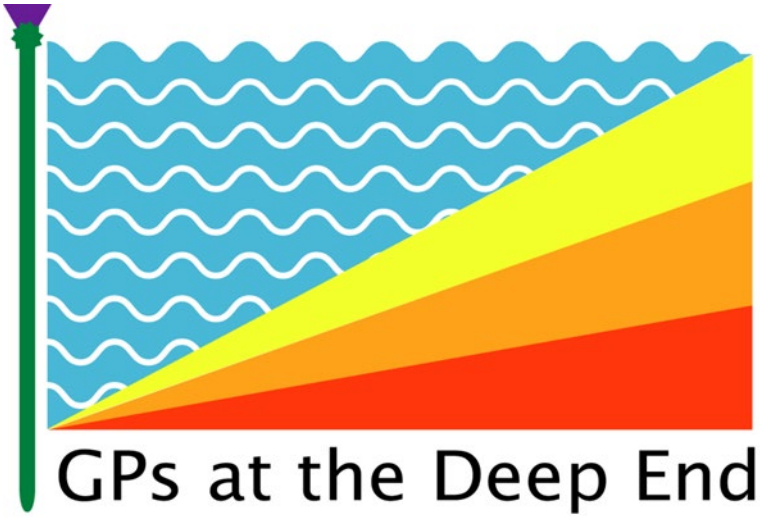

Deep End Report 40

What can general practice do to mitigate the effects of the cost-of-living crisis?

On Wednesday 30 November 2022, the Deep End GP group hosted an online roundtable meeting to explore the challenges of the cost-of-living crisis. Discussion centred on the various specific challenges, but also explored potential system-wide solutions to these issues.

January 2023

CONTENTS

EXECUTIVE SUMMARY

The purpose of the roundtable was to bring together GPs working in Deep End practices alongside key charities and community organisations to specifically consider how general practice can best support their patients experiencing financial hardship, in recognition of the fact that poverty drives poor health and worsens health inequalities.

Context/the crisis

Rapid inflation, compounded by the Covid-19 pandemic, Brexit and a period of prolonged austerity are some of the key factors that have led to what is being described as the 'cost-of-living crisis' [1]. It is recognised that low-income households are disproportionately affected by the cost-of-living crisis, because they spend a higher percentage of their household income on basic essentials such as food, energy, housing and transport.

Specific challenges

Participants were concerned about the impact on patient health of fuel poverty, inadequate housing, food insecurity, and access to health and other services due to transport costs. All of these factors are likely to affect both physical and mental health, and will be felt most acutely by those with the lowest incomes.

Impacts on practice workload and practice staff were also highlighted. It was noted that staff morale is as low as it has ever been, with negative media headlines compounding an already exhausted workforce. Increased workload leads to increased stress, which directly affects practitioner empathy and patient care.

Potential approaches general practice could take

- **Build teams that specifically promote social inclusion** – by recruiting, retaining and supporting the wider general practice workforce that supports patients with the complex social problems that impact negatively on their health. Community Link Workers, Welfare Advisors, and Care Coordinators were seen as assets, all working collaboratively with the voluntary and third sector.
- **Maximise the 'community hub' function of general practice** – through maximisation of co-located services, partnership venues, community pantries. Participants stressed the importance of personal connection in advice-giving, as part of a trusted teams and within familiar premises
- **Effective and sensitive sharing of practical resources and high-quality information** – this could be done in a variety of formats and languages, whilst mitigating for digital exclusion.
- **Advocate, lobby, and collaborate on behalf of patients** – drawing on available data and evidence, drawing on patient narratives, and sharing worked examples of how this could be supported in practices.

Recommendations

Five recommendations specifically for general practices are presented and five broader recommendations are made.

