Learning into practice

### Michael Kellet

Morning, colleagues. I'm hoping you can hear me clearly. My name is Michael Kellet, and I'm going to chair this morning's putting learning into practice session. I'm really grateful for everybody who's joined. I'm the Director of Strategy, Governance and Performance in Public Health Scotland. I've been asked to chair the session today, so let me warmly welcome all of you, really looking forward to the discussion today.

Hosted by Public Health Scotland, I won't say much. You're not here to hear from me today, but let me just provide a little context. I hope you know that in Public Health Scotland, we are working in partnership determined to improve the health of Scotland's people. We are very clearly focused on improving healthy life expectancy and driving down health inequalities. And let me just give you one stat today that exemplifies the scale and importance of the challenge.

Male healthy life expectancy for those males who live in our poorest communities at the moment in Scotland 44.9 years, it's over 70 / 70 in our most prosperous communities. That's a difference of 26 years and healthy life. Between males who live in our most deprived communities and those who live in our most prosperous.

We know in Public Health Scotland that we can only, as a society working together tackle these problems. We also know that we need to tackle the wider social determinants of health and have a step change and a shift towards prevention. As I say, we can't do that alone. We recognise, we need to work collaboratively with others across our communities, across public services, across local and national government, with the third sector. With business too, to bring focus and effort to what matters most to improving our population's health and reducing those health inequalities of that stat exemplifies and the purpose of today's panel is to get to those issues. To raise awareness of health inequalities in Scotland and really, importantly and most importantly, to consider what we can do to tackle them. And I'm really delighted to welcome our panel members who will share their wealth of experience and support us to do that, to deepen our understanding of health inequalities and to focus on what we can do, what action we can take to reduce those health inequalities. The panel will share their views, their insights, their experience of measures already taken and also what more we can do to make a difference. And as you listen to the discussion, please have a think about questions and put questions in the Q&A function. And we have colleagues behind the scene who will be helping kind of moderate and select the questions and we'll come on to that discussion in response to your questions in due course.

And the last thing I want to say, by way of introduction, before moving to introduce the panel was just to say, as it's probably obvious to you, that the panel session will be recorded and we will make available, hopefully, fairly soon for others to view as well, and to share the learning. So let me very briefly introduce the panel members and thank them. We were having a bit of a technical issue, folks, as we set up the meeting this morning this morning, so.

At the moment, unless somebody tells me otherwise, we've got three of the four panel members we anticipated having with us in the kind of panel that you'll see shortly. But we're working hard behind the scenes to get the other panel member with us.

So, I'm confident we do have Professor Donna Hall with us. Donna has been described as a public service pioneer by Andy Burnham, the mayor of Greater Manchester. As many of you will know, I'm sure she was the CEO of Wigan Council for eight years and developed the Wigan deal that very new dynamic relationship with the residents and the people of those communities, and she did similar work as CEO of Chorley Council as well. Donna, you might tell me, I've got the pronunciation wrong there. Donna was appointed the honour Professor of politics at University of Manchester on August 2019, and she's also an indicated care advisor to NHS England. So Donna, thanks for joining us and bringing your experience and wisdom.

In no particular order, next, we have doctor Carey Lunan. Many of you will know, Carey. She's worked as a NHS GP for 20 years, mostly in areas of high socio-economic deprivation. As she is chair of the Scottish Deep end GP project, which is, you know, works in the 100 practices serving the most deprived communities in Scotland, carries an honorary senior clinical lecturer, Edinburgh University. She's currently on to comment from her clinical work as a senior medical advisor in the Scottish Government on Health, Inequalities and Mental Health. Carey was chair of the RCGP in Scotland from 2017 to 2019.

We also have on the call on the panel Professor Gabe Doherty. Again, many of you will know Gabe. He retired as the Director of Public Health and NHS Lanarkshire in 2022. Gabe played a really important role chairing the Directors of Public Health group during the first year of then pandemic, but more broadly. Gabe and his work in Lanarkshire led the development the development of a strategic partnership with the University of South Clyde.

The key aim of developing innovative approaches to addressing health inequality, and Gabe has championed efforts to address health inequalities right the way throughout his career. The person we're desperately trying to get a kind of to join the panel so we can hear from our later as Susan Paxton and Susan, that you may be hearing this as an attendee. We're doing a level best to get you in as a, as a panel member, so please bear with us and my apologies. Susan has worked in community development for over 30 years and is really passionate about social justice and equality and equity, and she is Director of the Scottish Community Development Centre. She leads that staff team to support communities to be strong and sustainable for a more just and equal society. So, a really impressive panel here today. Hopefully the technical glitches will get us through and what we are, I will then do and if the panel want to say anything more by way of instruction, I'm very happy for you to do that, but we've got a number of questions that we've asked the panel to think about to really start our thinking and I'm going to start with a question to Gabe and which Gabe has knows in advance and just done some thinking about. So, Gabe, moving to you, could you answer the question as you know that we've asked you to think about is:

## In what ways can public services be tailored to address the unique challenges faced, by the most deprived communities across Scotland?

Gabe over to you.

### Gabe Docherty

Yeah, thanks, Michael. Good morning to everyone. Yeah, I'm actually, getting some flashbacks to the pandemic here, 'cause like, the only difference is I'm actually seeing smiling faces on the screen. Then another thing I actually, I've got a hot cup of tea as opposed to a cold cup of tea. So it's lovely to see everyone from there. Michael, it is a really good question to start off with. And that I suppose the first thing I'm really, you know, focus on is then we talk about, you know, like communities and immediately we think of like a geographical area. Or people of community, you know, community of interest. But one of the things I'd like to throw out there and hopefully might raise some comments in the chat is basically like the kind of how do we, you know, identify persons who don't fit into any specific group? You know, I'd love for us all just actually to sit down and get all education, colleagues, police colleagues and everything else that actually say, who have you got, who's got the most concerns for you and how can we collectively, actually look to address them? So, I'II put that one out there. So we're talking about, it's just not about communities, it's about people.

And there's news data zones. For example, we'll lose a whole lot of people in very affluent data zones. That's the first one. You know, I feel like to think of. I suppose kind of like. In terms of actually the specific you know question basically like you know.

The younger me are actually saying with public services I'd be saying like, OK, let's let's train staff, let's get them focused on brief interventions. Let's do this. Let's do that. Let's do this.

However, the older me is basically seeing this three things I really want to focus on. The first one is really pushing the whole issue of compassion.

You know I and the reason I'm saying this is 'cause I can. It was phone tracks in North Lanarkshire had a conference. It was a very, very senior retired civil servant and he told that the NHS and I apologise, I don't know the local authority system, you know well enough and the other systems well enough. But he talked about the NHS is about 10 years ago and he basically said listen, after he'd healthcare systems across the world, the NHS is ruthlessly, effective and efficient.

However, there's about one big but to that. It says you've got to comply if you don't comply. The NHS has not been set up for you. Right? So just hold that one. That thought from there. Take it when you know you need leadership things where you kind of like say it out to walk in people's you know refuse basically. And I was kind of like sent out to work with the homeless teams, the NHS homeless team in Lanarkshire. Brilliant team of people and see my observation at the end of the day I actually said to them do you realise that you spend at least 50% of your time pleading and negotiating with fellow clinicians to actually to reappoint a homeless person who hasn't turned up for an appointment. So there's that whole issue of compassion. And what are we here for? And it's really, really hard to systemize. But it's one thing which, you know, I really, really you really need. I think we need to focus on is that a system and that's the whole system. So that's got to come from the top. That's got to come from the chief execs and boards. You know, leaders are councils and everything else.

The second thing is about empowerment. You know, like and I can draw upon just another part of life's learning. I remember, there was a horrible case, two young men who were convicted of murdering this guy, and they're basically the CCTV showed them basically jumping in the poor, poor person's head, basically. And we're sitting in having, you know, in a meeting before it started. And it was two health visitors who basically says, oh, I could have told you that, you know, we've been with that families since those kids, you know, were born.

