

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**

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This independent report was produced by Chance 2 Change (C2C), an established community group in Glasgow.

It captures the views of C2C members and their facilitator on issues that were addressed by the Short Life Working Group on Health Inequalities in Primary Care. and it includes individuals' personal reflections from direct experience.

The Scottish Government would like to offer sincere thanks to Chance 2 Change for their commitment to producing this report for the Scottish Government and for their role, as an Expert Reference Group with lived experience, to the Short Life Working Group on Health Inequalities in Primary Care.

Foreword

The Scottish Government set up the Primary Care Health Inequalities Short Life Working Group (SLWG) in autumn 2020 to identify service improvements and policy actions which could help to reduce health inequalities and improve health equity. The SLWG were clear from the outset that the voices involved in agreeing on recommendations should not simply be those of professionals and policymakers but also of individuals with lived experience of the issues being discussed.

I invited Chance 2 Change (C2C) in January 2021 to take on the role of an expert reference group to the SLWG. Chance 2 Change is an established community peer support group in Glasgow, with historical links to my GP practice but hosted and supported independently by Drumchapel Life / Yoker Community Campus. The group is led by a peer facilitator who was one of the founding group members. The people who attend all have lived experience of long term health conditions and of living with the issues being addressed by the SLWG, such as social disadvantage, discrimination or economic exclusion.

Watch Chance 2 Change tell their story in this [YouTube video](https://www.youtube.com/watch?v=bVy6T7CXXjY):
<https://www.youtube.com/watch?v=bVy6T7CXXjY>

The expertise of the group is grounded in their own experiences of living with the issues being discussed. They were asked to respond to SLWG working papers outlining the themes and the draft recommendations. The group's peer facilitator played a key role in enabling the group to contribute in this way, drawing on both her training in community development and her own life experiences. She used a variety of methods to ensure that the group felt comfortable with the topics and able to contribute to them. The discussions took place naturally as part of the regular weekly meetings of the group over a period of approximately nine months.

This comprehensive report by the C2C group collates all of the feedback from these meetings. The author is the peer-facilitator, Leanne McBride, drawing on her notes and records of their work in which she was also a participant. The opinions and words captured in this report are those of the C2C group. It is presented unedited with the wording and format which she has agreed with the group. They have given their full endorsement that this is a faithful representation of their discussions.

The feedback and contributions from the C2C group have been pivotal in developing the themes for discussion, and the final recommendations of the SLWG. It has been a privilege to work alongside Chance 2 Change, who have offered an honest and often critical voice to the work of the SLWG. Although this is presented as a supporting document, in many ways the work of C2C has been the main achievement of the process. I hope that the voices and experiences reflected here come to have the influence they deserve in shaping a fairer and more just Scotland.

Dr. Peter Cawston, GP, Garscadden Burn Medical Practice, Drumchapel, Glasgow

Thank You Message from Chair of Primary Care Health Inequalities Short Life Working Group

I would like to thank the Chance 2 Change (C2C) group, their facilitator Leanne McBride and Dr Peter Cawston for their input throughout the course of the Primary Care Health Inequalities Short Life Working Group (SLWG) and for their detailed report.

As Chair of the SLWG, I have very much appreciated their input and steer as an Expert Reference Group with lived experience, and their challenge to the group to make sure any change is meaningful to those it affects. The personal approach of C2C in this report, from both their words and images, provide a vital, real-world perspective that should resonate deeply with readers of this report.

In their own words, “working with groups such as C2C should be the norm” and I am looking forward to the continued relationship with C2C as the recommendations take shape following publication of the reports.

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

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1. Initial Ideas for Participation - Part 1

Structural Inequality.

- “Agreement that the NHS should be ‘best’ where it is needed the most”. Person-Centred theory has been in existence for years but is still just that a theory, in most practices. At Chance 2 Change (C2C), it’s people-led, automatically making it a Person-Centred group, which benefits people by implementing active listening, building confidence and skills, which empowers people to make positive choices for themselves as well as challenge previous practice (e.g. GPs, healthcare professionals, mental health, etc.).
- Policy recommendation – This can easily be achieved through community groups with links to GP practices – such as C2C.
- Example question for C2C group:
 - If we were to build similar groups to C2C in other communities what would be required to make them as successful as this group?

Community Voice

- Each individual at C2C has their own stories to tell where health professionals/organisations failed their needs which when broken down are not at all complex. C2C has proven that people from deprived areas can learn and promote positive wellbeing within the context of a Person-Centred approach.
- Example questions for C2C group:
 - Think of a time when your health needs were not met? How could this have been better?
 - Has the group supported your needs? If yes, can we have some examples?

Sustainability & Leadership

- I don’t feel that this theme is for the group but do have some comments:
 - The paper talks about Clinical/medical expertise, which I have none of but the reason I feel C2C works is that I am an expert in growing up and living in a deprived area and all the issues and challenges that go alongside this.
 - An idea for a new model should be that academics need to collaborate equally with scheme experts and recognise each other’s worth. I guess this is what you are trying to achieve by working with us.

- Point 7 'Skills Curriculum' – this should be mandatory and we should have involvement from Relationship Scotland to enable professionals to develop skills that put people at ease, for instance 'non-judgemental' should not just be another theory but needs to be practiced. This should be for all front-line staff, not just clinical/medical (such as admin/reception).

Long Term Health Conditions

- I have learned at C2C that language is important – I used to believe that 'recovery' was a term that should be used for addiction and long-term health conditions but I was wrong and have learned that in life we are all recovering from something, especially in the current Covid-19 climate. There is a range of challenges that C2C group members face such as addiction, Bi-polar, anxiety, poor mental health, stroke, etc. By bringing the group together and empowering them to realise that we are all recovering achieves a collective togetherness, which has proven to have a positive effect on long-term health conditions.
- The paper states there should be 'greater responsibility on individuals to manage their own health'. This is true but people often do not understand what this means and require education and guidance.
- Example questions for C2C group
- Do you agree that you as an individual should take responsibility for your own health?
 - What things do you do to improve your own health?
 - Is it easier to make health improvements through a/the group than on your own?

Mental Health

- It is fair to say that Mental Health is currently the weakest service provided by the NHS. I am part of the North West Mental Health and Suicide Prevention forum and I have very limited knowledge of services that I can signpost to. These services either do not work or have such long waiting times that suicide rates are further impacted.
- The policy recommendation is that the 'Government invest in the infrastructure of kindness' – It's interesting to think what kindness looks like in this setting because it is currently the police that are first responders to a mental health crisis which either requires training or moving this responsibility away from the police.

- Example questions for C2C group
 - How has Covid-19 and the restrictions impacted your mental health?
 - What support has been available to you during Covid-19?
 - How would you feel if you were suffering from poor mental health and the police arrived at your door?
 - Can you tell me ways in which health professionals and mental health workers can show kindness?

Digital Health Care

- The whole world has gone digital and sadly we have an entire generation of people that do not understand technology. Since the Covid-19 pandemic, this is also a challenge that C2C is facing. What is currently in place to support education of digital technologies but also to ensure access to hardware for those people in financial difficulty? To support future decision making, could this be piloted at C2C, enabling the group to have the choice to communicate in this style but also highlight potential barriers in digital learning?
- Example questions for C2C group
 - How would you feel about speaking to your doctor online?
 - Would this make you more or less anxious?
 - Putting the health stuff to one side - if we all had the confidence and knowledge to go online would we and would we speak to each other?

2. Structural Inequality/‘Picking on the Wee Man’ – Chance 2 Change Group Discussion

People believe that structural inequality exists because of Covid when in fact it has always existed.

In deprived areas where there is considerable poverty and related issues around education, mental health, and addiction – some people do not have the knowledge and others have been trodden down so often by the system that they do not have the power that enables them to stand up and fight for services. This allows the Government and other authorities to continually pick on the wee man.

The pot of money allocated for funding, in real terms, is continually decreasing so resource and the ability to run quality services is increasingly difficult.

This leads to services becoming selfish, focussing on their own needs, which is more divisive as the best outcomes, are achieved through collaboration, and sharing resources. For instance, C2C runs on so little money we rely on other services to provide free facilitation and support and we do the same. If you remove funding from one service, you end up with a watered down product that affects a range of services and reduces positive outcomes for an entire area.

There is a shared responsibility on both the government to provide resource but also on services to create an environment that makes proper use of this.

Furthermore, the Government needs to identify and promote/develop good services as well as ensure those from the most deprived areas are given the same opportunities and support as the rest of society. This is clear from the current situation facing C2C.

We have a range of group members who by committing to the C2C model have made outstanding positive changes to their lives. However, come March this year (2021) there is no further funding available as it stands. Far more needs to be done by the Government and local councils to ensure services are provided with the resource necessary to continue as this isn't just about services going under but about the devastating affect it will have on people's lives which in turn will impact an already overwhelmed NHS.

Under Covid-19 guidance, C2C is categorised as an essential service. C2C is always on the brink of having no further funding which will result in this 'essential' service potentially ceasing to exist. As a peer led group the members are fully aware of the financial situation we face and the irony of being an essential service that could be lost.

Group members have voiced some of the following thoughts and feelings:

An overwhelming sense of sadness.
Some said that it was 'crap' and they felt angry.
One member said, "It's the only reason I get out of bed".

Sadly and most worryingly, another member said that the group is the only thing that keeps suicidal thoughts away and they are terrified about these coming back.

We understand that the Scottish Government has to work within certain constraints but it is our hope that the voices/concerns of the C2C group members will be heard and respected and where relevant actioned.

3. Mental Health, Long-Term Health Conditions and Community Voice – Chance 2 Change Group Discussion

Within the discussions that took place between the C2C group members it became clear that **Mental Health, Long Term Health Conditions and Community Voice** are linked and the discussion points have been compiled to reflect this. We would also like to echo the point made originally within the Initial Ideas for Participation section - we are all recovering from something and mental health, trauma, addiction, long-term health conditions should be viewed together and not in isolation, for example the impact that conditions such as strokes have on mental health and vice versa.

- Addiction has proven links with trauma and adverse childhood experiences (ACEs) which clearly impact mental health, diluting suicide rates, which are recorded as drug-related deaths. For example, Heroin or alcohol addiction is a form of escapism, which can result in a slow painful suicide. Mental health, long-term health conditions, addiction, trauma, ACEs should be viewed in the same way to enable the promotion of recovery. For example, when addiction services only deal with 'addiction' and mental health services only deal with 'mental health' we end up with fractured services and lost lives but imagine the service that we could provide if we were one united team promoting recovery?
- Community Voice is fundamental in supporting better understanding of where systems have failed people's needs, but more importantly to enable improvement of services and quality of life. The group discussed personal experiences of when their health needs were not met and identified small changes that they believe would have made a huge difference to them and other people who could potentially find themselves facing the same situation. These experiences are detailed below as well as available via a [YouTube video](https://www.youtube.com/watch?v=xjI5xJC7dbl) produced by the Chance 2 Change group: <https://www.youtube.com/watch?v=xjI5xJC7dbl>.
- One of the group members suffered a stroke and struggled to remember their own name or read. Whilst they remain forever grateful to the NHS for the care they received, there was nobody to support them with the significant life changes that affected their mental health. It is ironic that somebody finding it difficult to read is handed a 'stroke book' as a means of information. As much as this book contains useful information, working with the person to understand their individual needs is key to promoting recovery in the 'whole' person.
- Another group member has suffered from incredibly dark thoughts such as wanting to overdose and end her life. When she found the courage to speak to her GP about these thoughts, she felt as if they did not take her seriously because she was not screaming or crying. She was given the impression that

they felt she was “off her head”. Sadly, this made her life feel even less valuable, particularly when supplied with a prescription for a two-month dose of antidepressants. Furthermore, she was provided with a number for the Primary Mental Health team and having had this negative experience took another four weeks to regain the courage to make that call. The group member feels that had the GP listened and made the referral on her behalf that this would have reduced this additional anxiety. Unfortunately, this is not an isolated incident and highlights the experiences of so many people. If somebody is having thoughts of ending their own life, whether they have made a plan to action these thoughts or not, they are clearly demonstrating poor mental health. Immediate intervention is vital to reduce the alarmingly high suicide rate, whilst promoting positive mental health.