CONTEXT: THE CRISIS

Rapid inflation[i], compounded by the Covid-19 pandemic, Brexit and a period of prolonged austerity are some of the key factors that have led to what is being described as the 'cost of living crisis' [1]. It is recognised that low-income households are disproportionately affected by the cost-of-living crisis. These households tend to spend a higher proportion of their budget than average on essential goods such as energy, food and transport, which are rapidly rising in price – much faster than average wages.[ii]

In 2020, 30% of families in Scotland described themselves as either in serious financial difficulty or struggling to make ends meet [4]. Entering the crisis, low-income households were particularly vulnerable due to pre-existing hardship with 30% of households in Scotland not having enough savings to keep them above the poverty line for one month should they lose their income. This figure rises to 50% for the 20% of households with the lowest incomes [1].

In 2019, 1 in 4 households were identified as being in fuel poverty [5]. In 2022 this has risen to over 1 in 3 households, with 1 in 4 households now in extreme fuel poverty [6]. The Scottish Government recognise that the 'negative impacts of rising costs are already being felt in Scotland and are likely to intensify over the coming months [1]. Energy price increases were capped by the UK Government as an Energy Price Guarantee on 1 October 2022 and are set to increase by 25% on 1 April 2023. Alongside a less generous package of financial support it is estimated that there will be a further increase in the levels of fuel poverty as a result.[iii] In Scotland this may result in 1million households meeting the Scottish Government's fuel poverty definition [1].

In November 2022, the Deep End GP group hosted an online roundtable meeting to explore the challenges of the cost-of-living crisis on the patients they care for. By bringing together GPs working in Deep End practices along with key charities and community organisations, they considered specifically how general practice could best support their patients experiencing financial hardship, in recognition of the fact that poverty drives poor health and exacerbates health inequalities.

SPECIFIC CHALLENGES

Participants discussed some of the specific challenges related to the cost-of-living crisis facing patients and practices in Deep End communities. Concerns about patient health are presented first, followed by challenges for Deep End practices.

Patient health

Participants were concerned about the impacts of fuel poverty, inadequate housing, food insecurity, and access to health and other services due to transport costs. All of

[i] The Consumer Prices Index measure of inflation hit 11.1% in the year to October 2022 – the highest level since 1982 [2].
[ii] The IFS predicted in August that the poorest fifth will face an 18% inflation rate in October 2022, compared to 11% for the richest fifth [3].
[iii] National Energy Action estimates 8.4million UK households will be in fuel poverty from April 2023 [7].

these factors are likely to affect physical and mental health, and will be felt most acutely by those with the lowest incomes.

Fuel poverty/inadequate housing

It was noted that **fuel poverty has increased significantly** since the COVID-19 pandemic. Pre-pandemic, 1 in 4 households in Scotland experienced fuel poverty, but this is now estimated to be 1 in 3, or almost 900,000 households, of which roughly 600,000 are experiencing extreme fuel poverty [8]. This bleak situation is predicted to worsen when the mitigating effects of the UK Government's current Energy Price Guarantee and the financial package of support provided to households comes to an end on the 31st March 2023. It will be replaced by an increase in the Energy Price Guarantee and a significantly reduced financial package [9].

Poor quality housing kills, as highlighted recently by the tragic story of Awaab Ishak who died eight days after his second birthday, as a direct result of black mould in the flat he lived in [10]. Deep End GPs described increasing numbers of patients reporting problems with damp and mould in their homes, contributing to respiratory illness. Cold homes impact asthma, respiratory infections, hypertension, mental health and increase heart attacks and strokes and the UK has some of the least efficient energy stock and the highest winter excess mortality in Europe [11]. The World Health Organisation connects excess winter mortality to fuel poverty and has stated that approximately 30% of excess winter mortality is caused by fuel poverty. More recently Sir Michael Marmot has speculated about the increasing likelihood of increased mortality due to cold homes [12].

Food insecurity/malnutrition

The **rise in food insecurity** in Scotland is well documented [iv], predating the current cost of living crisis. The Deep End GPs involved in the roundtable discussion recounted growing numbers of patients attending with signs and symptoms directly resulting from malnutrition.