I could have predicted that would happen and part of the actually thinks how do we empower, you know, our frontline staff to work out the kind of system we've got. We're only system's got to do this, got to do this, got to do this. How come I actually empower our staff to actually say listen, I've got a problem here and get it sorted. I would actually argue that one of the few times I saw that actually happened in Scotland was Harry Burn's, early years collaborative.

But he was actually encouraging, you know, like staff to see if you see something go and try it, pot it and if it works. Let's kind of try to expand it. So if they look like the point I'm trying to make to stimulate discussion is basically we've really got to push compassionate care to really get to the people who need more help. I do. And one of my family members got a letter saying, here's your appointment. If you don't phone this number, you will be taken off the list. Imagine getting that if you haven't even got a house and you can't read, you know, like. We need to get that there.

And then it's for you. I don't really want to make is actually. How do I actually give the authority to our staff to do things out of their normal day-to-day life, have a bit of money to do that and to make the difference to help people. So I'll stop there Michael, sorry I went over the five minutes.

### Michael Kellet

No, Gabe, thanks in some real kind of helpful thoughts there and and some issues I'm sure we'll come back to a particularly like theme about how do we really empower our staff, our people and our systems to, to, to, to really kind of have the freedom to do what they think is right to support the people that that they serve. So but a whole range of issues and they're great. Thanks very much Gabe. We'll come back to many of these issues, I'm sure. So, we're going to move on, folks, to our next question. It was going to be Susan, we're still trying to get Susan then I think so.

Let me jump to Carey. So Carey, we're keen to hear from you around, from your perspective.

## What policy changes do you think are needed to reduce health inequalities on a systemic level across our public services?

And we envisage you will have a particular focus given your background on primary care. Carey over to you thanks.

### Carey Lunan

Thanks Michael. So, this feels like quite hard and big question. So, I think just starting off briefly by saying that, as you'd said at the beginning, I've worked as a GP for 20 years, mostly in areas of high seas economic deprivation, and I think.

It's been very humbling to witness on the front line how poverty largely impacts on people's health outcomes, but not just poverty, but stigma and shame. And loss of trust in systems and how they're often the things that we don't measure or see, but they really impact on people's ability to access healthcare. I think in general I would say that a lot of policy in Scotland has been focused and certainly describes an aspiration to address health inequalities. But the stated aims of policy haven't always been realised on the front line. In large part because of an implementation gap, because it's not easy to do.

And I think that it feels that policy is vulnerable to political cycles, to budgetary cycles. It's overly wedded to cautious tests of change or pilots, which are then not scaled up and made into sustainable changes, even if they evaluate well. And I would say there are a lot of the deep end projects that would fit into this category. And then we then get stuck in this pilotitis loop, which I think can be really damaging. Actually, sometimes it could be damaging, more damaging than not having done it at all, because the people that are delivering the care get used to being able to deliver care in a better way and more trauma informed way with more time and more support and the people receiving the care get used to receiving care in a different way. So, when the pilot doesn't continue, I think that can feel very damaging and erodes trust and morale. So, I think that all policy needs to be developed not just with health in mind, but with Health Equity in mind so that we're thinking more about how, do we ensure that Healthcare is at its best, where it is needed the most to address health inequalities.

Otherwise, we won't get any momentum around addressing the inverse care law where we know that access to Healthcare is often most problematic for those that need it most. And we also need it to be coherent, joined up across different sectors, clear national leadership and accountability, and committed to the longer term. So, none of these things are easy, but it also needs to be implemented following robust equality impact assessments. But then, crucially, to be evaluated and monitored for impact after it's been rolled out so that we can see whether what we thought might make a difference is genuinely, genuinely making a difference.

And we can also monitor for any unintended consequences and change the course if it's not doing what we hoped it would do. And I think another key policy challenge for me is thinking about how do we shift the balance of healthcare. We recognise that healthcare in and of itself drives 20% of health inequality. So it's not the biggest driver of health inequalities. They sit with the social determinants of health. But the way that people are able to access or not access high, quality healthcare can mean that it either worsens or improves health inequalities. So, we have a really key role to play in ensuring that Healthcare is at its best when it's needed the most and a big part of that is thinking about where healthcare sits, whether it's largely based in hospitals or whether it's largely based out in the communities where I would say that there is so much more potential to address health inequalities. So we see within numerous policies within Scotland strategy documents, vision documents, there's often a description of the desire to move care closer to home. Out of hospitals.

Of the importance of person centred, shared decision-making emphasis on proactive and preventative care and more sustainable healthcare. That to me, describes very much what we're much more able to do in primary and community-based healthcare and yet we know that that is largely not where the resources is funnelled to, and I know that there are lots of complex reasons around that. But we also know that the global evidence tells us that population health outcomes and Health Equity are much more likely in countries that have flourishing primary care systems and, in particular, in general practise where about 80 to 90% of consultations begin and end.

So if at this point in the healthcare journey we can ensure good access, we can ensure adequate time to build relationships, we can make good shared decisions and engage in all this proactive and preventive care. Then we start to see the benefits. But to achieve this, we need to see adequate support for primary care and this is where it gets hard because budgets are finite. So, again in one part of the system may feel like a lost in another.

In the short term, but in the longer term, I would suggest that that the outcomes will definitely improve. If we see primary care as underfunded, fragmented, overworked with exodus of its workforce, then we just can't achieve those things and we start to see health inequalities worsen. So, I think it's really important to think about how we meaningfully switch that balance and resource and enable the work that we describe to be done more out in communities so that we can start to address the inverse care law, so that we can start to apply the principles of proportionate universalism in terms of how we distribute resources to flatten the gradient and need.

These shifts need to be informed by high quality and equity, informed data and accountability framework so that we can know if we're getting it right. So, I guess for me, I'm really interested in in how general practice in particular can play this really vital role in addressing health inequalities. And there are three main things that I may just really quickly, one is how we build our teams and train our teams. So, it's about getting trained teams on the ground who are trauma informed, equity informed. Supported with the emotional labour of the jobs that they do to be able to do them well and compassionately.

As Gabe was saying, but critically also how we build teams that are designed to promote social inclusion. So, moving away from traditional models that are the doctor, the nurse and the receptionist to one that feels much more modern, inclusive and accessible, that has community, link workers, welfare advisors, care navigators, working on the front line and linking with communities. The second is how we design and deliver our services. So this is really, really important. Are our services accessible? Are they inclusive, are they sticky? Do we hold people in rather than seek to discharge people when they're not engaging? A terrible word, but that's one that we often hear. Are they culturally competent? Are they traumar informed? Are they Co designed with our community? So the way we design and deliver our services is also a key role, and I think how general practice can do a lot of this work. And then the third is how can we meaningfully use our influence and our advocacy potential to raise our voices on behalf of the communities that we serve, who often have no voice?

And there are lots and lots of practical examples of how we can do this well, which I'm really interested in exploring and sharing. So, I think it feels like we are uniquely placed to do this, have been able to do so because of the long term relationships that we have with people, the contextual care, the population coverage and the inclusivity of care because we don't need referrals into general practice and we don't discharge. So, I'm really interested in the key role of general practice and more widely the role of healthcare in addressing health inequalities that estimated 20% of the driver. Thank you.

### Michael Kellet

Hi, fantastic. Thanks very much indeed. And I was remiss, colleagues, I should have given our other panel members the opportunity to kind of respond to what they heard from first Gabe and now Carey. So, let's do that now. We're still trying to get Susan on the panel, but we haven't managed yet. Susan, again, my profuse apologies, but Gabe or Donna or Carey. In terms of what you heard from Gabe, is there anything stimulated by what you've heard from your panel colleagues that you would like to kind of ask or contribute at this stage before I bring Donna into answer her question.

### Carey Lunan

I'm genuinely really interested in how we ensure compassionate workforces, because I think it's such a key part.

Of what we need to be able to deliver trauma, informed equity, informed care and address health inequalities. Some of that is about accessing training. Some of it is about understanding how does stigma impact on the way that people feel able to access and accept care?

