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Inequalities in Primary Care,

A review of existing frameworks

Version 1.0

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Inequalities in Primary Care: A review of existing framework

Summary

Research Question

What frameworks exist to reduce health inequalities within primary care?

Why did we do it?

Despite numerous attempts to tackle health inequalities, they still exist and in recent years have been growing in the UK and Wales. Although the drivers of health inequalities extend beyond healthcare, the health care system plays an important role to address inequalities. Access to and the provision of healthcare based on need is often referred to as 'equity'. The World Health Organisation emphasis the primary care is vital in addressing health inequalities through equitable distribution of primary healthcare services.

Primary care in the UK is often considered one of the most equitable healthcare systems globally. The National Health Service (NHS) provides nearly universal access, with about 90% of the population accessing primary care services each year. These needs based, free at the point of contact access is a key factor in the NHS's reputation for fairness and equity. However, there are ongoing challenges and opportunities to improve equitable delivery of primary care and reduce existing health inequalities in outcome.

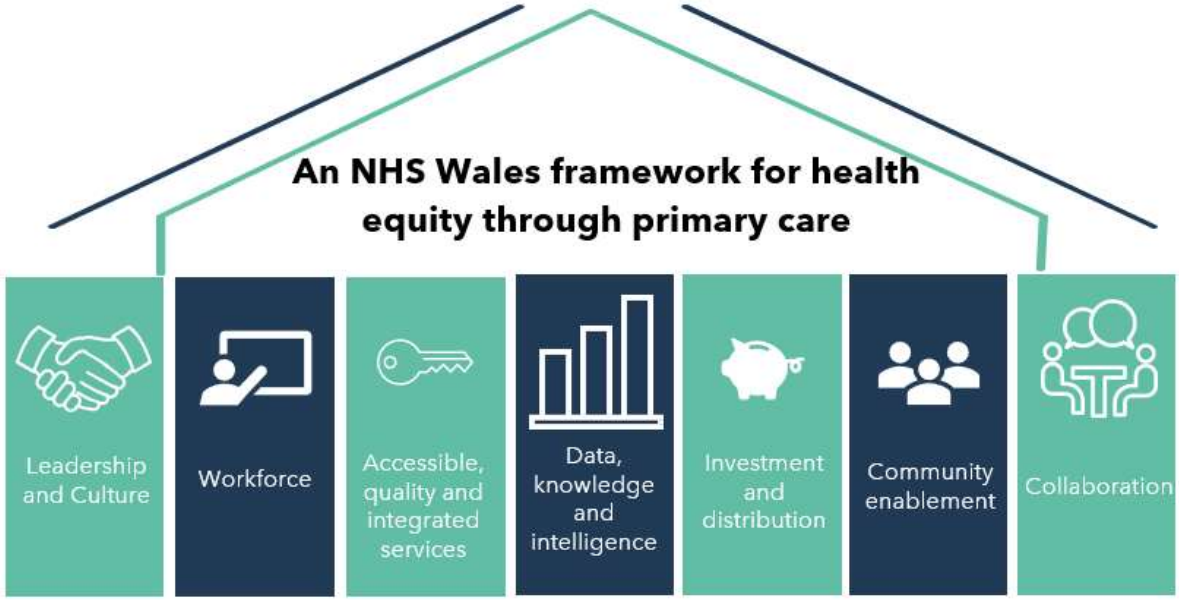
To understand and develop an action plan to illustrate the impact of primary care, we reviewed existing evidence regarding how others have tackled this issue. What frameworks are available, and what common areas of action have already been identified.

What did we do?

We undertook a rapid systematic review of grey literature and spoke to key health professionals in Wales, England and Scotland including the authors and leads of some of the developed frameworks in England and Scotland. We carried out searches on Centre for Disease Control (CDC), Department of Health (Ireland), Department of Health (Northern Ireland), Department of Health and Social Care (UK), Health Equity Evidence Centre, Improvement Cymru Academy, Institute of Public Health (Ireland), Kings Fund, Local Government Association, National Institute for Health and Care Excellence (NICE), NHS England, NHS Confederation, NHS Scotland, NHS Wales, Public Health Agency (PHA), Public Health Scotland, Public Health Wales, Scottish Intercollegiate Guidelines (SIGN), Social Care Institute for Excellence, the Health Foundation, and the World Health Organization. A total of ten frameworks and reports were included after eligibility screening.