As one of the GPs shared:

> *"We are seeing more and more examples of the impact of poor-quality diets on people's health. Due to malnourishment, more patients we are seeing are developing folate, B12 and iron deficiency"*

Malnutrition resulting in obesity is also worsening, with increasing incidence of new type 2 diabetes being diagnosed, thought to be secondary to an over reliance on cheaper but energy-dense, processed foods [13].

Participants **endorsed a cash-first approach** to food security, providing dignified access to food without gatekeeping or means-testing. It was recognised that a one-way system like food parcels or vouchers cannot provide the same benefits as mutual aid, relationship-building approaches like community pantries and kitchens, access to affordable growing space for low-income communities, and education and support with food and budgeting skills, which projects such as Cyrenians Community Pantries endeavour to offer [14].

[iv] Scotland saw a 108% rise in the number of emergency food parcels distributed in July 2020 compared with July 2019 [1]

Travel/access to services

Increased transport costs are a barrier to accessing services. One GP noticed an increasing trend in patient preference towards remote consultations due to transport issues, even in instances where a face-to-face appointment was felt to be indicated by the clinician. Reduced hospital attendances are also being noted, again in instances which are felt to be clinically indicated.

One example shared by a GP:

> *"I assessed the patient as sick and needing hospital admission. An ambulance was not needed, but the family did not have the money to pay for transport. We ended up paying £40 from our petty cash at the practice simply to allow to the child to attend hospital in a taxi"*

Participants reflected that patients also describe centralised vaccination hubs as difficult to access due to transport links and costs, and this is resulting in **reduced vaccine uptake**. Despite long waiting times for hospital outpatient reviews, some patients are **not attending these specialist appointments** when they do become available due to transport costs.

Mental health impacts

Participants discussed the **significant detrimental impacts of the cost-of-living crisis on the mental health of their patients**. These included the known direct impact of cold, damp housing on the mental health of adults and children; increased conflict within families during times of economic stress; higher levels of adverse childhood experiences having a lasting negative impact on future mental (and physical) health; a rise in domestic violence in situations where economic stress result in higher levels of volatility, and less personal ability to make choices that protect safety. Many of the themes were noted to be similar to those observed during the Covid19 pandemic during periods of lockdown and financial hardship.

Impacts on general practices

Many of the general practice impacts of the cost-of-living crisis follow directly from the adverse patient health effects described above. Despite increasing numbers of patients in Deep End communities affected by worsening physical and mental health, there has been **no increase in resource to support these needs** and the increase in workload that this creates.

GP participants shared that **staff morale is as low as it has ever been**, with negative media headlines compounding an already exhausted workforce. Increased workload leads to increased stress, which directly affects practitioner empathy and patient care.

Participants noted that community links workers and practice-attached financial advisers had made a positive difference, but were concerned that **short-term funding made it challenging to recruit and retain staff**. Furthermore, community links workers can only be effective if there are community resources to link *to*, and several participants described how community organisations have had to cut back their services due to increased heating costs.

Finally, participants reflected that another legacy of the COVID-19 pandemic is that **practices do not have the same 'footfall' as they had previously**, with hybrid consultations models resulting in more remote consultations. This means that the opportunity for practices to act as 'community hubs' is more limited than it was before,

and that different approaches would be needed to connect with, and support patients on an opportunistic basis.

POTENTIAL SOLUTIONS?

Build teams that promote social inclusion

Participants reflected on the importance of building teams that specifically promote social inclusion. This means thinking more widely than the traditional 'medical' model of general practice teams, to including roles within the practice that are better equipped to support patients with the complex social problems that impact negatively on their health, maximise the 'community hub' function of general practice and work collaboratively with the voluntary and third sector. Three specific roles were considered and discussed:

Community Link Workers

Community Link Workers (CLWs) work within general practices as generalist social practitioners. They have an **expert knowledge of community resources** and initiatives, tailored to the needs of the individual patients they work with and support. Originating as a pilot project in seven Deep End practices, CLW roles are now being rolled out nationally, prioritising areas of high socio-economic deprivation.