How do people who have experienced a history of psychological trauma make healthy, caring relationships? And we know that a lot of this is is very complicated to understand and it's not well covered in any of the training curricula for health or social care, both at an undergraduate or a postgraduate level. So I think a lot of it is about raising awareness and having access to high quality training. But I guess the thing for me as well is that we don't often then speak about how we create the conditions to be able to hold a lot of the emotional labour of working in a way that is trauma informed.

Because it's hard to do well and I think that often what can happen without the kind of safety nets in place, the emotional safety nets in place is that practitioners can become quite jaded. They can become quite burnt out. They can become quite unempathic because it's all very well doing the training. But what we also need is to have work forces and workplaces that allow enough time to unpick when things feel really, difficult or when things go wrong or when people feel criticised or angry or they get, you know, very distressed at what they're seeing.

To day work, so I think I'm really interested in how do we create these spaces to allow people to come together and kind of hold some of that and understand it and maybe they the options for reflective practise, which is something that I had the massive fortune to do for five years when I worked in homelessness, but it's not available to most people. So, I'm interested in that because I think it's a key enabler that we don't often talk about.

### Michael Kellet

Great. Carey, really powerful. And I mean, I've heard you kind of say that before, but thinking about it both from the frame of the person where kind of serving and they're kind of ability to trust the people who and the services that have been delivered. But ensuring that we support our people delivering those services, recognising the kind of support that they need to get really kind of powerful, Gabe, I see you've got your hand up. Do you want to come in?

### Gabe Docherty

Yeah, just saying what Carey was saying basically like, this needs to come from the top within organisations. We saw it with the early years collaborative with chief execs, you know, over the SECC. Basically, it needs to come through. So it's just continually reinforced is this is the right things to do basically and encouraged and praised. And that's the start of it. The bigger things that were raised there basically like the if it ever became dictator, I would actually say listen, we're going to actually have an independent commission to look at how do we actually support the whole of the public service forward into over the course of the next decade or so and effectively actually have almost a twelve year plan because it is like if you're in the factory of harm to get through, provide care, provide care, you're in a very, very lonely place. We've got to actually, refocus how we deliver all our services. I'll stop there.

### Michael Kellet

Great Gabe. Thanks very much indeed. Some really, kind of powerful points and some real kind of common threads running through what you've said Gabe and what kind of Carey's said. So yeah, we'll come back to these issues. I'm sure in the discussion that there's a bit of a theme there around kind of stickiness of our services. It's a pretty ugly word. And I think you said that, Carey, but how do we how are how are our services compassionate to understand the circumstances of the people that they serve and aren't kind of, as you said, keep demanding compliance before services can be delivered. So that that's maybe one thing that we need to think about. How do we support staff to do that? I'll move on if that's OK, colleagues.

We are still Susan, trying to get you in, but let me move on to Donna Hall and Donna invite you to answer your question and then again, we'll have a bit of a discussion before we go into the Q&A session. We've already got questions coming in, which is great. Thanks folks. So, Donna, as you know, the question we posed to you was:

## We know that interventions aimed at tackling health inequalities need to be sustainable if they are to lead to long term improvements to overall population health, what lessons can we learn from successful interventions today?

And we know you bring huge experience from South of the border from that and would be really, keen to hear that done over to you. Thanks.

### Prof Donna Hall

That's great. Thanks very much, Michael. And it's brilliant to listen to Carey and Gabe and I think a lot of what I'm going to say will hopefully resonate with their points because I totally agree 100% with their analysis. So, I'm a resident of the Scottish Highlands. I've been for the last few years. So although a lot of my experiences from Wigan, Chorley and the integrated care systems that I support. I live in Scotland and really I think there's some amazing work going on in Scotland too.

So, a little bit about to answer your question, I'll focus on a bit of a context. I think we underestimate just how broken public services are across the UK at the moment and the complete disarray that we find ourselves in at the moment in terms of our obsession with assessment and referral, that kind of impersonal, inhuman approach that Gabe has just outlined in the letter, we do that all the time. We're segmented, we're silo driven, the costs are going through the roof and we've lost something we've lost that humanity, the reason people become public servants, is to help people, not to continually assess people and refer them.

And what we started to do in back in 2011 in Wigan was we did some work with children whose families were really struggling and who were on the edge of going into children's social care. The age of being taken into care, and we worked out what we were doing collectively as a system to support them. We found we were spending between us. So that's the police, criminal justice, social care, Health, housing, mental health, drug and alcohol services. Everyone involved in the lives of those families.

And it was every year between us, between a quarter of a million and a half £1,000,000 per year, per family. And at the end of the year the most heart breaking fact was we had social workers in tears when we worked this out, they were in a worse position. Usually all the same position as they were at the beginning of the year. And we're spending all this money collectively 80% of our time on assessment. 80% of our time on measuring people against eligibility criteria.

Very often, telling people I'm sorry you're not bad enough to access this menu of services that I've commissioned for you. Go away, get worse, and then when you are worse, come back and I'II let you access my very tightly defined menu of things that I think you need so completely shifting the role of public service is what we tried to do in Wigan, completely redefining the role of the state and the citizen into a partnership arrangement. That's what the deal was all about. It was a new social contract between citizen and state.

We kept it really simple and really high level plan on a page. Every strategy was on one page. It was written with a reading age average reading age of eight years old, which is the average reading age in many parts of the UK, and we kept it really simple. We froze council tax for eight years to kind of help support people through the worst years of austerity and at the same time we said, tell us when we get it wrong. So this thing about compassion and humility, we're not right all the time. You know, as somebody with lived experience, some do you uses services, somebody who suffers from a condition, somebody who's homeless or with learning disabilities.

You know the reality of your life? We don't. We're just here to try and help often, and commissioning very often in ivory towers. So, let's really turn the whole nature of public services around and start to get back to being servants of the public rather than Commissioners of services and gatekeepers of eligibility criteria. I remember one I had at one point I was asked to run the Clinical Commissioning Group as well as the Council. And I was shocked, really, with some of the practice in there.

So eating disorder services, for example, we've told people if you didn't have a certain BMI, if your BMI was too high, you had to go away and get worse and then come back and then would help you. You know, what kind of place have we become, where that is our job to design services, to keep people out rather than supporting people and helping people to live their best lives. So, what we did was we we basically used an anthropologist to help us retrain everyone that we work with in ethnographic techniques and how to really listen to people.

And we did this thing called the B wigan experience, which was about values and behaviours of the workforce. It was very much around getting people to really reconnect with the person and the core purpose of being a public servant.

And we give people the permission to innovate in integrated frontline teams. We said go and do what you think is the best thing to support that family or that person or that neighbourhood or that community and work to support Andy Burnham in Greater Manchester. We had this thing called names, not numbers because we're obsessed with numbers, aren't we in?

In public services. So let's get to know the person where they live, which house they live in. Let's do risk stratification. Let's identify who needs the support before they need it, whether it's school readiness, an unplanned hospital admission, a fall at home, homelessness, debt, whatever it is we know usually what situation that person's in before it happens. And yet we just wait for crisis, for people to tip into crisis. So we completely change the way we work with people we invested over a 10 year period, 12 million in community and voluntary sector projects that weren't designed by us, but they were designed by people with lived experience, whether it was mental health.

Substance abuse, whether it was loneliness and isolation, obesity, and they designed with local community organisations, a different model. We funded 500 brand new projects to support people living in communities who needed that support and in the end of that ten year period, we managed to add an additional seven years of healthy life expectancy in the most deprived wards in Wigan.

And that was it at a time when everything was going the other way. So the King's Fund have written a really good evaluation of it. Lessons from the Wigan deal, a citizen approach to population health. And it was it was very much around the people was serving the people, an equal partnership rather than public servant, knows best and we'll tell you what you need.

Integrated neighbourhood teams frontline people working together. Forget your lanyard. Forget who you work for. Stop assessing people and passing people around. A fractured system help people support people, and very often the needs that people have don't fall neatly into a service. Very often the needs are social, environmental, community focused needs. So, let's help support people in the community to help people live their best lives. Let's focus on social care.

You know, councils across the UK at the moment to say there are only two or three children coming into children's social care away from bankruptcy. Why is that happening? Why are we sending people, children and young people with all this stuff in a black bin bag around around the country around the UK, saying basically, you know, this privatised service that we've developed while we're doing this hugely expensive, really terrible outcomes for the for the child and for the family.