- Another member was due to undergo a mastectomy and was invited into hospital to view an explanatory video. On arrival, the nurse stated that she would be leaving the member to watch the video themselves as they found the video too traumatising. Whilst it is clearly good practice to enable people to be informed of the procedure they will be facing this must be done in a way that offers reassurance to the person who is about to face life-changing surgery. Following the operation whilst still in recovery the member regained consciousness to find a nurse injecting her with something and asked what it was. She was told that her body had gone into shock and that she had nearly died during surgery, not to worry and to just go back to sleep. Ever since this has happened, she has tried to find out exactly what took place and nobody has been able to answer her questions. She has even requested her medical notes but has been unable to understand them due to the medical jargon contained within them, which has left her mentally exhausted. Furthermore, whenever the member now has to visit hospital she tries to explain what happened previously but feels she is never taken seriously and that the doctors look at her as if she is crazy. Undoubtedly, the trauma of undergoing a mastectomy would have a negative mental impact but the standard of practice here exacerbated anxiety with a detrimental impact on confidence and self-esteem. The group member expressed that had somebody just communicated what had happened in an honest way that they could better understand what it means for them, enabling them to process the situation.
- Prior to joining the group, another member who suffers from Bi-polar disorder was reliant on a range of medication. Having joined the group this person was able to reduce their medication to one tablet a day and their psychiatrist was impressed with the considerable work they had been able to do on themselves. At the start of lockdown, the member lost the entire support network that kept them well and had begun to become increasingly manic. When seeking help her usual psychiatrist was unavailable and the replacement without reading her notes properly or knowing her as a person prescribed incredibly powerful medication, even though the member was adamant they did not want it. The medication caused the person to feel as if they were “doped up to the eye balls” as well as causing slurred speech and distress. It took considerable determination from the group member, the original psychiatrist reducing her medication as well as support from her

family and peers to enable the person to feel themselves again. This is another example where a member felt unheard and the impact had devastating consequences, which could have been easily avoided. The member strongly believes that their own psychiatrist should have been contacted, their notes should have been read but most importantly, their views should have been considered. Any medical interaction should be a 50:50 partnership with all parties seen as having equal expertise.

- Another group member has struggled with alcoholism for the majority of their adult life. They have been involved with addiction services, which have provided some positive support in terms of help with understanding the health effects of alcohol and the ripple effect this has on family and loved ones. However, addiction services are designed to keep a person within the service so that they are constantly surrounded by their addiction and its consequences, which promotes a negative cycle of relapse and reliance on the service. Having moved away from this type of support and becoming involved in peer-led community groups this member has been able to build a positive support network combined with programmes that build skills and confidence enabling this person to live the life they choose.
- One of the group members has suffered from trauma, anxiety and depression for most of their lives. In 2019, they were attacked in their own home with a knife and a hammer, causing many of their past traumas that they had worked hard to overcome to resurface. This meant that the person's mental health suffered severely and they sought support with their increased anxiety and suicidal thoughts. Their GP was helpful in signposting/referring them to professional support which unfortunately never materialised. Had it not been for her family and the group this member might not be here now! Trauma has a disastrous effect on mental health and when somebody finds the courage to seek help, it should be readily available. As much as the GP was helpful, 10-20 minutes to explain that I want to kill myself and the trauma behind that is nowhere near enough. Furthermore, people who experience trauma are often provided with 6-12 week time frames to receive therapy, which is inadequate, as ample time is required for the person to work through and process their thoughts and feelings before changes in behaviour patterns can be made.
- Some years back one of the group members completed the Health Issues in the Community course (HIIC) and their chosen research topic was suicide and specifically the suicide death rate in Drumchapel. When investigating this subject they were informed that it would not be possible to receive the specific suicide rates for Drumchapel, as it would mean they could potentially identify people. It is hard to understand this as – how can it be possible to identify anyone from a statistic, which makes us wonder whether they are even recorded? Statistics should be there to guide future decision-making and improvements and this can only be done if they are accurately recorded. For instance, Glasgow and Greater Clyde covers a considerable area that has a mix of the poorest and most affluent areas which enables us to understand trends in medical care/provision as well as the health challenges faced by

large geographical areas. Statistics need to capture suicide trends in individual areas such as Drumchapel, rather than large cities or areas as a whole.

- More recently, the group has completed the HIIC course and are questioning why there is such a disparity between poor and affluent areas on a range of health issues. For example, the number of people prescribed medication for anxiety/depression/psychosis is way above the national average in Drumchapel but way below this in Hillhead. This has raised a number of questions amongst the group around how these statistics are recorded. It is known that Propranolol is prescribed for migraines as well as anxiety - is it likely that someone with migraines is being included in the statistics as having anxiety/depression/psychosis? Equally, there are many people that will inform their GP that they are suffering from poor mental health but choose not to accept medication – this should also be recorded to accurately determine the level of poor mental health in a particular area. It is interesting that we can record rates of anxiety/depression/psychosis for specific areas but are unable to ascertain the same level of statistical detail for suicide rates.
- The group were unanimous in describing doctors and healthcare professionals as unkind and uncaring. However, if you explore the reasons why these professionals come across like this it is interesting. For example, GPs are at the frontline of every trauma, mental and physical health condition with no supervision or outlets to express the impact this has on them. Doctors/Health Care professionals like all humans put up barriers as coping mechanisms to deal with difficult situations, which can be perceived as unkind/uncaring.
- It is fair to note that Health Care Professionals use a checklist when assessing Mental Health and suicide but people's feelings do not fit into boxes. A checklist enables professionals to ascertain whether a person is at immediate risk but this unfortunately results in people feeling as if they are unheard and do not matter which can accelerate/impact suicidal thoughts.
- It cannot be emphasised enough that whether a person appears to be at immediate risk or not – they are at risk, which at any given time can accelerate to high risk, requiring immediate support at the point of entry.
- C2C was initially developed to tackle long-term health conditions and we are proud to continually achieve and promote recovery in the person rather than the condition. However, it has come to the groups' attention that 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 (which has now been over twelve 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 masses that will become our future vulnerable.

- The groups thoughts and experiences clearly highlight areas for change, some of their most notable ideas are summarised below:
- 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 others expertise.
- The group would also like Peer support to be taken into consideration, as it is their experience that people build confidence in people far more effectively than medication.

4. Initial Ideas for Participation – Part 2

Digital Inclusion/‘Oor Plans to go Digital’ (implementation scheduled for early 2022).

As a result of the HIIC course (2020), the group expressed a need to be digitally up-to-date and were at the stage of discussing how to make this happen when Covid hit. Understandably, with the current pandemic arranging digital learning has felt impossible and ironically is needed more than ever.

The group have discussed initial training required to undertake this piece of work and have identified the following:

- Intro to tablets
- Intro to the internet
- Online safety
- Using a search engine
- Zoom/Teams
- Advanced training enabling the group to produce and edit videos themselves.

Following initial training, the group would like to use a platform such as Discord where all C2C members participate and this would be managed by a member to enable group empowerment. The reason something like Discord is recommended is that there are no ads or external messages that can exploit members.

The main purpose would be to create and establish positivity, which would be achieved by setting tasks within a time frame (week, 2 weeks, month, etc) that each member would then post to the platform. For example, these tasks could include 'take and post three pictures that make you smile', 'find the most positive quote', 'find the funniest joke', etc. These tasks can be developed further to be specific to the group, such as 'post a photo of your favourite self-defence move', 'what were the funniest lines from the HIIC course', 'post your favourite picture from the photography course', 'post the most interesting theme from the SG work and say why?', etc.

C2C would also set up a range of 'Guest Speaker' forums via zoom. The group could interview the speakers and learn about the way that the world is currently communicating/zooming enabling them to be part of this 'new world'. Lastly, the group would like to video the entire learning process (Action Research) outlined above (good and bad) to iron out the creases, enhance the positives, creating a model for future learning

Medical staff often talk about encouraging people to take accountability for their own health - with knowledge and resources, they can. The group have proposed having a medical professional teach them how to measure weight, take blood pressure, peak flow etc, but, most importantly, the danger levels and when to seek medical advice. It

has recently come to the group's attention that digital appointments with medical staff may become an option where appropriate. The group would like to run mock consultations with GPs/nurses using all the knowledge learned above (videoing the whole process to use as a learning aid). This piece of work will empower people with the knowledge/resources to care for their own needs as well as those of their communities, whilst reducing the pressure on an already overwhelmed NHS.

Peer Support

- The group have been discussing the key ingredients for a successful peer support group and have found this the most challenging theme to answer.
- In my opinion, as facilitator it is a process of development but for the group it is a 'feeling' that they are finding difficult to express.
- Previously the group had the privilege of taking part in workshops conducted by Charlie Sherry of [Inclusive Images](http://www.inclusiveimages.org/), a social enterprise helping Community Voice groups to share their stories via photography (<http://www.inclusiveimages.org/>). C2C used photography as a form of identification and expression. The workshops were hugely successful. Therefore, the plan is to utilise this previous learning and implement a small project where group members take photos that they believe represent C2C. This will form the basis for discussion with the hope being that this enables the group to identify/express their views on successful peer support.

5. Unmet Need

Topics that the group have identified for further discussion:

- Waiting all day for a GP to phone you back.
- Maintaining specialist support with regard to long-term health conditions.
- In regards to Mental Health - prevention vs. intervention.

Unmet Need

Waiting All Day for a GP to Phone You Back.

The original topic that had been identified was waiting for the GP. However, the discussion developed into many areas that the group felt were equally important to document. Group members are in agreement that waiting all day for a call back from the doctor is distressing, some of which could be alleviated with simple things that are outlined through their experiences below:

- One group member shared that they are a full time carer to their dad/step-mum as well as tending to their own mental health and due to these factors do

not often get time to themselves. Normally when the person believes they have a free day, someone they care for might need a telephone call with the GP. This means the person with poor mental health that has been up all night has to be awake and alert to call the doctor at 8.45am (some surgeries this is 8am). This is exacerbated by having to sit with the person they are supporting the whole time because they are anxious about speaking to the doctor on their own as well as missing the call. The free day is ruined by a magnitude of stress that the person believes could be avoided. For instance, if there was a system in place where you could go online the night before and book a telephone consultation for the next day or even that week with a specific time slot added, this would relieve stress for everyone involved.