Welfare advisors

Welfare advisors based in general practices, with access to medical records (with consent) can offer individuals **tailored support and advice on financial challenges** such as debt, utility bills, benefits, and rent arrears. Evaluation of this model has found that patients experience improved health and wellbeing, feel less stigmatised, and report increased feelings of self-worth. Also originating as a pilot in four Deep End practices, these roles are now being rolled out more widely with core funding, with two-year funding to further evaluate their effectiveness in 150 of the most socioeconomically deprived practices.

Care co-ordinators

Care co-ordinators offer much more than the traditional 'medical receptionist' role, with **additional training in signposting and social support**. Examples were shared of the work of care coordinator teams during the COVID19 pandemic.

One GP reflected:

> *"Our care co-ordinators really are 'the frontline of the frontline'. During Covid, they were often the first to notice when our most socially vulnerable patients on the practice list were 'missing' because we had had to close our doors to limit infection spread and everything was telephone-first. They compiled a list of the patients whom they would ordinarily have regular contact with at the front desk, and made 'outreach calls' to offer advice on Covid resources and support, identify any unmet needs and offer signposting into clinical and social services, and offer reassurance that practices were still 'open'. 8 out of 10 of these calls resulted in an ongoing referral – to clinicians or other support roles in the team, or to outside services such*

as Citizen's Advice. They were so grateful for the contact. Many were scared, and felt alone"

It was recognised that these social inclusion and **support roles are vital to linking with services**, offering expert advice and making maximal use of all roles within the practice team, especially at a time when clinical workforces are depleted, and workload is extremely high. These roles are recognised as the 'linchpins' to accessing social support, and practices in areas of highest socio-economic deprivation would benefit from greater access to these roles. Examples were shared at the roundtable of colleagues in these roles seeking more secure or competitive employment elsewhere. Addressing issues that may negatively impact on recruitment and retention was also discussed, such as ensuring long-term funding, favourable terms and conditions in the workplace, and access to high quality training and induction.

The **importance of personal connection** in advice-giving, as part of a trusted teams and within familiar premises was discussed. The limitation of space in many GP practice premises was noted to be a challenge to achieving this.

One GP commented:

"The personal connection cannot be under-estimated… it is significantly more valuable that just resources on a website".

There was much discussion around the **financial viability of third sector organisations**. Community link workers, as generalist social practitioners signposting to, and linking with, relevant community organisations can only be as effective as the third sector supporting them. Our group recognised that third sector organisations are also feeling the direct and indirect impact of fuel poverty on running their own services and the need to advocate for more sustainable wider support is paramount.

GENERAL PRACTICE AS A COMMUNITY HUB

The role of the GP practice as a community hub has long been recognised, and discussion included **how to make the best use of practice premises** and methods of information-sharing. In some areas, participants described how partnership venues are developing, with community pantries and third sector organisations being co-located, allowing both physical resources to be distributed, as well as a central face-to-face point for individuals to be signposted to community services and support.

As a group we recognised the **importance of *how* information is shared**. It was felt that information needs to be shared in a way people understand and feel able to accept, and that this is often easier within a trusted relationship or setting. Face to face provision has always been the most effective and impactful support for vulnerable households for the reasons discussed earlier in the report.

However, the group also recognised that reduced foot fall into practice premises is occurring post-COVID, partly because of new hybrid models of consulting, and partly because of prohibitive travel costs for patients. We agreed that we **need to think innovatively** about how resources can still be shared effectively in these instances. Utilising practice websites, Facebook pages and answer phone messages may be a

way to do this, and standard templates could be developed and shared with practices to avoid duplication of workload and ensure consistency and quality.