Let's think of a different way, and really that's what I think needs to happen. So sorry that has gone on a bit longer than five minutes, but I'm going to show some slides at the end about some great work going on in Gateshead. I don't know if you've seen it called the liberated method. It's exactly what Carey and Gabe mentioned at the beginning. It's freeing up people to do the right thing and support people and it's system wide. It's not just one organisation. Everyone's doing it and they're going to show the use of the story of a guy called John at the end under key messages. And I think hopefully that'll bring it home to you. Cheers.

### Michael Kellet

Brilliant, Donna, thanks very much indeed. It's really impressive. I look forward to hearing about the Gateshead experience of I've read about Wigan. I've read the King's Fund report. It's hugely powerful and I think there's real lessons for us in Scotland to to learn from the approach you took there and just that stat about increasing heavy life expectancy in your most deprived communities by kind of seven years is is hugely kind of impressive. Thank you very much, Donna. Look forward to continue to hear from you folks. We've had to give up. And Susan, I'm really sorry that we've not been able to get you in as a member of the panel. My profuse apologies.

But I was keen and it builds on what a donor says, so this is the question that we had kind of that Susan was playing tip to answer but as unable to because of the technology but it builds on I think what you said Donna. So I wonder if Donna you or Gabe or Carey or maybe all of you have a view around the question that we had envisaged that Susan would answer at this stage which is around:

## How have grassroots organisations played their part in improving the health of communities at local level?

And I wonder if we should take that further and ask about your views about what more we could do to support grassroots organisations and I think the experience that you've just described of that investment in those 500 projects is maybe an example of that.

But keen to hear from the panel around those issues. Gabe, you've got your hand up. So I'll bring you in first. Thanks.

Gabe, you're on mute. Sorry.

That's another tenner in the swear box, but nevermind c'est la vie from there, Michael, I'll kick off and get what we've just saying. My apologies to Susan because I wouldn't do it any justice to what she would have done. Basically, from there, I'm thinking back in my time in the in the mid-80s, but basically the Strathclyde region, which effectively used to half of Scotland basically had, you know what community development workers you know effectively they're gone, you know from there. There may be a few, still surviving effectively like the volunteer sector has become a new way of delivery, basically. And I've got examples from my time in Lanarkshire. It's three in particular, but basically they've actually stood the test of time they survived for almost, you know, two decades and how they've been successful is because they've actually had someone at the top of that, you know the leads, who's actually got, it's just so sharp, you know, they kind of like, they understand the politics, they know how to establish relationships and they keep things going.

But I actually took the time to actually, you know, reconnect with one. And she said basically saying, listen, I'm spending most of my time chasing funding. You know, I'm not actually doing what I'm actually getting paid to do. I'm actually, trying to keep this, all alive basically. The I think one of the key challenges for us going forward is actually how do we recognise the, you know, the volunteer sector and the first sector that we want to deploy are actually just, I know, a part of our basically a public service. And how do we get away from the point of view of actually, seeing what every two or three years they're up to actually to get their funding renegotiated or whatever basically. So, I think it's a real challenge for us, as a system can actually see, we actually value and we'll make things happen. And I suppose the one analogy I look at see if we're trying to get a new clinical service and time and lands have a new clinical service was trying to get funded, they get put through the ringer. You know to actually to make the case. But once the case was made and the funding was approved, once that funding was approved, I was allowed to then go and deliver. It wasn't called back in two or three years time to actually to say what have you done basically. So we've got you actually starting applying some of these principles to how we're actually like support. You know, our colleagues in the first sector, I'll stop there, hand over to Donna.

### Michael Kellet

Great. Donna, can I do you want to come in at that point that you make a really good point, Gabe, around the amount of effort that third sector colleagues spend chasing funding I for a short well for a number of years actually was a trustee of a small kind of charity in Edinburgh North of Edinburgh called the Junction who support young vulnerable kind of young people around sexual health services but more kind of broadly and I got a real sense there of how much time the director in particular but her team spent resources to continue to fund where a real sense of frustration and that meant she her team weren't able to to focus on supporting doing the work they they were, they were really determined to do so. Some real lessons for us there. There's issues around multiyear funding. I know there as well which is a challenge for, for for everybody, right across the public and third sector. So no really helpful. Donna, Carey any kind of perspectives from you on that point around kind of grassroots third sector community. organisations.

### Prof Donna Hall

Go on, Carey. You go.

### Michael Kellet

Yeah, go and Carey.

### Carey Lunan

Really just to say that. Particularly during the pandemic, the really crucial role of grassroots organisations really came to the fore. And I remember well working in practice at the time it was right at the start of the pandemic. We were very concerned about the medically vulnerable, rightly so. But we'd sort of maybe slightly forgotten about the socially vulnerable, a little bit right at the beginning when we were doing a lot of the work around shielding and, you know, prioritisation of care. So, I remember being through in the reception area of the practise, speaking with the Community link worker in our Care Navigator team. And they were saying, we're really worried about the people that we're not seeing that we normally see that just come in because they're struggling. So this is, you know, the big part of I guess community based healthcare that is not about medicine. It's about more than medicine. And they were so crucial to kind of raising awareness around this missing group of people that we should be worried about. So we sort of made a list of those people and we contacted them just to say, are you OK? Do you know that the practice is open? Do you know how to keep yourself safe during COVID, how are things at home? Have you got enough food? Have you got enough heating? Are you feeling safe at home? Do you know how to keep yourself well?

And eight out of ten of those calls resulted in a referral either into the practice to see someone or to link into one of these grass roots. Community organisations and the role of the Community link workers were absolutely, key to this for us because it's really hard to keep up to speed with everything that is going on in a local community, particularly when funding is unsustained. It's short term and we don't always know if things are still available or not to people. So Community link workers for us.

They're the conduit to us for the kind of social support that's available out in communities and I guess my appeal would be sustainable funding for third sector organisations, but also sustainable funding for Community Link workers, particularly in areas of deprivation. There's been huge concerns around this in Scotland, as you'll probably know, we've got more than 250 community link workers in Scotland, most of whom are located in areas of highest deprivation. But their funding does not feel secure. And what happens then is that even if there are last minute interventions to put funding in. It creates massive insecurity and anxiety within the workforce and really, good people leave and these are people that have built up relationships with communities and practices over many, many years. We can't afford to lose these people. They are, I think, a real golden nugget and how we address health inequalities around linking people with organisations that support social isolation, domestic security, exercise, gardening, food security, domestic security, all of this stuff. So. yeah, that would be my my thought. Thank you.

### Michael Kellet

Thanks, Carey. You make a very powerful case and a particular community link workers and this one that I've seen the evidence of the benefits, the community link workers bring and I think it's an important lesson for all of us despite the financial challenges we face right across our public services. Donna anything you want to add building on what you've already said on this point?

### Prof Donna Hall

Yeah. I mean, I think it's because of the financial challenges we face that we need Community linked workers. You know, you think if we're not supporting people through community link workers, they're coming into the really expensive acute end. And that's much more. It's like three or four times as expensive. So, and that's what they've done in Gates. So, they've brought more generalist community link workers into the system to really work differently with communities. And it's it's essential that we do that. And I think very often, you know, we'll protect the acute, won't we at all costs to protect the acute when there's an overspend? Just give it more money.

And you know, so Greater Manchester where where I'm from, 180 million overspend in NHS Greater Manchester and they've just been given it. I'm sorry it's wrong, you know, that is wrong that, you know, we've got to think differently about the way that we deliver our services. I also think we've got to start to think differently about the relationship between the community and voluntary sector and public services. It is often one of suspicion. We don't really believe in them. We don't really think they're going to do a good job and we micromanage them to within an inch of their lives for, you know, a £10,000 grant, we spend more than they actually give in the grant on managing them and micromanaging them. And with that relationship is not one of trust.

So, we completely transformed that relationship through the Community investment funding Wigan, we believed in people of the 500 projects only two run away with the money and didn't deliver. So that's not bad really. And we got much more because of that relationship was one of trust than we would have done if it was one of micromanagement.