- Another group member said they are very distressed the whole day, so frightened to miss the call they won't even go to the toilet. The question they ask is that if you are given a specific time to see the doctor why can't there also be a specific time provided for the telephone consultation? The person also stated that even being given a two hour time slot would be better than waiting the whole day full of anxiety.
- One of the group members was honest in saying waiting on the GP to call them back stresses them out so badly that they need their daughter to sit with them the whole day. They get that worked up they become confused and panicked. They also shared "calling at 8am is very difficult when you haven't slept to then be kept on hold for 20 minutes only to be told all the appointments are gone. Sometimes the receptionist will ask if it's urgent, "what is urgent"?"
- A group member echoed the points above adding "you wait all day, you can't go out because you need privacy when speaking with the doctor especially when it's a sensitive issue". Another group member stated "it's terrible because if I turn up 5 minutes late for an appointment, I have to wait 45 minutes to an hour, yet I usually have to sit in for 7 hours waiting on a call back from the doctor. All group members are in agreement that the provision of a time slot would be more beneficial.
- One individual would like to express the challenges around having bloods taken for themselves and people they support. Presently you need to call your surgery to verify you have to have bloods taken, you are then provided with your CHI number as well as a phone number to call to arrange an appointment with phlebotomy. This appointment could be arranged for anywhere in the city which is believed to speed up waiting times but how about the people this person supports that struggle to even get to their own surgery. Another member echoed the same story but said they went through the whole process getting the CHI number from their own surgery to call an additional phone number, to be sent for bloods at their own surgery - which in their words "was a complete waste of time". This is an example of the confusion that can be caused when systems are changed without

informing/consulting with the individuals that use them every day, as highlighted by the concerns of the group in relation to the recommendation of the '**Expert Medical Generalist**' role.

- A member would also like to add that the pre-recorded message which you now get when you call the surgery with three options just causes confusion and extra anxiety. The person said: "I called the surgery as directed to make arrangements for my bloods to be done expecting to speak to a person but instead was given three options which did not match what I was phoning for. In an absolute panic I hung up the phone and thought about not having the bloods done at all". The person shared that if there was a fourth option on the pre-recorded message for "everything else" they would have pressed that option which they believe would have reduced the overwhelming stress and panic.
- One member would like to document the ongoing issue that has plagued them for many years. "I suffered from a prolapse which needed something professionally inserting, which I was told would hold everything up. I was aware this piece of plastic was due to come out and called the hospital because I was concerned and experiencing a range of symptoms from pain to smelly liquid. At the appointment to have it removed I was told it should have been removed six months earlier! I was also given a new plastic piece which looked like a big dummy and told to insert it myself. I was so frightened with not a clue on how to insert this contraption! Two years have now passed and I am still dealing with the same problem, I just wish someone would listen to me and try to understand the difficulty of dealing with such a sensitive problem on my own".
- One person shared that they called their doctor to speak about their Hormone Replacement Therapy (HRT) and the GP expressed their concern as they had not had any communication or correspondence with their psychiatrist in nine months. In the group members words " I only had to see my psychiatrist once a year because my Bi-polar was stable, I was well but last March due to lockdown I started to become manic" (as documented above). "The psychiatrist called six months ago and told me there wasn't very much they could do at the moment that they would get me in when Covid was over! Which is when?" It is deeply worrying in this case like many others that health professionals do not communicate more which could literally be the difference between life and death. This evidences the need for the recommendation to **support primary health care professionals to work more together** (below). As Support Worker for C2C I find it deeply distressing that mental health needs have to wait for Covid to be over. It is highlighted in section 4 that this person has been struggling with impaired hearing which is having a considerable impact on communication, isolating them from their family/peers, and increasing the risk of fracturing an already fragile mental health. As of November 2021 this person has been waiting 12 months for a hearing consultation and as stated on this lack of support/assistance reinforces an "I don't matter" mentality resulting in people who are less likely to ask for help or

engage with support. The person and the group are in agreement that they are sick of Covid excuses. Hearing is one of our primary senses and it must be exceptionally frightening as well as frustrating to lose. Can you imagine being manic or having auditory/visual hallucinations and not being able to grasp or hear reality?

- A group member shared that since 2019 they have had ongoing problems with their foot without any definitive answers. After an x-ray, they received a call from the GP receptionist who disclosed it wasn't much to worry about just looked like arthritis and then booked an appointment with the doctor who told them it's nothing just wear and tear which they feel is simply not good enough as it does not help them live with the problem! They asked to see their x-ray but were told no and would like to understand why? They were also offered a referral to the foot specialist to be fitted for surgical socks but were told it could be a considerable wait. Feeling the constant pain and knowing how long their friend has waited to receive a hearing consultation forced them to buy the surgical socks themselves at considerable expense as they had to have them imported from a clinic in America.
- The same group member would also like to share an experience where they recently called to speak to a specific doctor to be advised this doctor does not work Mondays and to call back on Thursday. They called back on Thursday and were informed that the requested doctor would call them back but he didn't - "I got some doctor I didn't know meaning I felt annoyed and no further forward. I can't repeat enough See me, Listen, Be honest, Help me understand and remember I'm an expert in your professional hands."

Maintaining Specialist Support with Regard to Long-Term Health Conditions

I suffer from a rare and extremely painful long term health condition called Hidradenitis Suppurativa (HS) which means my brain sends signals to my body advising of an infection. This will force my body to completely shut off that area resulting in painful abscesses ranging in size from a small pea to a football which will eventually erupt leaving huge scars all over my body. Unfortunately there is no known cause or cure for HS and most GPs/professionals have never heard of the condition which in the past has led to torturous mistakes. HS can flare at any time, requiring drug combinations that can only be prescribed by a hospital/specialist. I currently have a great doctor who was honest in explaining that they know very little of this condition and would be taking the lead from myself and dermatology as we are the experts. Thankfully for the last year my condition has been under control and the dermatologist is very impressed but because all appears well I can no longer remain a patient at the dermatology clinic! I totally understand at present I do not need that specialist support but given the nature of my condition that can change rapidly. I asked the dermatologist if there was some kind of system for people like me because I was worried about my condition flaring and not having specialist support. I was informed that there is no such system and the best she could do was retain me as an out-patient for the next six months but if nothing happens in that

time - "You'll be signed off my books because I have a waiting list as long as my arm!" I asked what I should do after those six months and was told to see my doctor and make a new referral! Why should I have to bother my doctor who now needs to make another referral because I require a specialist? How long will I wait to be seen as a new referral? How many unnecessary painkillers and drugs will my doctor have to prescribe while waiting on this appointment? More importantly how do you retain specialist help in regards to a long term health condition?

This is just one example of being unable to retain support in terms of long-term health conditions. Sadly, this is not an isolated case (as documented in the Chance 2 Change group experiences, section 4) and there are many examples of peoples' long-term health needs not being met (especially recovery/mental health) leaving people to suffer needlessly whilst unnecessarily increasing administrative pressure on the NHS and overwhelming already underfunded GP practices.

Mental Health/Suicide: Prevention vs. Intervention

According to the Samaritans website, "there were 805 deaths by probable suicide registered in 2020, a decrease from 833 in 2019.¹ Data from 2020 shows that people living in Scotland's most deprived communities remain three times more likely to die by suicide compared to those living in the most affluent communities."

These statistics and geographical gaps are absolutely shocking but what is even more disturbing is the powers that be knowing these facts, doing nothing about it and people are dying unnecessarily.

In 2016, I completed the Health Issues in the Community (HIIC) course and along with two other people chose the topic of suicide to research as part of the final assignment. The data available at that time showed 659 suicides in Scotland in 2014 and 656 in 2015. The Samaritans state there has been a decrease in recorded suicide rates since 2019 which is true but considerable concerns remain over the lack of investigation into the overall increase since the data supplied in 2015. It is disgusting that our government along with the British Medical Association have not done more to prevent the many needlessly lost lives. The research conducted in 2016 highlights the concerns as well as positive tangible ideas to promote suicide safer communities, as described below, but no one listened resulting in more lives/families/communities continuing to be destroyed by suicide.

The HIIC research highlighted a lack of information, posters or helplines at suicide hotspots. How difficult would it be to run off a poster with lifesaving information and have a helpline supporting it? Another problem is where to go if you feel suicidal:

¹ Source: Samaritans website: <https://www.samaritans.org/scotland/news/samaritans-scotland-welcome-decrease-in-deaths-by-suicide-but-calls-for-sustained-action/>

- One nurse stated “not the doctor.....”
- Another nurse stated “there is a waiting list for primary health services and that you should always speak to your doctor to gain access to secondary health services.”
- A range of services were contacted and asked “if they would help me if I wanted to kill myself” to be informed “No” – for various shocking reasons. We concluded that there is nowhere that you can go or call and just say “I want to kill myself”.

Some places made us feel terrible for just asking the question, enhancing the thought- “if I really was suicidal and being treated like I was doing something wrong – I would probably kill myself”.

Clear information/communication across the board is key to eradicating confusion about where to go, what numbers to phone, etc. We all have to work together as previously documented (section), **Mental Health, Long-Term Health Conditions and Community Voice**. A united team, promoting recovery incorporating prevention strategies would reduce the number of deaths by suicide not just here in our local communities but for Scotland as a whole. A good starting point following the 2016 research would be to print information posters with helplines and display them everywhere in the community. Training in Mental Health First Aid and ASIST should be provided to employees/people at suicide hotspots. For example while collating the research we spoke to a local professional at a known suicide hotspot, who shared that they are provided with a list of vulnerable people to watch out for with no training or support and instructed that if they have any concerns to call the police who are overwhelmed and entirely the wrong service. Sadly at the time of writing, another beautiful soul has been lost and a family destroyed due to a preventable suicide at a well-known hotspot. Another considerable concern is places such as DIY stores being a suicide paradise and once again their staff having no training on how to identify the warning signs or more importantly how to save life. Under Health and Safety legislation, every work environment is required to have first aiders - this should be extended to include mental health first aiders.

The most ambitious idea would be to build local walk-in hope cafes/well-being hubs. This would provide a safe space where a person can just say they don't feel right and all the relevant professionals and resources are on hand at the point of crisis – no more waiting lists, no more gaps – life with hope! After the research was relayed to our community we had the opportunity to present our findings/ideas to a senior manager at the NHS who just laughed at us and stated “you don't get money for hope!” Maybe if the Scottish Government and all medical associations invested in hope we wouldn't be left with so many unnecessary deaths on our hands.

With regards to prevention vs intervention (responding instead of reacting) - we should promote positive mental health and not wait until crisis, teach people practical coping skills that will enable self-prevention, reducing the need for intervention.

The Voices of C2C in Response to Mental Health/Suicide Prevention

During an extreme bi-polar episode I spent time in a hospital, whilst there my hay fever was playing up really bad and I asked for one of my pills which is on repeat prescription. As I am seen as mental I am told I don't need a hay fever tablet. I nearly let those so called professionals take my power but then decided that I know me and I know what I need, and called my own GP who appeared at the hospital with the tablet. My GP not only helped my hay fever but also my mental state just by seeing me as a person.

I would rather know how to take care of my mental health than waiting until I'm suicidal because then it's too late.

Children as young as 10 years are learning on the internet how to kill themselves, videos are being put into kids games for example Santa telling children to stab themselves or their parents to get more Christmas presents - is anyone monitoring this?

Doctors ask "what do you want me to do?" - "I don't know, I am here because I don't feel right."

Prevention stands a better chance of saving lives than intervention.

Prevention Vs. Intervention

Kindness empathy and compassion are essential - I was in hospital because I tried to take my own life and the doctor told me the next time I do it - to do it right!

Medication has its place but it won't fix me, talking therapies can help but I need purpose/connection which cannot be attained through medication alone. Well-being groups provide focus, build confidence/self-esteem.

Suicide gaps are getting bigger but no one cares.

Nurseries should be teaching kindness, relaxation techniques, exercise which primary schools can build on and develop along with other practices such as the bullying/apple demonstration, 'blue eyes - brown eyes' experiment, etc. High schools could further expand by teaching mental health first aid/suicide prevention but most importantly educating young people on how to look after their own mental health as well as those they care about. Prevention before crisis.