The group also recognised the **risk of digital exclusion** if information is only or largely available online. Access to data and digital literacy is known to be a major issue for many patients in accessing online resources or making online applications for additional support. In recognition of this, one participant shared that some charitable organisations are offering free SIM cards with unlimited data, wider re-distribution of which could be beneficial for patients experiencing financial hardship. Examples were shared of practical resources[v] that have been created by third party organisations. These include Energy Action's collaboration with Scottish Power Energy Networks on a winter focussed leaflet offering tips to help keep warm. Scottish Fire and Rescue have also developed a 'Keep Warm and Well this Winter' safety leaflet to share with people at risk. Building on the safe, warm and well focus, areas such as Aberdeen have also piloted a 'warm home prescription' service, where NHS staff can refer patients to a service to pay the energy bills for eligible patient to ensure that their homes are heated to a safe temperature, all winter. If this evaluates well, there could be the potential to roll out more widely.

There was a recognition that **sign-posting needs to be both effective and sensitive**. Dignified access for all patients to choose the services and resources they need without gate-keeping or means-testing was unanimously supported. It was recognised by GPs that there is a need to embed resources for patients within the practice without creating additional GP workload if this is to succeed, given the existing significant pressures. For example, the option for patients to self-refer to support services such as community link workers and welfare advisors, should be supported.

Potential mechanisms to achieve this were discussed within the group, such as creating a national template of collated resources or a 'tool kit' which could be populated locally and distributed to local practices. **Creating templates that can be shared widely** to update practice websites, waiting room screens, and posters was also encouraged. This helps to share the wealth of resources that exist whilst also recognising the need to try to mitigate additional workload for busy general practices.

ADVOCATE, LOBBY, COLLABORATE

It was recognized that the personal stories and lived experiences of those encountering cost-of-living challenges provide the **most powerful narrative for collective lobbying**. Front-line GP practice teams are in a privileged position to be able to capture this

[v] Such as:

- Keep Warm and Well this Winter SP Energy Networks / Energy Action Scotland- https://new.theclaymoreproject.com/uploads/entities/1230/files/Publications/SPEN%20A5%201122%20(for%20print).pdf
- Scottish Fire and Rescue Service Leaflet Keep Warm and Well this Winter - https://www.firescotland.gov.uk/media/2384040/sfrs-keep-warm-and-well-this-winter-a5-booklet-v10-digital.pdf
- Aberdeen — Warm Home Prescription – https://www.warm.homes/aberdeen
- Free family conflict resources – https://www.scottishconflictresolution.org.uk

narrative and both support patients to self-advocate, and work with community partners to advocate on behalf of the individual patients and communities affected.

The work of Chance2Change was discussed [15]. It is an **established community peer support group** in Glasgow, with historical links to a GP practice but hosted and supported independently by Drumchapel Life / Yoker Community Campus. One of their many strengths is that there is a strong dialogue between patients and the practice. There is an openness/humility (on both sides) to listen, accept that the service is flawed, and to work together to improve things. Problems – and solutions – are often local.

Supporting patients to self-advocate where possible was recognized as having the **benefit of empowering patients** to have more control over their personal situations. However, it was also recognized that many patients struggle with literacy and confidence to raise concerns or lobby for change. Challenges with cold, damp housing and requests to general practice to help support with this are not infrequent. The group discussed the option of creating a template letter for patients to use to raise concerns with their local MSP ((see Appendix 2 'The Impact of a Cold Damp Home on my Health'). Practices creating and sharing petitions in waiting rooms for patients to sign if they wish can also enable patients to self-advocate. Having a patient-practice participation group to work with on these initiatives can be hugely valuable.

It was recognised that one of the most effective ways that general practice can assist their patients is by **collaborating with community organisations** and across sectors, to collectively lobby for support. By drawing on the data and evidence, and combining this with the personal stories of individuals and communities, the collective voice can be strengthened to focus on locally-led solutions.