I think the whole way we buy in Commission and procure needs to be needs to be changed as well. I chair a social enterprise for people with learning disabilities and autism. And very often we we get invited to bid for things. But it's a very much a kind of you cannot talk about this bid, you will just have to put in a tender, no conversation about it and there's literally no conversation with anybody who actually has learning disabilities or autism as part of that procurement process. None whatsoever.

So they basically procuring in the blind spending money, wasting money on things that very often are not needed and not wanted. So, we've just got to completely change the relationship of public services to citizens that's at the heart of what I'm trying to say. And I'm so sorry Susan's not here because she's brilliant and she would have said it much better than we have.

### Michael Kellet

Yeah, I'm really sorry as well, Donna, but thanks for your contribution. We'll need to do this again, folks and get the technology right. So we can get Susan and and hear from her great, really important. So we've theme of trust coming out for me from the discussion so far. So trust in our staff and and those supporting serving the colleagues and people in our communities, but also trust between public services and third sector organisations as well, and what I'm hearing from the panel, was a strong sense of actually that trust is broken down in both those respects and actually part of the solution must be to to rebuild that trust.

So that's maybe something we can come back to in terms of the questions, folks, we're going to move on to the questions now. We've had a whole range of questions submitted and I'm really kind of grateful and I've got the kind of order here and I can see that they helpfully build on the discussion today. So what I'm going to do.

Is just articulate the question and then ask our panel for their views and whichever order they choose in terms of the question and we'll run this now till about just 20 past 11, maybe just after that because we want to give the panel members a chance to have a final kind of takeaway message. And you've heard a bit of a preview from Don already about what she might say about Gateshead, which sounds really interesting. So I want to protect time for that. So that's where we're going to colleagues.

So let me start with the first question and it really builds on the discussion we've just had about the important role of the third sector and grassroots and community organisations.

So the question is, the third sector is deeply concerned about the impact of the Scottish budget as it filters down to community groups, volunteer organisations at the heart of tackling poverty, inequality and sadly, destitution. We fear the loss of critical Community infrastructure.

## How can we get national and local decision makers to understand this and the damage likely to emerge? So who would like to kick off on that topic?

### Donna Hall

I think it should be the other way around. I don't think it should be down to the community and voluntary sector to make the case. I think it should be down to Scottish Government and decision makers to really look at the: What will happen if we continue as we are? If we continue to cut services that are community and voluntary in focus, it's a huge investment in prevention to fund the community and voluntary sector and it pays back tenfold in my opinion, probably even more than that.

And again, you'll see from the end of some of the stuff they're doing gets it. And what we did in Wigan and what happens in parts of Scotland too is people who invest in the community and voluntary and third sector. It pays back, you know, financially and in terms of outcomes. So, you know, why would you not do it? People might do it because a bit like the UK Government, they cut local government because it's not them and it's easy to do it. Sometimes, I think we all do that, don't we? We cut people are not us and pass the burden on. But it's it's absolutely a crazy thing to do to cut the community and voluntary sector. Just does not make sense at all.

### Michael Kellet

Sorry I had my mute off. Brilliant Donna. Thank you. Gabe. You've got your hand up.

### Gabe Docherty

Yeah, a couple of points in this. One, can I make a manifesto commitment from the government, you know, Scottish Government for the world class public health system. You know that that was kind of taken around the time of, you know, like the pandemic. Basically, from there the reality is like, how do we make that case? And part of that case is actually what actually have is a fully funded, you know, like voluntary sector to be part of that world class public health system? I know it's really challenging. But through austerity and everything else basically. But we've got to keep making that case it might not happen just now.

I remember a story was doing the MPH. It was a retired DPH was talking about the history of the Chief Medical officer. I think it was called that in Glasgow basically and effectively everyone who actually called for the slums to be cleared got sacked. But what actually happened? The person that came after them actually, cleared the slums, you know, from there. So, reality is what we've got to do is we've got to continue to make that case. And at one time we'll find the right conditions to make that actually happen. But I'd really do believe we'd really need to actually reconfigure how we deliver all our services software. I'II stop there.

### Michael Kellet

Great. Thanks, Gabe. And can I just take the liberty as chair of I'll bring in a set carry of of of saying from a public health Scotland perspective we think part of our role as the national public health body for Scotland as being that advocate being that advocate for the power of investment and prevention and community and grassroots organisations. And let me just reassure you that that's something we are doing, we do it kind of publicly in terms of some of our publications we published really important, we think work on the value importance of prevention over the last year or so in Public Health Scotland. But in terms of our discussions with government and with opposition parties across the Parliament. We are seeking to make the case about the importance of that investment in prevention and Paul Johnson, the chief executive, and I were in discussions yesterday afternoon at the Scottish Parliament with I will tell you who, but with, opposition MSPs making precisely that case and and to be honest, we all kind of sympathy there amongst. All the parties are in the book, but we need to see politicians nationally and locally deliver on that. So I want to be clear, we recognise in Public Health Scotland our role and being that advocate for the understanding of the value of that work. But Carey, I'll bring you in and then Gabe, you get another shot and then we'll move on to the next question.

### Carey Lunan

Thank you. I think this is a really important question because I think this kind of gets to the nub of what can we do and how can we do it, which I think is often where we often end up landing at the end of these discussions. And it can feel a bit overwhelming and a bit hopeless. So, I think it feels to me like there are two sides to how we tackle this. One is from the ground and I guess maybe one is I don't think from the sky is the right part of the metaphor, but one from the ground, I think it's important.

I would agree with Donna. It's not really the responsibility of the people that are delivering the service to be able to make the case for why their service is important. But I do think that there is real power in community organisations, health organisations, voluntary sector organisations all coming together with a collective voice to say this is what is happening by removal of these services. So, I'm particularly, you know, interested through the work of the the deep end and the work that we've done that has been collective lobbying.

For example, around the removal of Community link workers or the threatened removal of welfare advisors, which are another really, key role of how we ensure social support and practises. Having welfare advisors and practices. So, I think working together to make the case both by clever use of data collection but also narrative which I think is often missing from discourse within government, this is how it feels on the ground. Stories from the front line. Anonymised of course, but this is how it impacts on real people's lives on real families and then using our collective voice, whether it's through parliamentary petitions, whether it's through inviting MSPs to visit practices or visit places of work out in the community, whether it's through effective lobbying and advocacy work. So there's a lot of stuff about this on the on the Deep End website. And then I think from from the other side of the coin, it's ensuring that that we have meaningful accountability frameworks for what we say we're going to do within government translating into what we actually do and then understanding whether or not policy is actually making things worse or making things better. So that meaningful data collection that then drives improvement or change of direction as well. But also making use of the existing legislation and duties like the fairer Scotland duty and various other pieces of legislation that very specifically talk about the role of public services and lots of other parts of the system in addressing health inequalities. I'm not sure that we make the best use of that or that we use it to its full power. To challenge the decisions that are being made. So I guess it's from both sides.

### Michael Kellet

Great. Thanks, Carey. Gabe

### Gabe Docherty

Michael, just very, very quickly. See, don't want to talk about a sum of 12 million. See what we're talking here in the first sector seem to use one of my favourite phrases is washers, and the scheme of things is absolutely washers in terms of what we're actually talking about here. And I'm sitting on a cross party Commission, you know, looking at 7030, the prevention of abuse to children, basically. But what do you something like 4 to 6 billion? That we could actually save the Scottish economy, if we actually could have got this this sorted basically. So we've got to be pushing on this to actually value for money for actually invest in this and the returning the money is phenomenal. So, what I got social returning investment we've got to make that case. Thank you.

### Michael Kellet

No. You can tell the man from Lanarkshire using washer. I would call it pennies. But you you're absolutely right. You make a really strong point. I just want to write very quickly to to one of the things you said Carey, because I think that point around how our policies framed how our duties on public bodies.