No time on how long it takes to get well - it takes as long as it takes.

Peer Support – A View Through the Lens



“Every Monday when I come I feel so happy, I really enjoy my Chance 2 Change group and I enjoy seeing my friends that all go with me. We do so many things such as out walking, photography, keep fit, diamond painting, self-defence and so much more. In the future we are going to be learning how to use tablets and lots more interesting things.”



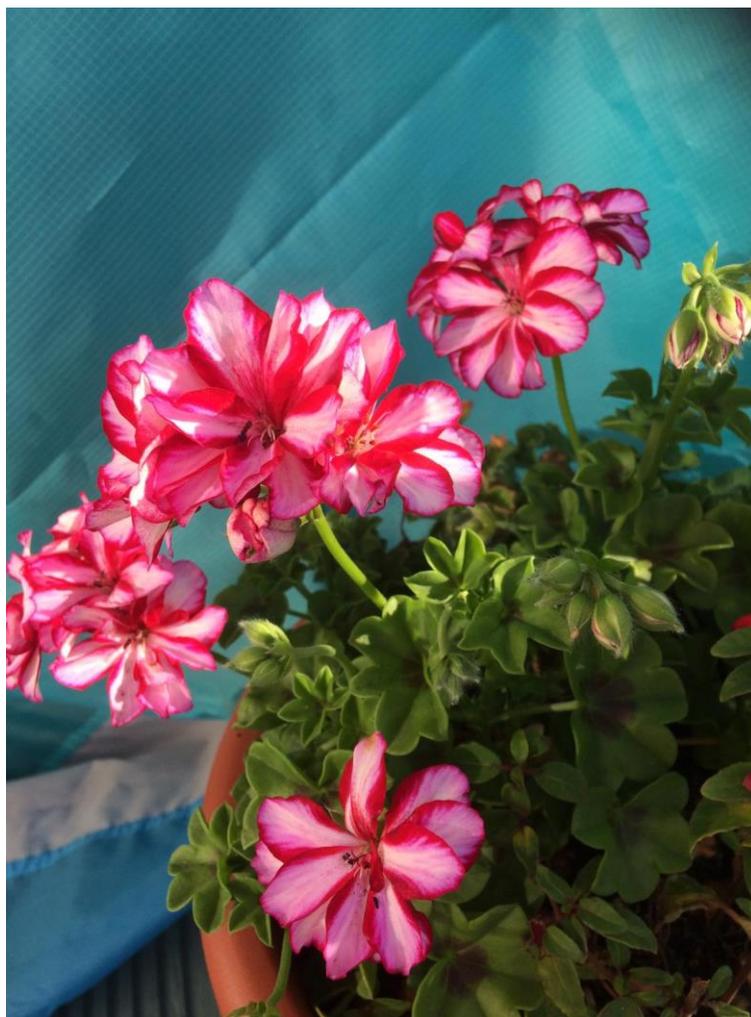
“The support worker has been so good for me and if it hadn’t been for them and the group I wouldn’t be in such a good frame of mind. My life is so much better since I have been involved in Chance 2 Change. I have been so happy with all that I do and take part in with the group.”



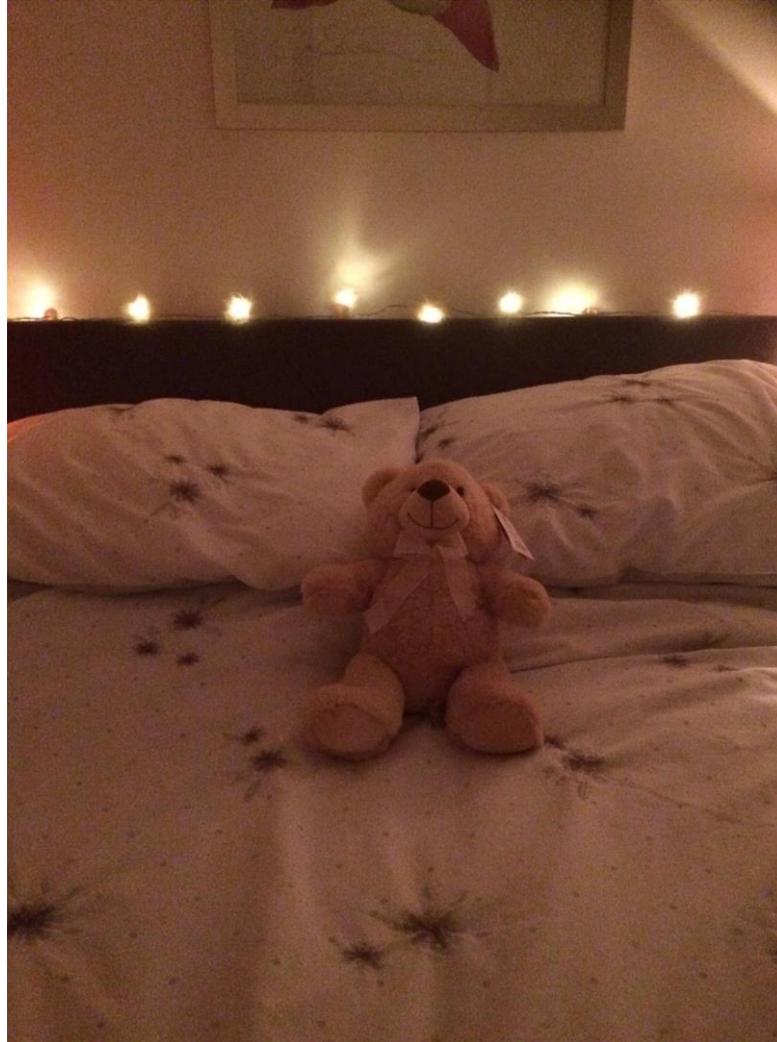
“Having fun at the outdoor gym.”



“Chance 2 Change – masked friends forever.”



“Being in Chance 2 Change has taught me new skills like photography.”



"Chance 2 Change gets me out of my bed."



“The group is like a family to me as from the first day I joined they welcomed me as part of the group. As a group nobody judges anyone and when you’re having a bad day, the group are there to listen and they make you feel better by having a laugh and a joke.”



Climbing the Humphrey - "Chance 2 Change has been challenging, as the group has helped me to challenge myself and to do things I never thought I would do."



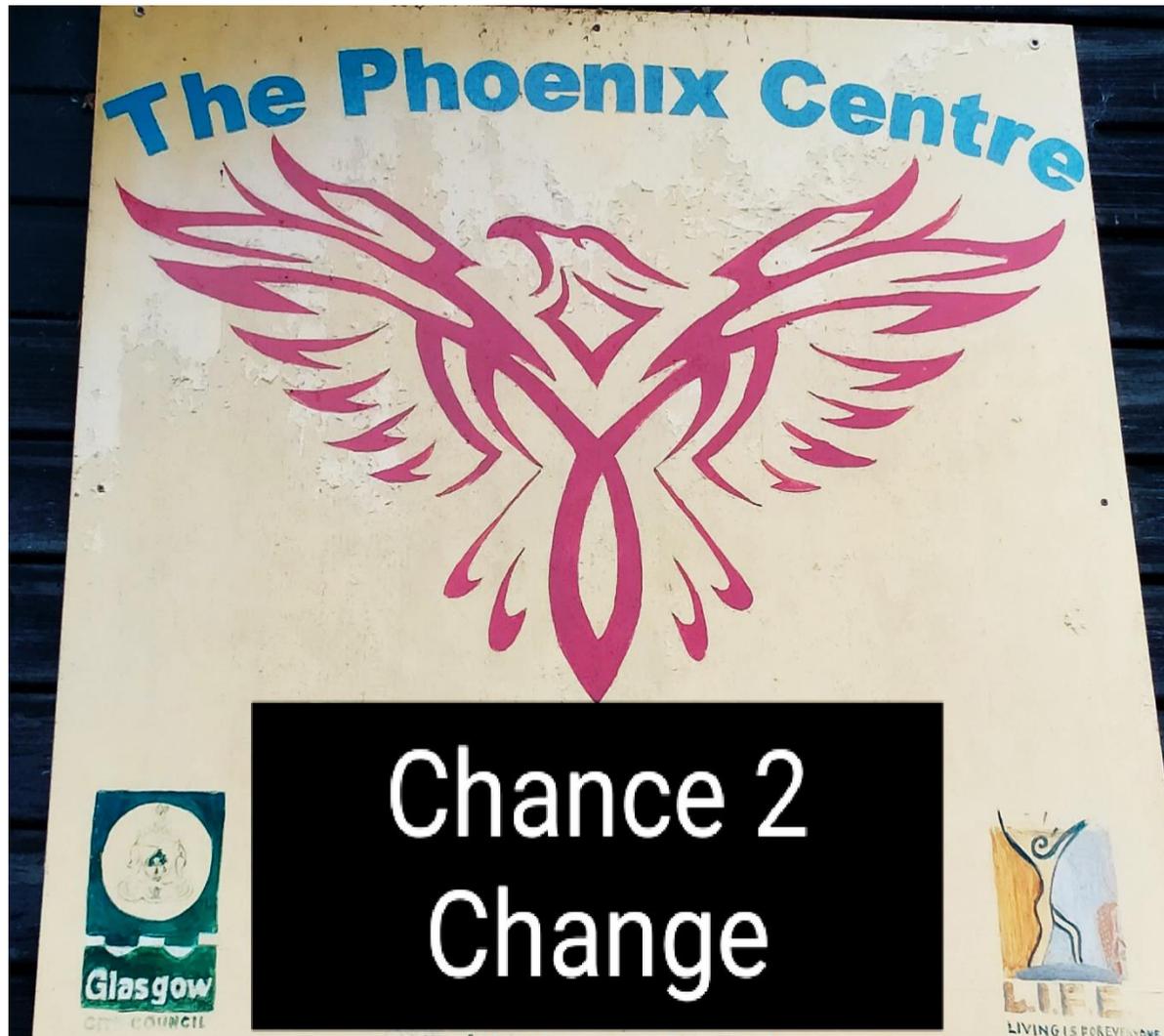
“Chance 2 Change is my safe place where I feel safe and I can share my problems - I know what we share in the group stays in the group.”



“Chance 2 Change gives me the confidence to believe in myself.”



“Chance 2 Change for me is like a family - when I come in feeling down they lift me up by just talking and laughing within the group.”



“Chance 2 Change’s family home - the staff are amazing, part of our extended family. The place is equally as important as the people.”