RECOMMENDATIONS

Specific to general practices

- Up scaling and sustainable funding of the 'social support' and 'conduit' roles within general practice (welfare advisors, CLWs, care coordinators), addressing the barriers to recruitment and retention of these critical roles.
- Ensuring a sustainable and adequately resourced third sector, otherwise no-one to 'link' to.
- Collate and share existing high-quality resources with practices in a way that is accessible to patients and easy for practices to use.
- Create and share a lobbying letter for local MSPs around the impact of cold, damp housing on health (Appendix 2).
- Engage in practice training opportunities that raise social awareness and empower teams to support vulnerable patients (e.g. Women's Aid).

Broader recommendations

- Lobby for practical support for transport poverty to facilitate equitable access to healthcare (e.g. wider roll-out of transport vouchers (e.g. for GP appts, hospital appts, vaccine appts) – based on the Angus 'free bus travel' pilot, wider rollout of free bus passes.
- Lobby for investment in energy efficient homes, recognising the dual benefit of reducing fuel costs and addressing climate change (which also has a disproportionate impact on the health of the most vulnerable in society).
- Push for full implementation of the recommendations from the (Primary Care Health Inequalities Short-Life Working Group, established during the COVID19 pandemic, with active contribution from Deep End practitioners (see Appendix 3, includes specific recommendation on wider scale up of welfare advisors and CLWs, and improving access to transport).
- Work alongside the BMA and RCGP to unite the profession in its belief that addressing health inequalities and the social determinants of health is 'everyone's role'.
- Continue to make the case for the importance of continuity of care, coordination of care and patient-centred care, particularly for those patients who have complex health and social care needs, and/or for whom relationships of trust have been hard-won.

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APPENDICES

Appendix 1 Attendees

Deep End GPs

- **Carey Lunan**, GP in Craigmillar, Edinburgh and Chair of Deep End Group
- **David Blane**, GP in Pollokshaws and academic lead
- **Ula Chetty**, GP in Possilpark
- **Gillian Dames**, GP in Parkhead
- **Jennifer Dooley**, GP in Port Glasgow and Cluster lead in Inverclyde
- **Katherine Jobling**, GP trainee in Tayside, Scottish Clinical Leadership Fellow
- **Marianne McCallum**, GP in Paisley and researcher
- **Paul McNamara**, GP in Port Glasgow
- **John O'Dowd**, GP in Gorbals and Clinical Director
- **Munro Stewart**, GP and RCGP Scotland clinical lead for climate change

Invited others

- **Naureen Ahmad**, Deputy Director Primary Care, Scottish Government
- **Ewan Aitken**, Chief Exec of Cyrenians (homelessness charity in East of Scotland)
- **Nicola Bisset**, Health Improvement lead for Community Link Workers, Glasgow City Health and Social Care Partnership
- **Suzanne Glennie**, Health Improvement Manager, Glasgow (oversees CLW and Wellbeing Hubs)
- **Sarah Gray**, medical student doing survey on impacts of CoL crisis on primary care
- **Lorna Kelly**, National Strategic Lead for Primary Care at Health and Social Care Scotland.
- **Carol McGurin**, Health Improvement Lead, Welfare Advice Partnerships
- **Ashley McLean**, Policy Officer from the Poverty Alliance (deputising for Fiona McHardy)
- **Roddy Samson**, Welfare Advice Service Facilitator, representing Welfare and Health Partnerships
- **Frazer Scott**, Chief Executive Officer, Energy Action Scotland
- **Marsha Scott**, Chief Executive Officer, Scottish Women's Aid

Apologies

- **Eleanor Dillon**, Glasgow Community Food Network
- **Fiona McHardy**, Poverty Alliance
- **Claire Stevens**, Voluntary Health Scotland

Appendix 2 MSP template letter

(Patient address) (Date)

Re: THE IMPACT OF A COLD DAMP HOME ON MY HEALTH

Dear (enter name of local MSP)

I am living in a cold, damp home with a significant negative impact on my health, and I am writing to ask for your help in addressing this.

The UK already has some of the least efficient housing stock, and the highest winter mortality in Europe. The current cost of living crisis, and specifically the cost of fuel, will worsen this further, with an estimated 66% of households living in fuel poverty by January 2023.