Do they support us and tackling kind of improving Health Equity, one of the things we are doing in, in public health Scotland is working both with Scottish Government and with Sarah Boyak MSP on. There are kind of competing bills around well-being and sustainable development, and one of the ideas and both the bills that we might have a future generations Commissioner equivalent to the one they have in Wales, in Scotland. And that's really for me, I suppose our own systematising that longer term approach about systematising that focus on equity and tackling inequalities and one of the things we are doing. And Public Health Scotland is advocating for, that approach kind of publicly and across the Parliament, but also practically trying to help both Sarah Boyk and her team and the government team who are thinking about those bills. So more on that because I think there is something around how do we make sure public sector and its duties support putting health and well-being at the centre of everything we do? So more on that. Let me move on to the next question. I'm going to kind of change it up in terms of I'm not sure if they all just been kind of published, but I was keen to get into some of the questions around kind of the social determinants of health that we maybe haven't spent a lot of time and there was a question which I thought is quite difficult actually, but I wonder if it might help gets into that space. So with apologies to the panel, I'm going to go to that.

A question next which is Question seven on my list.

## So the question is, what are the panel's views on the extent to which addressing health inequalities in Scotland requires a focus on economic factors and on economic policy systems change, at a wider society level versus or perhaps as well as a focus on supporting those who are most disadvantaged.

I think that gets into that social determinants of health question. I'd be very keen to hear. If the panel had views on that question, who would like to kick us off?

### Gabe Docherty

Michael, can you give us a question again, please, just so I can.

### Michael Kellet

Yeah. So what are the panel's views on the extent to which addressing health inequalities requires a focus on economic factors and economic policy systems versus a focus on supporting those who are at most disadvantaged, I'm not sure it is a versus my own perspective as we need to do both, but I'd be keen to hear the panel's perspective on that question. Donna, I'll bring you in and then Carey, thanks.

### Prof Donna Hall

Yeah. Thanks, Michael. I think it's a really good question because I think often the two are done separately. You know, initiatives to address economic development are completely separate to initiatives to address Health and Wellness. And I, but I think as Carey said at the in her introduction, the two are intrinsically linked with poverty as a real defining factor, and looking at the Marmot recommendations, you know all of the things that Michael Marmot says that we need to do. I've got an economic link to them. There's a really good piece of research that's just come out. It's all. Oh, no, there is a they they did use a part of Edinburgh as part of the research IPPR Institute of Public Policy Research came out was launched on Monday. I spoke at the launch event with Andy Burnham and Norman Lamb.

It was basically recommending the creation of health and prosperity improvement zones across the UK, where the two pieces of policy come together and we work differently to support people. One of the best things we ever did in Greater Manchester was we did this thing called working well the Andy introduced where basically we use primary care GPs as the main kind of trusted. I think GPs and schools are the most trusted public servants in the neighbourhood. So well done, well done, Carey and Gabe, you are most trusted than anybody else. Councils are not trusted, really, DWP are not trusted. And what we did was we we looked at people who are long term unemployed and asked people to go for an appointment.

For the GP and let's do some more intensive work around the reasons behind. You know what illnesses you have? How whether it's mental health and it usually was, how we can support your back into employment, the success rate of getting people back into work through that, you know, linking economic development, linking DWP and linking primary care was amazing. So, more initiatives like that that bring the two things together and not just creating job opportunities that we expect will trickle down to the poorest part of Scotland and the UK because it doesn't trickle down. We all know that.

### Michael Kellet

Thanks, Donna. Really powerful Carey.

### Carey Lunan

So, I would agree with everything that Donna has said and what you said, Michael, at the beginning, which is I don't think it's an either or. Of course, we need to address the social determinants of health. It's the biggest driver of health inequalities and when you look at poor health outcomes, they very closely mirror poverty. So we can't not address poverty because poverty impacts on people's choices, the ability to have their voice heard, their ability to navigate complex systems and just live well and live healthy, fulfilling lives.

So, we need to focus on that as a bigger picture thing. But we also need to think closely about how we ensure that our healthcare systems are doing their part. Their estimated 20% impact on health inequalities. And it goes back to a lot of the things I was saying at the beginning in terms of how do we make sure that our healthcare services are at their best, where they're needed the most? Because if they're not, then they will actually worsen health inequalities. So, if we have a system that is, it doesn't have resources matched according to the needs of its local populations.

Then some people will be able to better make use of services than others. And we see health inequalities worsen, so we need caution around lots of different things. In modern healthcare like remotely delivered healthcare, like healthcare, that requires people to travel a great distance or read lots of material.

At a reading age, that makes it difficult if health literacy and functional literacy levels are low. Appointment systems that come out just insecure postal addresses, and it's two strikes and you're out, and then you're off the waiting list and you are back to square one.

We have systems that are really not designed for the people that need them most. They're often designed by healthy people for use by healthy people, and they're not designed for the people that need them the most. So, in terms of supporting those who are most disadvantaged, I think there are lots of discussions ongoing at the moment about whether we target certain cohorts of, of people with more support, which has some advantages or whether we apply a proportionate universalism approach.

Which is where we maintain the founding principles of the NHS, so that there is universal coverage, but that resource is then matched to the level of needs. So it's about flattening the gradient and in many ways I think that feels like a a fairer way that is harder to argue against and is less stigmatising than saying you are getting this because you are homeless or because you live in a in a certain type of community. So, I think it's both and I think we need to be careful about how we match resource according to need and using the language of fairness which is difficult to argue against.

### Michael Kellet

Great thanks Carey.

Gabe, your perspective would be really helpful.

### Gabe Docherty

Make other is what done in New Zealand about 12-14 years ago and I don't understand the New Zealand system but it's a kind of crazy kind of like private, you know, like mix between public and private sector basically. And what they do is they get actuaries to come in to actually look to see where we going with this. And they looked at one area was like adverse childhood experiences and effectively like the expectations or spend on a person up to the age of 35. If you didn't have any, it was like somewhat 35 Kiwi dollars.

See, we had four adverse childhood experiences, they explained was something like 235,000 you know like Kiwi dollars and what the actuaries is the money men and money women basically says you cannot afford to go in with this. You need to actually start to do things that actually try to prevent these things. So, the reality is that I think Donna actually said that we can't think of these in isolation these got to be actually quite intertwined you know got to actually look at that and that way and maybe that's how we build the arguments going forward.

### Michael Kellet

Great. Thanks very much, Gabe. So, a bit of a consensus there amongst the panel that one of the things and when we think about health inequalities. It's tackling the social determinants of health is really, important. And that's certainly something we are pushing hard and public health Scotland and that work and prevention I've talked about in our kind of a general approach, but also thinking about how we support the people who are in a most deprived communities or most of a lot of help, and I think it's it's not an either or it's we need to do kind of both. But that focus on primary prevention being a really strong point that made and that IPPR report that you described Donna sounds kind of really interesting. It almost feels folks if we need to do a bit of a bibliography kind of after today that we can share with participants about some of particularly the kind of evidence that you've described kind of Donna. So, we think about how we best package that and make that easily available to folk alone. We can clearly do kind of Google and access it for themselves, so thanks really helpful discussion.

Let me think of the next question. I've got a question here that I liked and I'm not going to ask the person and I don't know who asked this, but it's a personal question and the person asking who's anonymous discloses a bit about their background, but I think it's a good one. So the question is:

## As someone who's old enough to have worked in the old Community health projects. In fact, the original Ferguslie Community Health project back in the days of healthy cities. Do we think that's a model that we should revisit and seriously consider?

Donna, I'm not sure. I'm aware you are of those kind of models, but I'm pretty sure Carey and Gabe will be aware of them. And do we think that that's an approach that we should revisit? Any views, Gabe, I might come to you first if that's all right. I imagine you, will know about those approaches.

### Gabe Docherty

Yeah, it's going back. Way back basically from there. I think these type of approaches we need to take and I suppose one of the points I was hoping to make in this this kind of like you know seminar basically was like. We're very good in Scotland at doing what I would call individual dosages. So, we do one bit of work, we evaluate it and we show it works really well and all that good stuff from there. But what we don't do is we don't do that industrial dosage across the whole of the country.

