health and Social Care Partnership not meeting the health needs of at-risk populations and reduce the risk of achieving the Mediation Assisted Treatment Standards by

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March 2023 by increasing the capacity available to support specialist drug services and improve the quality of care.

Aligned to the Primary Care Improvement Plan – Low

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

The text below is an extract from the Primary Care Health Inequalities Short Life Working Group which is being used as a benchmark for consideration of Health Inequalities and Primary Care and future planning.

"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.*

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- ***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.*

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- ***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.*

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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]

- ***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"*