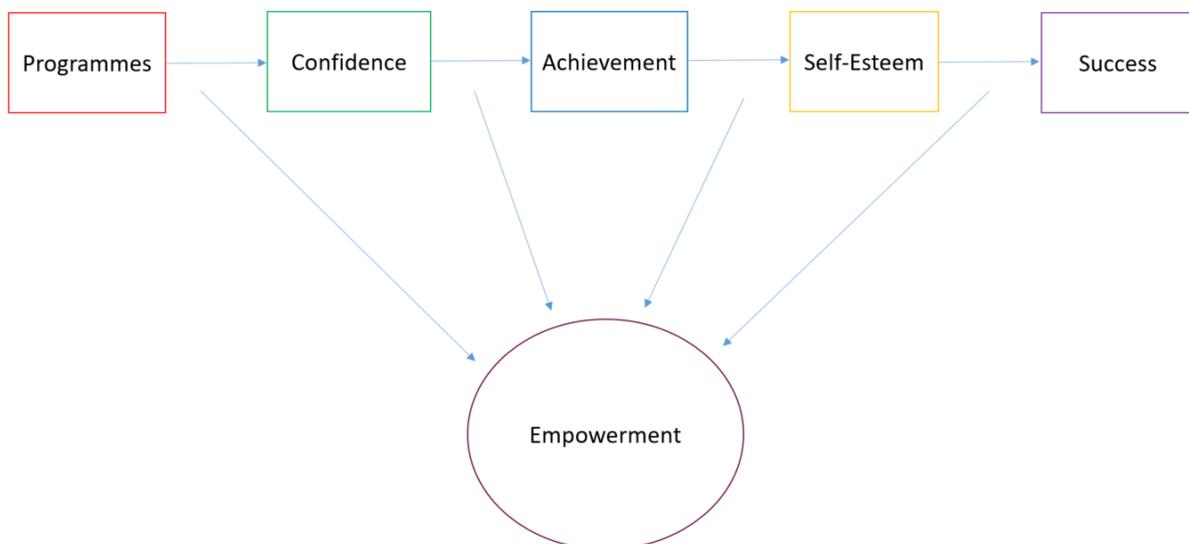
Facilitator's Summary

Group members decided collectively that they should be known as Chance 2 Change which couldn't be more appropriate given that group is a safe environment where confidence is developed enabling people to make the changes they desire. The environment needs to be right to create a safe place where people can grow. As one member states above "the place is equally as important as the people!"

All groups should start with a code of conduct; C2C call it "Dae As Yer Telt" (appendix 1) it has to be built by the group so that they will enforce it, creating empowerment and responsibility from day one. Group structure provides motivation and discipline in terms of time management, completing tasks/homework, etc. The group decide the programme which generates choice and decision making but most importantly creates empowerment. All new skills/hobbies/learning achieved unconsciously builds confidence, raises self-esteem, promoting focus and purpose which generates positive coping mechanisms. It is not just about a few hours per week but about building self-esteem/the right frame of mind to cope with life. The groups' greatest motivation is each other, supporting/lifting one another up when times are hard to screaming with delight at individual/group achievements. Programmes should be achievable but equally challenging to build confidence and

self-esteem - all achievements no matter how small are significant and should be celebrated. One small step forward is success and should be measured as such.

Chance 2 Change isn't a talk shop where people sit and discuss negatives but a social network with a choice of programmes/activities that are designed to develop skills, build confidence/self-esteem whilst teaching discipline, problem solving, overcoming challenges in a positive way that can be adapted into any part of that person's life. Activity evaluations (appendix 2) are completed at the end of every session to monitor how well things are working and inform change where required, as well as quarterly group evaluations (appendix 3) empowering people to have their say in the decisions and programmes that affect them. A collective togetherness is developed through the group which creates a significant change in perception such as "I am not alone." Sometimes knowing there are other people who feel the same as you can provide comfort and reassurance which is why we feel peer support is just as vital as professional intervention - people identify with lived experience. Social connections are vitally important particularly in light of Covid-19 restrictions - it was these links that kept the group motivated and individuals well.

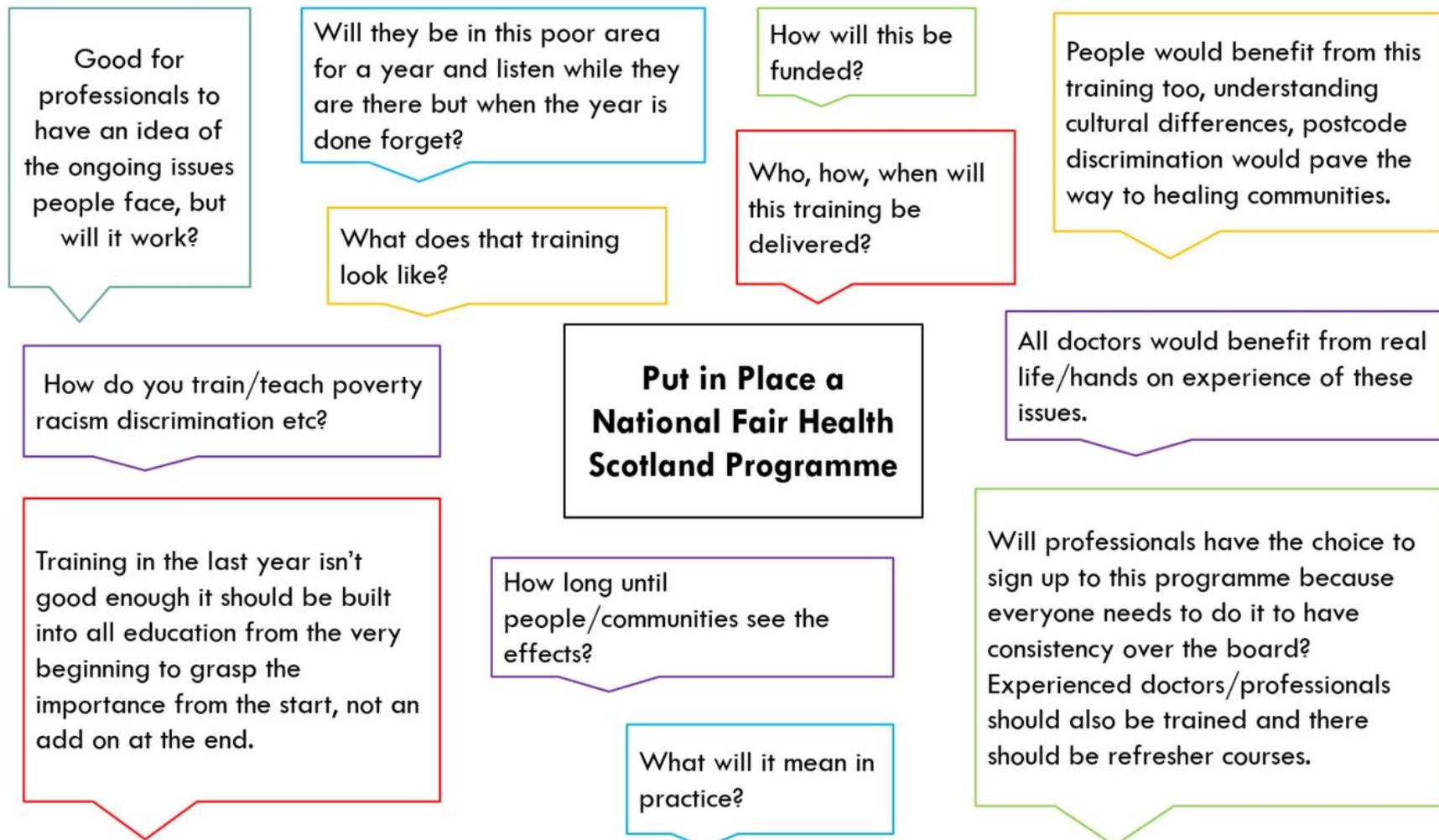


6. The Voices of C2C in Response to SLWG Recommendations

The C2C group discussed the draft recommendations from the SLWG and provided their individual and shared views on these. All of the recommendations can be found at Appendix 4 of this report.

The group unanimously feel that all the recommendations are full of jargon that they now aptly refer to as 'jaggy words'. They believe this type of language creates a divide between people and professionals, creating inequalities. To understand communities you have to speak the language, you wouldn't go to Switzerland and change their systems without first learning the language and consulting with the people - so why would you think this approach will produce a positive outcome in our communities?

C2C Responses to Empowering and Developing the Primary Care Workforce



C2C Responses to Empowering and Developing the Primary Care Workforce

Who will decide who needs it more than others?

How long until people/communities see the effects?

What are these additional enhanced services? What will they look like and how will they support me and my family?

Enhanced Service for Health Inequalities

How will this be funded?

The support of the Community Links Worker and Chance 2 Change are great additional services that I have accessed through my doctor that have really helped me.

Good idea if it works and the additional services are relevant.

C2C Responses to Empowering and Developing the Primary Care Workforce

Creating a joined up care plan for people with complex needs is a great idea but how do you define a complex need and how do you provide that same care to everyone with a complex need?

When people work together, we lose fewer lives to the gaps.

If done properly it would mean I don't need to keep repeating myself over and over to different professionals!

Joined up care is a good idea but it would need more professionals, where are they coming from and who is going to pay for this?

**Support Primary
Health Care
Professionals to Work
Together**

How do you bring everyone together?

I am supporting vulnerable people and know that unpaid carers are not treated fairly.

What does the training look like?

It would be easier to achieve this recommendation if every individual had their own named person/professional within each service/team where it is part of their job to regularly update all other professionals involved.

C2C Responses to Empowering and Developing the Primary Care Workforce

How do you bring everyone together but more importantly teach people that sharing resources is key for individuals to have choice in how they stay well, creating empowerment.

Create a National Priority to Reduce Harm

It should be built into GP contracts - but more importantly what does a GP contract actually look like and why have we never heard of them?

I'm shocked to hear that this is not already a priority!

More money should be invested in trauma and ACES to reduce addiction as well as long term health conditions that result in physical health conditions leading to disability.

C2C Responses to Empowering and Developing the Primary Care Workforce

Create a National Priority to Reduce Harm - Continued

I believed that as long as I felt fine there could be nothing wrong with me, so who needs a smear test? Luckily for me my very scary loving mum thought differently and forced me to have this unpleasant test. Unbeknown to my mother, the results showed that at 22 years old I had pre-cancerous cells requiring laser treatment but I felt well/thought I knew everything and believed there was no need for treatment. I don't like hospitals there was no way I was going to Colposcopy for laser treatment. I binned the letter, stating to call and confirm attending the appointment - I did not! Oddly the day before my appointment a nurse called to ask why I had not confirmed my attendance. I told her, I don't like hospitals and that there was nothing wrong with me. She calmly explained the severity of my situation and informed me sincerely that if I did not have this procedure I could be dead in the coming years! I know this nurse went above and beyond the call of duty to speak to me and this is not normal procedure but it should be. I am eternally grateful to the nurse that saved my life. If all professionals cared and worked to these standards – how many more lives could be saved?

C2C Responses to Empowering and Developing the Primary Care Workforce

I don't like it but think it is the way the world now works. I have real concerns for my wee elderly uncle who can't cope with the internet or anything online, he finds it difficult to make calls. I would like professionals to be aware and understanding of people who will struggle.

Good idea especially if we ever go into another lockdown, it would mean professionals could still provide a service.

The next step for C2C is to be digitally up-to-date (p.13-14), we are hoping this project will highlight the barriers people face resulting in a good future learning model for professionals and individuals alike.

Invest in the Training for Digital Inclusion

Training and resources for professionals is great but if individuals don't have or can't afford the technology, what is the point?

Who will pay for the training and technology needed for all, not just professionals?

Consideration needs to be given to people who have experienced trauma/ACES as well as those who have had bad online experiences or have had to give evidence via video link. There will be certain aspects of digital inclusion that will re-traumatise some individuals which professionals could mistake as a reluctance to engage.

C2C Responses to Empowering and Developing the Primary Care Workforce
Of all the recommendations this is the one that concerned us the most!

More should be done to retain good GPs within communities because it is the only barrier stopping our hospitals from collapse.

One of our recommendations is: Listen – my opinion matters! However nobody has asked how we feel about this new way of working - which is worried, concerned, anxious and incredibly frightened.

People still want to have the reassurance that seeing a GP brings. Would one way of ensuring GPs have more time to devote to patients with complex health issues be to create a Health Centre Hub? This could be comprised of health experts such as the Community Links Worker, Welfare Officer, Mental Health specialist, Yoga Teacher, etc. and staffed by all GPs on a rotational basis to maintain consistency for people used to seeing their own Doctor? For example, if there are 5 GPs in a practice, 4 would be doing the Expert Generalist role and the other would rotate and continue the trusted practice that people already know and understand.