So you know, it could be Eldeslie, it could be Glasgow healthy cities, it could be the Wiggin stuff that they were doing, you know, like talked about from there. What we need to do is do this actually, across the whole country. We've only got a really small population, basically. Why can't we actually drive that whole approach across the whole of the country and then make that difference. I think the real challenge is basically what we do is short term funding. We find a reason to ration it and basically we do that basically. And then we cut it off and then I think, you know, like you know, Carey talked about it then.

Do at the very start of this we loose communities because we've done all this work. We've raised all these expectations and we say, oh, sorry folks, we're off and it really, really gets the community basically from there. So I I think like we've got to learn from the past done these things. We're sure they've got potential or they're working basically. And then we just walk away from them. We've got to stop that cycle. I'll stop there.

### Michael Kellet

Then goes back to Carey's point earlier about kind of pilotitus and how that breeds mistrust and lack of progress. Donna, any kind of views from if you get a sense of what we're talking about here about kind of from your experience.

### Donna Hall

Yeah. No, I totally agree. I think that the two things that the Kings Fund said about the work in Wigan was the first thing was it was clarity of purpose what we were there to do as a partnership, what was the job of public servants and how do we work with citizens. It was dead simple, dead clear and consistently as Gabe said, driven through everything. Every single person went on this Be Wiggin experience. Everyone is a public servant working in the place did went on this values- based training around courage.

You know, supporting people differently and innovating. And then the second thing the Kings Fund said was it was constancy of purpose. So instead of keep chopping and changing as Carey and Gabe have both said, having new initiatives, new plans, new strategies, we stuck with it and it's still going on now. I retired a few years back, but it's still going on because it's by the people and it's about the place, not about the individual ego of the leader who's in that job. And I think we tend to find that you get a little pot of money. My background is policy and strategy. I've written hundreds of the blasted things.

Some of them have worked except this one because it describes a relationship. It describes a relationship and it's really clear and it's just you stick with it. You don't keep changing and create a new one when you get a new leader. I did some work with Birmingham a couple of years back and they had, I think something like four chief executives in four years and they had four different strategies and no one knew what they were doing. You ask anybody who works in Birmingham, what is our strategy? They haven't got a clue. So a strategy isn't the strategy if people don't know what difference it makes to the way they work.

### Michael Kellet

Great. Thanks Donna. Carey, any perspectives from you, I mean, particularly given your work in GP practise largely support in in areas of kind of multiple kind of deprivation about what what you've seen that works kind of I suppose I mean you've described very powerfully today and I've heard you otherwise in terms of what works in terms of your approach to primary care. But what works more generally in terms of the communities that that you have been a part of and worked in?

### Carey Lunan

So I don't actually remember healthy cities. So I would be lying if I was trying to give an informed opinion on that, but I would agree with everything that's been said around the principles underpinning. If something is working well, we need to capture the essence of that and sustain it rather than keep reinventing the wheel and eroding trust and morale and sense of purpose and all of the stuff that we've we've talked about.  
I think when I was listening to to Donna talk about the Wiggin deal, which was so pleased to be able to hear from her first time because I've read extensively about the Wigan deal and just think it's amazing.

Some of the elements of the essence I guess feel not dissimilar to the Govan ship project in Scotland where it was a three-year funded pilot. It was based in Govan in Glasgow and it was about integrating genuinely integrating on the front line, healthcare and social care and other organisations including third and voluntary sector for the most vulnerable families who tended to present the most frequently across multiple parts of the system, and no surprise if you bring people together, people all have their knowledge of the families that are vulnerable. But they don't always join up the thinking around it because they have different databases and different systems that they're working within. But if you create the time for professionals to come together to talk about the families they're worried about to bring together the different data they have to do some proactive care planning, to think about what might actually work well tailored for this family to try and support them to stay well.

And have a more preventative and proactive approach. It makes a difference and it's again, it's about the the essence of just the things that we know well, which are about, I guess, protecting the relational elements of care, whether it's care within health or care within a community setting or care within social services. We don't. I think we're going back to what we said at the beginning. We're kind of in peril of moving away from that more than we realise because we become so embroiled in targets and paperwork and doing things online that we forget how powerful it can be to just come together and have a conversation and hear directly from someone about what it is that really matters to them. And we talk about it a lot, but we don't do it as much as we should and it's what makes the job feel fulfilling and it's actually, what reduces burnout, I think for many when you feel that it's what is working well.

### Michael Kellet

They carry really helpful carry. I'm going to ask you a question when it's it's a bit cheeky, so please forgive me if, but I've heard you talk about powerfully about what you've done in Craigmiller in particular. And I suppose when I think about the approach that Donna talks about. It seems to me that's around in any individual community or kind of neighbourhood. GP is like you and your kind of colleagues coming together.

### Michael Kellet

But also with the school, the head teacher in that area, with perhaps the police that are working in that community and other public services too. And I suppose my question for you is, does that happen in in relation to Craigmiller for example, or other areas that you've worked in. Is this or something that we need to think about in Scotland whether that's going back to healthy cities or neighbourhood, whatever the kind of label is that allows that and part of the reason for massing carrying, I don't know if we've described this to you, but one of the pieces of work we think is quite a glimmer for us in public Health Scotland is what we are doing to support secondary schools and giving them bespoke information is not generic information but bespoke information about the health and social care needs of the community that they are operating in. And the kids that they are supporting. And I'm just wondering if we're doing that kind of join up enough in your experience or is that something we need to think a bit more radically about in Scotland? Sorry Carey. Hopefully that makes sense.

### Carey Lunan

No, no, it absolutely does. And I think that certainly those types of inter-professional relationship building opportunities were something that we talked about a lot in Craigmiller.

Did it always happen? No, and it wasn't because we didn't want it to. It's because we literally spent all our time firefighting demand. And that is the inverse care law in action. It's a very busy practice. It's, you know, underresourced for the level of need.

On it's very difficult to kind of get your head above the parapet before 8:00 o'clock at night to then think, oh, it would have been really, good to engage with the local school today. So, but I think that when it has happened and it has happened at points over the years when we've had, you know, we've tried different ways of working. So for example, we had a community, sorry, a primary care mental health team, of nurses working in our practise. At one point we had three and we were doing some really fantastic interface, working with the local high school which really struggles with its attainment and also really struggles with the mental health of its pupils. And so we were seeing a lot of the same people and our lead mental health nurse Kat, who was absolutely phenomenal. We'd go over to the school in a reasonably regular basis, just check in with the teachers and do some support work with them, almost like reflective practice with them, but also make sure that we were using common language and common advice around well-being and mental health for students and young people when they were presenting either to us or to the school. But also along the way, building relationships with the school, which felt really powerful.

I think that the third sector, our link is Community health community link workers with the third sector. We would love to have more time. We've run events in the practice where we've invited third sector in to come and have stalls in the waiting room and invite patients in and just have discussions about Community assets and building health. But we would love to be able to do it more as with most practices because it's the sort of thing that gives you joy. But I think that there are also some really great examples in other parts of Scotland where there are meaningful, lived experience groups that have been established. And this for me is key and it's really not done well. Not because people don't want to do it because it's hard to do and you need to put a lot of time and emotional effort into making these groups work really well and feel supported and feel heard. But the chance to change group in Drumchapel is a fantastic example of a meaningful, community connection group that has really influenced how the practise runs and is actually also a lived, experience group with Scottish Government influencing policy making and primary care, which is which is great. So, I think you know, there are some enabling things that we need to think about how we make that happen, maybe having a Health Equity champions in general practise. Looking at how we manage workload, how we resource that time to free up like the Govan ship model to have those conversations. And some of the work that's being funded in Glasgow, at the moment, which is part of a pilot called the Inclusion Health Action in general practice, which is just giving a little bit extra resource to practice, to do things differently. And one of the streams in that is community engagement. So, there are there are there are lots of there's, there's a reasonable evidence base of what works. It's just making it happen and a more sustainable way. Sorry, that was too long.

### Michael Kellet

Thanks, Carey. Really helpful and thanks for responding so eloquently to a question you weren't expecting and I think I should have made that point around that the Community themselves lived experience bottom up rather than top down. There's no good professionals coming together so even if their relationships are really good. If the community aren't involved, great. I'm going to ask one more question. I'm going to give you a minute. Each panel members, it's a really, tricky question. So apologies again and then we'll go into the wind up and and give you a chance to give your kind of take away message. So it's a bit of a I'm changing slightly the question but the question for each of you is.