Cold damp homes make people ill, with impacts on the NHS, on education, on work, and on the economy.

It is known that living in cold, damp homes has negative impacts on many aspects of physical and mental health, including:

Childhood development – children who are cold need more calories to stay warm, grow and develop. Children living in a household with fuel poverty are also more likely to struggle to have access to adequate nutritious hot food. Cold homes impact negatively on the mental health of parents and carers, causing adverse childhood experiences, with the lifelong impacts that these have.

Lungs – cold damp homes make people more prone to respiratory infections, as more viruses circulate in cold environments, and immune systems are less resilient. It is estimated that around 10–15% of new asthma cases are caused by the dampness, mould or poor ventilation (therefore more dust) in homes that are difficult to keep warm and dry. This was highlighted by the recent inquest into the avoidable death of two-year old Awaab Ishak, who died from a respiratory condition caused by mould in his home.

Heart – indoor temperatures of less than 12^0 cause blood vessels to narrow and blood to thicken. This in turn, causes a rise in blood pressure and an increased risk of heart attacks and strokes.

Brain – cold damp homes have negative impacts on the mental health of both children and adults. It has also been shown to worsen dementia.

Social – the negative impacts on health as listed above, and the financial impact of heating inefficient homes when fuel costs are high mean less money is left over to buy food, spend on transport, keep up with rent, and maintain social connections. Living in a cold damp home impacts on sickness absence from work and education. If only one or two rooms can be kept warmer, this impacts on privacy, and on having space to work and study. Overcrowded cold damp homes with higher levels of stress have been associated with higher levels of domestic violence and homelessness.

It is known that some groups in society are more at risk than others of fuel poverty and living in cold damp homes, for example people who are living in poverty, people with chronic diseases or disability (especially if having to operate medical equipment at home), people who are frail and elderly, pregnant women, young children, single parent households and people from ethnic minority groups.

It is estimated that 867 people die prematurely in Scotland each year due to living in cold, damp homes. Please do not let me become a statistic.

Yours sincerely

(Patient name)

Appendix 3
The recommendations from the Primary Care Health Inequalities Short-Life Working Group

The list of recommendations is summarised below. The full text and context can be accessed at:

https://www.gov.scot/publications/report-primary-care-health-inequalities-short-life-working-group/

THEME Empower and develop the primary care workforce

Creating the right conditions; sustaining the workforce and leadership.

- Implement a national programme of multi-disciplinary postgraduate training fellowships in health inequalities (foundational recommendation)
- The Scottish Government should create an Enhanced Service for Health inequalities (foundational recommendation)
- Empower primary health care professionals
- Invest in the training and resourcing of health and social care staff for digital inclusion
- Articulate and embed inequalities as a core concern in the Expert Medical Generalist role

THEME Leadership, structures and systems

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

- Strengthen national leadership (foundational recommendation)
- Create a national priority of reducing premature disability due to long term physical and mental health conditions
- Commit to ensuring social and financial inclusion support and advice are available through primary care
- The MoU and the GMS Contract Offer, should be underpinned by a commitment to address inequalities
- Funding allocation
- Transport and health
- Recognise digital as a social determinant of health

THEME Empower and enable people and communities

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

- Develop a network of expert reference groups with lived experience
- Invest in wellbeing communities (foundational recommendation)
- Pilot and implement a national programme of digital empowerment for health
- Raise awareness of health care rights and responsibilities

THEME Data, evidence and knowledge

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

- Publish high quality, accessible information on health inequality
- Develop mechanisms for recording, assessing and reporting on unmet health needs in general practice
- Equip communities with data and knowledge to empower them to demand or make changes that matter to them
- Commission an investigation into how barriers to healthcare themselves contribute to excess deaths and premature disability related to socio-economic inequalities (foundational recommendation)
- Mechanisms to support increased and enhanced collaborative and complementary working between public health and primary care
- Improve recording of health data in general practices in marginalised communities
- Monitoring and evaluation of primary care reform should more explicitly address health inequalities.