People will stop using healthcare altogether because we won't know what we are doing.

Expert Medical Generalist Role

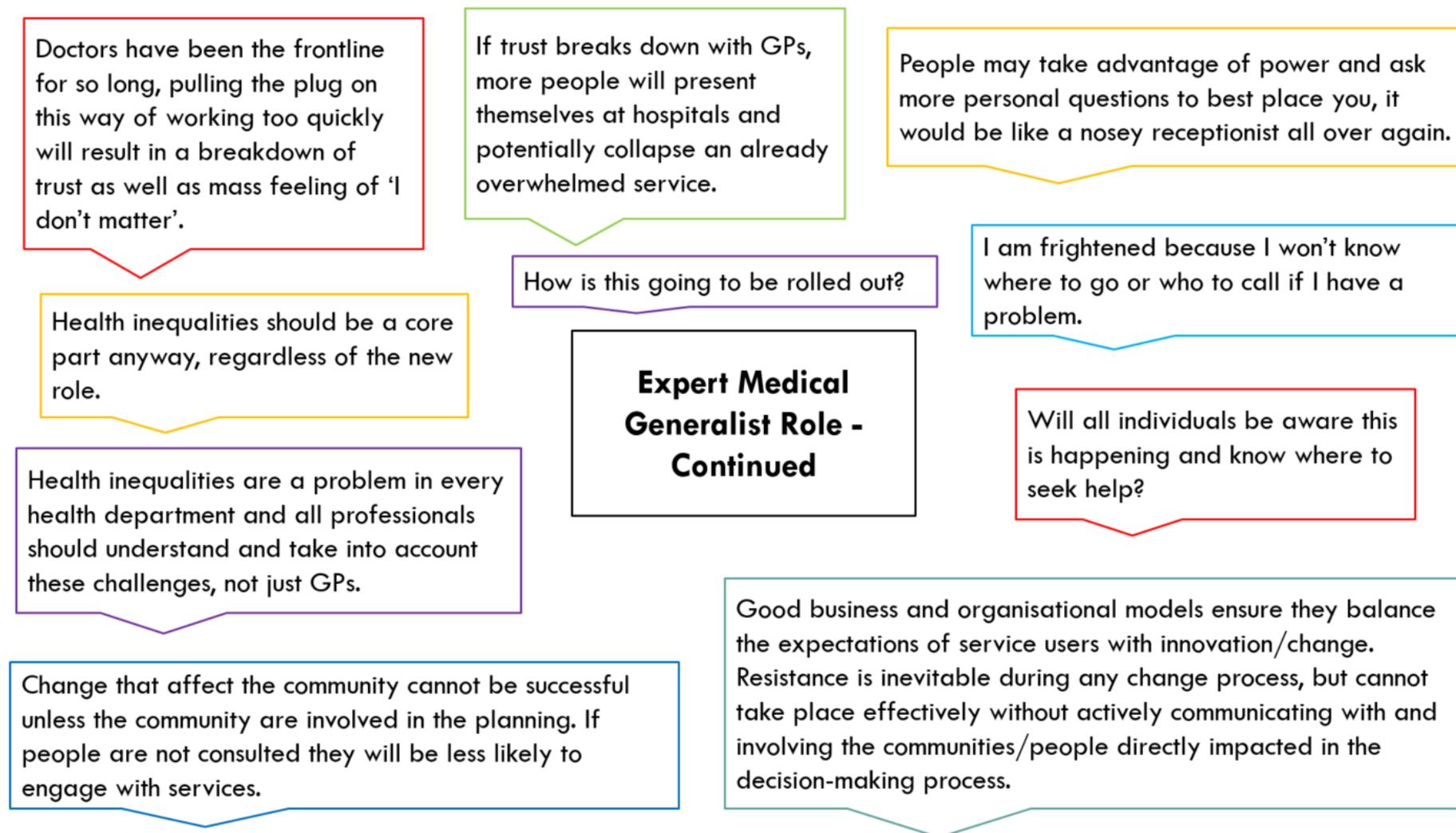
If communities/individuals are not part of or consulted about this change, they will be more reluctant to engage in life saving services which totally defeats the purpose.

Who decides if you need the doctor, how do I know when to see the doctor?

Who will see me if not the doctor?

Who do you call if not the doctor?

C2C Responses to Empowering and Developing the Primary Care Workforce



C2C Responses to Leadership, Structures and Systems

Children with breathing difficulties can be traced back to damp houses that breed illness and disease. These houses are rotten and adding to the many health problems that are killing people as well as needlessly stretching the NHS. Will the Commissioner have the remit to address this?

I don't know what I think!

The Commissioner needs to be someone who has lived experience of inequalities with understanding of the issues and the barriers people face.

Will the Commissioner only deal with inequalities in health or will they be able to assist with all inequalities that can contribute to poor health, such as inequality in Higher Education where Universities receive higher fees for international students and focus their recruitment in this area rather than support for home students, especially those from deprived backgrounds.

Health Inequalities are a problem for all departments where the buck constantly passes, hopefully the new Commissioner would be able to stop this and relevant action taken to provide equity.

The rubbish is everywhere causing more rats which is creating more disease. Will the Commissioner have the authority to address this?

Strengthen National Leadership

I don't think it will work because these people never work, they always blame someone/something else and that's where it all falls down.

Life and Healthy life expectancy gaps are continually widening and there needs to be someone to hold people to account.

The Commissioner should understand situations at all levels, maybe they would benefit from or be part of the new training being developed for the **Fellowship Programme**.

It is not the first time this idea has been thought of, why has it never been actioned?

Great if it works but I think the role is too big for one person.

C2C Responses to Leadership, Structures and Systems

The majority of the group have never heard of a Community Links Worker, therefore have no idea what their role is, how it would benefit them or how to access that support! Money and time need to be allocated to advertising these great services because they are no use if nobody knows they are there. Poor promotion of a service could be viewed as poor engagement.

Great idea - should have this support in all surgeries.

How do you refer? If you self-refer do I have to call, fill in a form or can I choose the format that suits? Do I have to wait for the Doctor to offer this service/support?

Mental health is one of the oldest departments in the National Health Service and it's never worked!

Ensure Social and Financial Inclusion

Mental health has always been the weakest service provided by the NHS, sadly since the pandemic this has further deteriorated. Poor services, systems that don't work and long waiting times are adding to the many lives lost.

Services that offer timed support such as six weeks or months is no good, mental health can be long term - I believe I should have the time and support I need to get well.

Current financial support services are awful at filling in benefit forms, they don't understand illness/medical terms or most importantly the impact it has on me. This new Financial Officer will have access to my medical records with a basic understanding of my condition enabling a more detailed report which could relieve some of the stress that comes with these situations.

C2C Responses to Leadership, Structures and Systems

Why are paramedics/police the first port of call to a situation of poor mental health? Mental health is an emergency but we are relying on the wrong emergency service, completely overwhelming that service when there should be specialist emergency mental health provision with community bases.

Mental health workers in or connected to my surgery are a great 9-5 idea but mental health is 24/7. Can you provide that same joined up consistent service 24/7?

It is people who don't care or understand that work in mental health.

Services thrive when the people who need them, build them - listen to the experts.

The nurse referred me to the Community Links Worker who supported me with many aspects of my life but most importantly they helped me to not feel alone.

Ensure Social and Financial Inclusion - Continued

I'm caught in the in-work poverty gap which obviously affects my finances, impacting every aspect of my life from where I live, what I can afford to eat, what bills can be paid to my mental and physical health. All I need is a regular basic pay to lift me out of this poverty trap but instead I receive irregular ad hoc funding that messes with my benefits keeping me in a cycle of constantly feeling worthless and trapped.

I have seen first-hand, the benefits of the Community Links worker, I can also see the benefit of the Welfare Advisor. I have to be honest in saying that mental health support is still the weakest service provided by the NHS - "I have very limited knowledge of services that I can signpost to. These services either do not work or have such long waiting times that suicide rates are further impacted."

C2C Responses to Leadership, Structures and Systems



C2C Responses to Leadership, Structures and Systems

Will these new contracts come with resources to support people/professionals in vulnerable communities?

What do they look like, why haven't we seen or heard of these contracts before?

In the previous contract were objectives achieved because if not, how will the Government ensure that they are in these new contracts?

Why has nobody ever heard of these contracts?

Contracts/Health Inequalities

Why do health inequalities have to be written in? Should they not already be part of the contracts?

For individuals/communities to have confidence and trust in these new contracts (especially the **expert medical generalist role**, p.42-43) they need to be written in partnership with the people. When systems change with no consultation/warning all that is created is fear and panic resulting in disengagement.

My understanding is this new contract will help guide GP's to transition to the new **expert medical role** (p.42-43), how? What will this look like in practice?

People should be given the care that best supports them, at the time they need it. It should not have to be written into a new contract, it should just be!

C2C Responses to Leadership, Structures and Systems

The Primary Care Improvement plan has a legal duty to stop public bodies making decisions without communities but it is clear to see from the new phlebotomy service, the “**Expert Medical Generalist Role**” (p.42-43) and the way funding is allocated that communities are not part of the decision making process.

The new phlebotomy system doesn't work because you did not ask the people how it could best work for them. The new system as documented in 'Unmet Need' (p.15-16), has created unnecessary stress and more inequalities such as transport/costs to get to the other side of the city. In your words, this is one of those “unintended consequences or risks which a new funding model can cause?” Poor monitoring of the new system and not dealing with the issues that arise continues to put people/lives at risk.

Funding

Routine is really important when you suffer from anxiety/depression, when you change systems without communicating with people it doesn't work - waste of money.

People should have a say in the way funding is allocated, for example it is known that GP practices get more money for elderly patients. In deprived areas people don't have the luxury to grow old, ironically this means there are less doctors/health professionals in the areas that need them the most. In areas with high drug deprivation you can see a person aged 40 who has the body of an 80 year old but there is no available resource to treat the person who will never see old age. The way funding is applied is discriminative adding to the many health inequalities and preventable deaths.

Are inequalities considered when funding is allocated?

C2C Responses to Leadership, Structures and Systems

Circling the car park at surgeries/hospitals for hours trying to get a space is extremely stressful and not environmentally friendly.

Poverty is a disease and providing transport to health appointments could slow the spread whilst saving lives.

What do you mean about environmentally friendly as most public transport, mini-buses and ambulances are not environmentally friendly?

I am worried that the money to provide transport which sounds great in theory will end up coming from the appointed health service, such as the stroke unit or physiotherapy clinic. This results in a watered down support which goes against the aim.

Transport and Health

Should also be open to the people who support others, for example unpaid carers equally struggle to find the money to support their loved ones to appointments.

In terms of mental health it would be good to have transport to appointments especially in the early days of treatment as I believe this would alleviate some of the stress.

C2C Responses to Leadership, Structures and Systems

GP's and their patients would benefit from being aware of what support is available in local communities.

The way that funding is currently allocated goes against the objective of partnerships/joined up care, see 'Picking on the Wee Man' (p.6-7).

How do you provide this care/wellbeing to rural Scotland?

There needs to be a clear communication strategy put in place so professionals can directly feed into decision making processes because front-line staff are getting the blame for poor services, leading to people dying in hospital corridors as a result of the government's lack of investment.

Invest in Wellbeing Communities

Good for all professionals to know what is happening around them - Community Links workers are leading the way in terms of building relationships with communities.