## What concrete action should Scottish Government, NHS Scotland and PHS, so please feel free to point this at us take to address health and healthcare inequality, so maybe one or two from each of you concrete things that you think government, NHS Scotland and PHS should be doing to improve Health Equity.

Gabe, I'll go to you first.

### Gabe Docherty

Please, in a minute

* One: when cross party get cross party support.
* Two: ban short term funding and then
* Three pick the big ones which are going to actually make a difference and do them on a universal scale and do not allow the one pilot to be used.

Stop there.

### Michael Kellet

Great. Under a minute. Brilliant. Donna, do you want to go next?

### Prof Donna Hall

I think build an evidence base of where investing really pays back well, and that's bound to come back to the link workers and community and voluntary sector, third sector, you know, really look hard at where cost lies, don't just cut things because they seem easy to cut because that's going to have a negative impact on demand. It's going to come up elsewhere in a much more expensive bit of the system. And as Gabe and Carey have said throughout, stick with it, have it as a long term, multi- agency strategy.

Across health boards, across local government, so it's everyone working together for a long time period to do it.

Brilliant thanks Donna and Carey.

### Carey Lunan

Can I just say what they said?

### Michael Kellet

You can.

### Carey Lunan

So yeah, what they said, I think national leadership on health inequalities, so that there is kind of clear. Cross sector knowledge and accountability of what's happening because I think often it feels very siloed would be good, making sure that we make the best use of the legislation and the statutory duties that are out there, making sure that we do meaningful impact assessments before things are rolled out.

Increasingly that we monitor and evaluate them for how they are working on the ground and thinking really, carefully about the decisions we make about healthcare, that 20% coming back to that, how do we make sure our workforces are in the right place? How do we make sure that they're trained and enabled? How do we make sure they're socially inclusive? How do we prioritise the work that is done? How do we design and deliver our services so that they are accessible inclusive, low threshold, high fidelity, they hold people in their sticky.

### Carey Lunan

Just a few.

### Michael Kellet

Great. Thanks, Carey. Gabe, do you want to come back briefly?

### Gabe Docherty

Very quickly, Michael, if we got it, what should be key in this? It shouldn't be predetermined. It should be going to communities and saying what matters to you and then what matters to you is where you start from.

### Michael Kellet

Great. Thanks very much, colleagues. Prompted by what you said around national kind of leadership, Carey, I'm. I'm. I'm absolutely kind of with you and there's something that surprises me and this is a bit of a personal. So this is not phs speaking, but.

We sometimes describe the health inequalities we've discussed today as Scotland's shame and and I think that feels right. That's the right language given the extent of them and for me sometimes and I've got part of this because I'm a kind of leader in these systems, I wonder why it's not the subject of more kind of national political debate about the extent of those health and inequalities. So that's again something when public Health Scotland, we're trying to kind of make the case for. So brilliant. Thank you very much colleagues, so this us we're coming to wind up now, colleagues and what I want to do is give each of the panel.

In turn, the opportunity to give their kind of key message. We maybe have the bit of that already, but if you want to see anything more. Donna, I'll ask you to go first because I think you've already said that you might have a slide or two to share and then I'll come to Carey and then Gabe and then we'll wind up and get finished on time. If that's alright. Donna, over to you.

### Prof Donna Hall

Yeah, that's great. This is the inspiring work that they're doing in changing futures, Northumbria, absolutely, amazing work and if anybody's interested in finding out more about it, there's loads of podcasts and interviews with this brilliant guy, Mark Smith, who's the director of public service reform at the Council. But this is just to answer the question that the person asked in the chat about the evidence base for investment in the community and voluntary sector and in a different type of model.

An investment is something that's not reactive, that is proactive, that's preventative, that's community based. That is social as well as being medical, so I'm just going to show you a few slides. Mark, if you can put up the first slide. This is a guy called John, not his real name. He is a resident of Gateshead.

And this is his journey through public services over a 10 year period. So this is the ambulance call out and acute system response to John, all separate, all siloed. He was going into A&E more or less everyday access in mental health support more or less everyday. Nobody was helping him. It was all assessing him against eligibility criteria. He was being arrested on a regular basis. Again, no one actually, working out why that was and what the root of the cause of that was and the overall cost was £2 million for one individual in public services in Gateshead. This is the evidence base about why we need to change. This is where all our money's going. So, people say we need to make savings, you know, don't cut the voluntary sector cut that ridiculous way of organising public services.

And also more heart breaking, heartbreaking than anything is all those opportunities to help him that we missed to really help him by building a relationship with him and what the liberated method does. And Gateshead is freezer frontline teams of people to work differently and support people in different ways. Go in, help them clean the house up. You might think that's not the role of a public servant. Well, yeah, if it if it helps him regain his sense of perspective and pride, then go in and clean the house up.

Go with him to do some shopping. Help him with his budgeting. Help him support him in a different way. And that's why, you know, often need doesn't fall within a need service category. That's a Commission service need is social. Brilliant. Thank you.

### Michael Kellet

Thanks, Donna really powerful. Carey, your takeaway.

### Carey Lunan

Thank you. I've probably said quite a lot of it, but I guess it's just about maximising the role of healthcare to address health inequalities by meaningfully addressing the inverse care law, which has now been around for more than 50 years and is not getting any better. Where access to care is poorest for those that are most in need, and we see people missing within our systems. So people who serially don't make or don't turn up to appointments. Don't make use of healthcare. Particularly if have a mental health diagnosis, have a huge increase in their rates of early death. So the people that we're not seeing and not hearing from are the people that we should be most worried about. But our systems are not designed to search them out and support them. So, I think it's just thinking about the inverse care law about missingness, about maximising the ability of how we design and deliver our systems to address health inequalities.

Genuinely, shifting that balance of care out of the most expensive part of the NHS, which is A&E and hospitals out into the community so that we can start to more meaningfully, build resilience within community-based settings, not just within health but with our communities and with our voluntary organisations. So, that we can create a different kind of healthcare that feels more socially inclusive that has more time within it to build relationships of trust and support well-being and enable a different kind of conversation and one that is much more proactive and more kind and socially orientated.

### Michael Kellet

Thanks Carey. Much appreciated. And last but not least, Gabe.

### Gabe Docherty

Yeah, Michael, we started with the data about healthy life expectancy having been 44. One of my colleagues led homeless needs assessment, in Lanarkshire a few years ago and actually life expectancy of people who are chaotic home was I apologise when using the term was actually less than that. We're almost actually in Victorian times you know of life expectancy basically. So that's just a we take home from there.

To quote Andrew Fraser inequalities are unjust and avoidable. That's number one basically. We need to go for industrial dosages in terms of the response, we've got to get away from the short term pilot. Do this basically from there.

I would really beg for actually economic evaluation going alongside it basically, 'cause I actually think we could actually show, really quite clearly you know what the contribution that is to society by actually doing this work. And then the last thing it's got to be sustained. We've got to get out of this cyclical change. You know, in difference of up, you know like policy or new projects or whatever. I'll stop there.

### Michael Kellet

Great. Gabe, thanks very much indeed, colleagues. I'm really conscious of time. We're almost out of time. I want to say thanks particularly to the panel to carry to Donna and to Gabe for sharing their thoughts with us today so eloquently thanks again to Susan. and apologies to Susan that we weren't able to bring in Susan, I'm really, really sorry that that didn't work out for us and for you. It's our kind of loss. So apologies again and thanks to everybody who's joined thanks to the team in PHS who've who set this up.

The one request colleagues, as we hopefully posting or have posted a link to an evaluation in the chat, if you could complete the evaluation, that would be really helpful in ensuring we understand how this was for you today. But how we can better shape such experiences going forward. So with that, colleagues, I'll let you get back to the rest of your day. Thank you very much indeed. It's been a really thought provoking but hopefully energising session about tackling health inequalities. Thank you.

[End of transcript]