Peer support without labels should be available for all aspects of life, whether you manage diabetes or bi-polar. There should be wellbeing groups in every community promoting recovery in the person not the condition.

C2C Responses to Leadership, Structures and Systems

The digital project that C2C are undertaking next year has been difficult to get started due to funding in terms of tablets and tutors. Hopefully the project will serve as an educational model highlighting the barriers as well as the positives of digital learning.

How do you plan to reach the people who don't have access to technology?

Libraries used to play a huge role in supporting people to access technology but due to funding cuts and closures, services are very limited.

Access to Digital Technology

Digital access could improve service and stress levels - for example, people could have the choice to book a telephone consultation the night before (p.15).

Digital access can improve health in terms of being able to see/talk to your health professional remotely such as a lock-down or in rural settings. As always if you can't afford the technology or bus fare to access these services we could create further health inequalities.

C2C Responses to Empower and Enable People and Communities

People should be involved in the policy making from the start, to enable clearer understanding of what is working and what is not but most importantly to balance expectations.

The way that the Scottish Government are working with C2C should be the norm not the exception.

It is imperative that communities are part of the decisions that affect them because when they are not, they become disengaged creating further issues in regard to unmet need and inequalities.

Develop a Network of Expert Groups

Please do not ask for my opinion or the communities if you are not going to take action? Lived experience matters but we need to see change - lip service is not consulting or listening to the people.

When planning new systems and services, scope needs to be in place for change when things go wrong.

Not consulting with people who have lived experience is like a trauma councillor with no experience of trauma saying they know how you feel when they don't.

Bevan would be turning in his grave at the way services are operating as he wanted a joined up service in communities.

C2C Responses to Empower and Enable People and Communities

To bring change we all have to work together, how often do doctors, professionals or the government actually listen to the people or each other?

I can't even demand my preferred doctor or an allocated time for a telephone consultation but I have to demand change, how?

Suicide is something we are all embarrassed and don't want to know about. Relevant statistics would bring the problem to the forefront, forcing change.

Statistics can say what the powers at be want them to say.

There will always be people who don't like change. This can be balanced by clear, honest communication and relevant information.

Provide Communities with Data and Knowledge

How will knowing statistics change anything without resources?

It is shocking that where you are born determines how long you can have a healthy life - accident of birth!

Who will support us to make these changes? It will cost money - who will pay for it?

Knowledge is power that brings change - most people living in a deprived area are completely unaware they are seen as deprived or that their healthy life expectancy is twenty years shorter than their affluent neighbours. We know these gaps exist, we know what works in prosperous areas why are we not incorporating what works in our disadvantaged areas?

C2C Responses to Empower and Enable People and Communities

The digital project that C2C will undertake next year (p.13-14) is a great idea because it will produce a digital education model highlighting good and bad practice enabling other groups/people to eliminate the barriers, be ready for the challenges as well as see the outcome as achievable.

I have concerns for the elderly/people with complex needs, teaching methods may need to be adapted and the model may need to be adjusted to meet individual needs.

Our project will hopefully identify the barriers making it easier for people to go digital.

Pilot a Digital Learning Programme for Health

All members are anxious about what they call this 'new digital world' which is one of the many reasons the digital project needs to go ahead, so people can see that technology is not as frightening as imagined.

It is the way the world is going but not all people have access to technology and learning which could create more inequalities.

I hope the digital empowerment works better than the patient access app. I thought I could find out my latest blood results but it is only designed for making appointments and ordering prescriptions. Another group member added it is more hassle to order your prescription using this method, I prefer the prescription line. Someone else added the app is dreadful, it doesn't work which is not helped with me always forgetting my login details - this is why I am really frightened about everything going digital.

C2C Responses to Empower and Enable People and Communities

Sadly we live in a world where how you look or present yourself will have an impact on how professionals treat you and in many cases you may not be able to register with a service such as a GP, because the professionals don't like the look of you.

I don't even know the complaints procedure at my own surgery.

It says in the pharmacy/surgery that aggressive behaviour will not be tolerated, treat staff with respect etc. - yet in most cases the staff do not treat us with respect. I am a person and also have the right to be treated with respect.

It is a big undertaking to implement all these recommendations and changes to systems - it could create chaos; re-education will be needed for everyone to know how to access healthcare or even an appointment with their doctor - what happened to being informed or my rights being considered?

Raise Awareness of Health Care Rights and Responsibilities

I don't know my rights - echoed by the whole group.

Teaching people their rights and responsibilities is really important for empowerment which in turn will create positive change in our communities.

I would be scared to stand up for my rights because professionals have a way of making you feel small and insignificant.

C2C Responses to Data, Evidence and Knowledge

Ensuring information is clear and easy to find is important but are you going to fund and empower people/communities to be able to use this information for positive change?

Different formats need to be available so that information can be accessed by different groups such as sensory impaired or people with complex needs.

If I knew my child was going to die 10 years younger than the children living in our affluent neighbouring communities I would want it to change but would not know where to start.

This recommendation states “different forms of inequality can interact and impact each other” understanding that non health inequalities contribute to poor health - will the Commissioner look at all these inequalities?

**Publish High Quality
Accessible
Information on Health
Inequality**

Knowledge can sometimes be more frustrating/dis-empowering if not accompanied with the resources and skills to create change.

I find all this talk of inequalities really sad but I wouldn't know what to do about it.

NHS Health and Care Experience survey - how and where is it disseminated? How is it possible to record health inequalities in this way? The survey doesn't capture the health discrimination experienced by vulnerable groups, many of whom would be unable to respond to a survey without support. This is a poor method of data collection that creates gaps rather than fills them.

When talking about accessibility and ensuring “people have more power over the decisions which affect them”, the information needs to be presented in a way that is easy to understand without jargon as just being available is not helpful.

C2C Responses to Data, Evidence and Knowledge

At the moment resources are not equally shared in terms of GP surgeries receiving additional money for elderly people when there are communities that do not see old age due to a range of inequalities such as poverty and poor education. Different communities require specific resources - funding should reflect this if we are to close the gaps.

Develop Methods for Recording Unmet Health Needs

Recording, assessing and reporting in unmet need is really important - the analysis and data output needs to be properly funded with experts employed to do this properly and not be an extra burden on already under resourced GPs.

Build local well-being groups like C2C which will create panels of people with lived experience - listen and work with them.

Who would I report these unmet needs to? Who actually cares?

C2C Responses to Data, Evidence and Knowledge

Accurate qualitative data should not be measured from the outside, relationships need to be forged with communities to understand, identify and locate the missing people.

In certain cases it is the people/groups who do not engage with services that need them the most!

How will the system recognise and document unmet need?

Have Knowledge Exchange links been established with Scottish Universities around research that is already being conducted on health behaviours?

Services such as the dentist are not taking on any new patients since the pandemic, is it the same with the doctor? If so how do I get myself a doctor or a dentist?

People often feel like they are not being listened to/taken seriously which the group believe will account for many missed appointments.

Data on Missingness Should be Recorded

People miss appointments because they have to wait so long - they could be dead!

Is there going to be funding available to resource Community Champions within each hard to reach area?

Unmet need is the biggest contributing factor in 'Missingness'.

Long term/persistent conditions when no one cares or listens makes me feel like a hypochondriac or a mental case encouraging me to be one of the missing people.

More action is needed not more research.

To understand communities you have to speak their language.

C2C Responses to Data, Evidence and Knowledge

Sick people do not want to be in a hospital waiting room only to see its 3-6 hours to be seen, equally staff do not want to see that there are 300 patients to go, it makes you feel more down/demotivated. Statistics and data need to be displayed where and when it can be actioned/at the right time.

You have had years to listen, collaborate, take appropriate action but you didn't listen creating more gaps unnecessary suffering and needless lives lost.

We need better monitoring/recording systems, they should be the same as hospital 'minute by minute' systems.

There should be better collaboration between the Government and all relevant medical decision makers because right now they are like two parts of the same brain that don't work together.

Surely information should be shared between everyone, not just professionals.

Develop and Support Better Collaboration

This day and age and our NHS has a wobbly wheel with no real appropriate action.

Professionals should be asking each other more relevant questions such as why are there more suicides in my area.

There are less doctors and nurses (per head of the population) dramatically decreasing everyday which can be linked to inequalities and unmet need all over the board. For example lack of financial resources to enable people to study, more interest placed in overseas students, not enough funding given to GP practices resulting in overwhelmed burnt out doctors/nurses - The NHS is like a broken down old banger and it is because the Government made it that way.

Queues and waiting times are unacceptable and COVID 19 is being blamed when it was equally as bad before the pandemic, has this been documented?

C2C Responses to Data, Evidence and Knowledge

As mentioned previously in **Mental Health, Long-Term Health Conditions and Community Voice**, (p.10-11) - data is not recorded properly. To allocate funding to the places that need it most data needs to be accurately recorded/monitored.

All GP surgeries record data in different ways meaning there is no consistency or definitive ways to understand patterns and themes - there needs to be a clear monitoring system all over the board.

Every sickness/death since lock-down is being recorded as COVID such as urine infections, heart complications. For clear data, root causes have to be recorded.

Improve How Health Data is Recorded

GP surgeries need to record data 'minute by minute' the same as hospitals, meaning just like hospitals data inputters will need to be funded as local Health Centres do not have the resources to do this.

If I can't get an appointment with my own doctor, which we are all struggling with at the moment, is there anything to record/monitor?

Why only deprived communities? It should be collected across the board so people don't feel deprived, so we don't have deprived communities - If you call someone stupid for long enough they will believe they are stupid same goes for deprived!

C2C Responses to Data, Evidence and Knowledge

Tracking/monitoring already used in our hospitals should be the same all over the board with funding allocated to data inputters.

All new policies/systems need to be tracked/monitored in order to understand benefits and limitations.

Only when you address these inequalities can we start to locate the missing people and close the gaps between life and healthy life expectancy.

**SG to
Track/Understand
Impacts of Policies**

Policies can effect and create health inequalities, this needs to be tracked/monitored to mitigate the risk of losing more unnecessary lives.

Practice Nurses were in our surgeries to take blood which I felt comfortable with but now we have the new phlebotomy service which is a waste of time. What do nurses do now? Is someone tracking this phlebotomy service because it is awful and creating more inequalities?

Great, if you're recording/monitoring methods work

The voices of C2C pose a final question in response to the SLWG recommendations

Sick, dying people are waiting in ambulances or hospital corridors, suicide rates continue to increase along with life and healthy life expectancy gaps which you can't seem to fix - so how do you plan to fund, develop and implement all of these recommendations?

7. Reflections

Working as an advisory group to the Scottish Government has been challenging but equally amazing for the group's confidence.

The reason I believe the project went so well is that C2C is a well-established group who don't feel embarrassed to talk openly in front of each other. Trust is pivotal to obtaining honesty and should be taken into consideration for future projects. Further consideration should be given to the language adopted by the Scottish Government which is often unclear ("jaggy words"). I often required clarification via Dr Peter Cawston in order to enable me to clearly convey the recommendations to the group. This highlights the need for intermediaries to ensure information can be understood at all levels.

The Scottish Government have been fair and flexible in terms of the timeframes provided to the group. However, small local groups of this type are not used to working to these sorts of deadlines and at times it has been challenging to maintain progress/focus as well as balance the wellbeing of individuals and the group.

My main priority (as it should be for any Support Worker) is the wellbeing of group members which sometimes resulted in no work being carried out on the Scottish Government report and instead allowing the group to talk, play dominoes or whatever it might be that they needed to find inspiration. This had a short-term impact on timeframes but in the long-term has enabled the group to complete a meaningful, high quality piece of work.

Some of the themes were difficult to discuss, for example mental health and long-term health conditions which had a negative impact on the mood and energy of the whole group. One of the group members stated "they had never thought about any of the bad stuff at group before and did not like feeling this low in the place that makes them smile". C2C agreed to complete this piece of work but not at the detriment of their health or by diminishing the essence of the group. This is where the group learned to balance work life with wellbeing (turning negatives to positives); the group session was split into two parts with the first half focussed on completing the Scottish Government work and the second half consisting of fun activities such as quizzes, games, etc. Group has always been about people leaving feeling better than they did when they arrived, so splitting the sessions in this way maintained the C2C ethos.

I believe it is fair to say the whole report echoes the need for change but some key factors for success in similar future projects as well as services as a whole. Where to start: listen to the people who have lived it; balance our needs with your expectations, then we can collectively achieve success. 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

Appendices

Appendix 1

Chance 2 Change

Code of Conduct – Dae as Yer Telt!

Take responsibility for yourself, but always be a team player:

- Anybody found to be under the influence of harmful substances will be asked to leave the group session.
- Mobile phones should be switched off during group sessions.
- Punctuality is essential, so as not to miss out on activities.

Abide by health and safety rules:

- Take responsibility for personal hygiene; e.g. hand washing.
- Tidy up behind ourselves, leaving premises as you would expect to find them.

Respect other people and their privacy:

- Any discussions within the group should remain confidential.

Be non-judgemental of others:

- No bullying or harassment, but constructive honesty is respected.

No aggression or violent outbursts:

- Be kind to each other and ourselves.

No show people:

- All group members are equals - one singer one song.

No negativity:

- Empower and build each other up.
- Fun and laughter.

Appendix 3

Chance 2 Change

Group Evaluation Questionnaire

So that we can monitor and improve the quality of your experience with the group, we would value your feedback.

Date:

Before you began attending the Chance 2 Change group, how would you rate your overall sense of self confidence, where 1 is low and 10 is high?

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|----|

Today how would you rate your overall sense of self confidence, where one is low and 10 is high?

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|----|

Which activities that you have participated in do you feel have been the most help?

| |
|--|
| |
|--|

How well do you feel that your peers on the group have listened to you and taken your needs and wishes into account, where 1 is poorly and 10 is really well?

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|----|

How well do you feel that the facilitators of the various activities have listened to you and taken your needs and wishes into account, where 1 is poorly and 10 is really well?

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|----|

Is the information you are receiving from the group activities clear and helpful where 1 is not at all and 10 is very clear and helpful

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|----|

Are there any ways in which the group experience could be better for you?

| |
|--|
| |
|--|

Appendix 4

THE PRIMARY CARE HEALTH INEQUALITIES SHORT LIFE WORKING GROUP DRAFT RECOMMENDATIONS

Version shared with Chance to Change, November 2021

What is Primary Care in Scotland?

Most of the time, people look after their own health and wellbeing in whatever ways are best for them. Most people also rely on their family and community to support them. Primary health care professionals offer extra support when it is needed.

Primary care is provided by many different health care workers. These include, GPs, pharmacists, nurses, link workers, health visitors, optometrists (opticians), physiotherapists, mental health workers, dental practitioners (dentists), podiatrists (chiropractors), and many others. They work together to give people the right advice.

Primary care is delivered 24 hours a day, 7 days a week. When people need urgent care outside of standard working hours, out of hours services provide people with the help they need. When primary care professional cannot offer the correct support, specialist advice or services (such as from a hospital doctor) may be sought.

Health is caused by a wide range of different factors which are often called 'determinants of health'. These include such things as genetics, diet, exercise, wealth, employment, or being exposed to things in your environment. Health inequalities are the unjust and avoidable differences in people's health across the population and between specific population groups. These usually are caused by 'social or economic determinants' of health. People living with greater poverty, discrimination, disadvantage and prejudice with lower access to quality housing, education and employment may live shorter lives, and have fewer years spent in good health, without disability (lower healthy life expectancy).

Empower and develop the Primary Care Workforce

How to create the right conditions for better primary care. How we support the workforce and leadership.

- Put in place a national Fair Health Scotland programme to educate health care workers about health inequalities. This will involve an educational programme (called fellowships) to build a network of leaders who understand the bigger picture of poverty, racism, discrimination, injustice and privilege in providing care. Health care workers will learn the skills to plan better care with other agencies and professionals and, most importantly, with individuals and communities themselves. The programme would bring more health care workers to vulnerable communities where they are needed.

- **Enhanced Service for Health Inequalities:** The Scottish Government should fund GP practices to be able to offer additional services to vulnerable individuals and communities. This would be used to give better access to care, improve the patient experience, offer more support to people with additional challenges and to improve health and wellbeing. Funding would be targeted to the areas that need it the most, using the best evidence available. This would help to deliver many of the other recommendations in this document.
- People with complex health and social care needs often need care from different services and professionals. It is better if that care can be planned in a joined-up way. We should support primary health care professionals to work more together to plan and deliver care for people who have complex health and social care needs. This will require enough time and training. Joined-up care planning can bring together primary health care workers with social care, mental health, link workers, education, police, carers, housing, families and individuals themselves.
- Invest in the training and resourcing of health and social care staff for digital inclusion:
All primary care staff should understand the benefits and the limitations of digital care. They should understand the challenges people face with digital technology and how to help them. They should have the skills, confidence and equipment to make the best use of digital technology to support people. This is especially important to help people learn the skills to look after their own health, for example through online communities, peer support groups, home monitoring, YouTube instruction videos, etc.
- Make health inequalities a core part of the new GP 'Expert Medical Generalist' role:
The work of GPs is changing as more types of health care workers become involved in primary care. In the future, GPs will be more focused on supporting people with complex and difficult health care problems. This is called the Expert Medical Generalist role. GPs should understand and take into account the challenges caused by health inequalities when they work in this way.

Leadership, Structures and Systems

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

- **Strengthen national leadership:** The Scottish Government should consider options, including a new Health Inequalities Commissioner, to strengthen leadership for health inequalities in health and social care. Every means across government should be used to drive change and hold system leaders and managers accountable for tackling health inequalities.
- **Create a national priority to reduce the harm caused by long term physical and mental health conditions on disability and healthy life expectancy:** The NHS, the Scottish Government, and new National Care Service should make

this a priority. Everyone needs to work together to use all their resources to empower individuals to stay well, supported by their families, carers and community. This priority should be built into the contract for GPs.

- Ensure that social and financial inclusion support and advice are available through primary care settings: The Scottish Government should extend its support for roles like Community Links Workers, Welfare Advisors and Mental Health Workers to make them more easy to access through primary care. These workers link people to services in their community, such a social, financial and wellbeing support, which in turn can have a positive effect on their overall health and wellbeing.
- Contracts with Health and Social Care Partnerships and GPs should have health inequalities written into them: Inequalities and equity should be included in current and future commitments and decisions about health care planning. Equality Impact Assessments should be mandatory for Health and Social Care Partnerships, in line with their statutory duties.
- Funding: any changes to how funding is used and spread out across primary care services should take account of socio-economic inequalities, rural issues, equity of access and unmet need. The Scottish Government should also commit to monitor unintended consequences or risks which a new funding model could cause.
- Transport and health: The Scottish Government should create a group which will review and take action on transport and health and should 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 environmentally friendly.
- Recognise that people's access to digital technology can have an influence on their health: Technology can itself cause or improve health inequalities. It should be treated as a determinant of health alongside socio-economic and environmental factors. The Scottish Government and Public Health Scotland should look at ways to include access to technology and digital skills when they look at inequalities.

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 groups of individuals with lived experience of health inequality: This would help to ensure health inequalities and people who experience them are included from the start of the policy making or planning services . This should take account of social, financial disadvantages and other characteristics related to social inequality. GP Practices should support and use these groups so that they can engage more meaningfully with their communities.

- Invest in wellbeing communities:

The Scottish Government should support the development of a more coherent and long-term approach to local action to reduce inequalities. Communities have different social and material assets . Partnerships between communities, third sector, public sector, and the NHS and social care system should prioritise and promote peer-to-peer support, shared community spaces, local groups & activities and other community infrastructure to protect and promote mental health, resilience and wellbeing. GP practices should be part of wellbeing communities.

- Pilot and implement a national programme of digital empowerment for health through community-based peer-supported learning programmes. These would, e.g., enable patients to safely use digital networks for peer support, to access health resources on-line, and to gain hands-on experience of remote appointments.
- Raise awareness of health care rights and responsibilities: People should be informed about their rights and responsibilities in relation to health care. They must be provided with information that is easy to access and understand. 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 are important to this.

Data, Evidence and Knowledge

Make sure that information about inequalities and health is publicly available where appropriate.

- Publish high quality, accessible information on health inequality: National and local organisations should improve the collection, quality and transparency of data on inequalities. This should include how different forms of inequality can interact and impact on each other.
- Organisations should also identify and try to fill gaps in data. These bodies should also review how they publish and report on data and information about health equity and health inequalities to ensure that information is clear and is easy to find and understand so that communities and individuals gain knowledge to help them have more power over decisions which affect them.
- Develop methods for recording, assessing and reporting on unmet health needs in general practice: this is very important if the way resources are shared out is to truly reflect the needs of different communities and individuals.
- Provide 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 information that is easy to understand. This should help them to see the links between health and its social and environmental causes. It should allow communities to understand clearly the reasons why some

communities in Scotland are unfairly affected by early deaths and shorter healthy life expectancy.

- Commission research into how things which can make it difficult for some people to use or find the healthcare they need may play a part in worsening healthy life expectancy related to socio-economic inequalities. This would look at: why different groups of people don't get support they need; the effect of long waiting times and delays in treatment on serious conditions; why some people are missing out on health care; what are the effects of targets for things like waiting times; and why some people harm themselves through drugs, alcohol, binge eating or even suicide because they are unable to access the care and support they need. Data on missed appointments and 'missingness' should be recorded and reported: People who provide health care need to understand which groups of people are more likely to miss appointments and which people do not use health services. This is important if care is to be safe, effective and equitable .s. Some research has already been done in Scotland to look at who does not engage with healthcare, what impact this might have on their health and what can be done to address this problem.
- More ways need to be developed to support better collaboration between professional involved in public health and staff in primary care This should help to improve the health of the overall. This would build on progress during COVID-19 to share information and understanding more effectively and routinely.
- Improve how health data in general practices is recorded in deprived communities: The Scottish Government should test the impact of providing a sample of GP practices in deprived areas with dedicated support to improve the quality and accuracy of the information they record about patients and to improve efficiency. One aim of this would be to identify practical measures to improve data about demand for healthcare.
- Work to deliver the Scottish Government's commitment to track and understand the impacts of policies to reform Primary Care should more explicitly address health inequalities.

Abbreviations used in the Report

ACEs – adverse childhood experiences
ASIST – Applied Suicide Intervention Skills Training
BMA – British Medical Association
C2C – Chance 2 Change
CHI number – Community Health Index number
CLW – Community Links Worker
COVID-19 – Coronavirus disease
EMG – Expert Medical Generalist
GP – General Practitioner
HCE Survey – Health and Care Experience Survey
HIIC course – Health Issues in the Community course
HRT – Hormone Replacement Therapy
HS - Hidradenitis Suppurativa
NCS – National Care Service
NHS – National Health Service (Scotland)
PCIPs – Primary Care Improvement Plans
SLWG – Short Life Working Group



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