Key findings

There exists a wide range of frameworks focusing on health inequalities, but few focus on primary care. Applying inclusion criteria, we identified and reviewed ten frameworks, one operational framework specifically targeted at primary care and nine with a wider lens but relevant to primary care. Combined with the expert views the following key action areas were identified:



What does this mean? Our approach examined diverse range frameworks with common enablers to help address inequalities in primary care by focusing on identified themes and incorporating insights from professionals in England and Scotland. Our findings on priority areas for action are consistent with numerous current frameworks in the UK, including the health and quality standards framework, indicating that interventions in these areas could help to establish an equitable and high-quality primary care system. However, how these would look like in practice and who needs to take them forward needs further consultation with key stakeholders in Wales to co-develop an action framework that is relevant to the Welsh primary care context.

The table below provides a summary of the key findings.

	Leadership and Culture	• A strong collaborative and inclusive systems leadership and accountability on health inequalities[4-5,12,13,14,16,16] • strengthening national leadership for health inequalities including considerations for a health inequalities commissioner, and a coordinated cross departments and organisation efforts, led by cross- portfolio leadership and accountability[16.] • leaders to explicitly prioritise inequalities in organisational, and teams planning and strategies. It should be well communicated to staff[15,16]. • Assign named leaders and champions, giving responsibility to a board, or working group to drive work forward within teams and organisations[11,15.] • **Integrate equity in all regulatory activities to foster a culture that prioritise tackling health inequalities[15,16]**
	Workforce	• Develop schemes to promote the recruitment and retention of local staff especially in disadvantaged areas. Composition of the workforce to ideally reflect the communities they serve & regular monitoring[14,15,16]. • Ensure a sustainable workforce planning process that supports progression of existing staff, and creates opportunities for new workforce to enter health, social care, and primary care workforce[14,15,16]. • Delivery of health equity focused training should be an integral part of undergraduate and postgraduate medical education.[14,15,16.] • **Build a leadership network in primary care to develop skills and generate additional capacity for multi- agency & interdisciplinary working within communities[16]**
	Accessible Quality and Integrated Services	• Incorporate services within specific locations and cultural communities[4-17]. • Normalise integrated working, consistent joint training, and shared vision development[5-17.] • **Addressing barriers like cultural differences and technical jargon are essential across organisations and professions[5-16]**
	Data, Knowledge, and intelligence	• National and local commitment to developing and publishing high-quality data and accessible information and investing in data development[4,6,9,15,16]. • invest in robust, routinely collected data at individual (socio-demographic and health) and population level (e.g., health service and community data on social determinants)[15,16.] • Look at the ways and approaches to standardise analysing data including both uptake and outcome defined by WIMD, ethnicity, age, sex, employment status etc.[15,16.] • Develop mechanisms for recording, assessing, and reporting unmet primary care health needs[15,16.] • Improve recording of health data in general practices in marginalised communities[15,16] • **Identify models and approaches that work for underserved communities though research and evaluation.[15,16]**
	Investment and funding	• Invest time and commitment to review funding and resource distribution[6]. • Give higher patient list weighting for practices in disadvantaged areas[6]. • **Funding allocations in primary care should explicitly consider socio-economic inequalities, rurality, equity of access and unmet needs[6,16].**
	Community enablement	• Foster long term relationship between teams and community such as locating services near community landmarks, offering transportation options, conducting targeted home visit and co designing services with communities and partners[5-17.] • Raise awareness of health care rights and responsibilities[16] • **Develop a network of expert reference group with lived experience to ensure inclusion[16]**
	Collaboration	• Take ABCD approach to provide community centred care through working with local authorities, voluntary sector, community groups and social enterprise partners[5-17].

Introduction:

Despite many efforts to address health inequalities it is still widespread in every sector of society, including income, employment, education, and health[1]. Primary care is no different, where inequities in access, experience, and quality impacts health outcomes. These inequalities have been recognised for many years[1].

Although the drivers of health inequalities extend beyond healthcare, the health care system plays an important role to address inequalities. Access to and the provision of healthcare based on need is often referred to as 'equity'. The World Health Organisation emphasis the primary care is vital in addressing health inequalities through equitable distribution of primary healthcare services[2].

Primary care in the UK is often considered one of the most equitable healthcare systems globally. The National Health Service (NHS) provides nearly universal access, with about 90% of the population accessing primary care services each year[3]. These needs based, free at the point of contact access is a key factor in the NHS's reputation for fairness and equity. However, there are ongoing challenges and opportunities to improve equitable delivery of primary care and reduce existing health inequalities in outcome[3].

Given the essential function of Primary care as a cornerstone of the healthcare framework, many of us frequently inquire about:

- How can primary care help create more equitable service?
- What does good look like?
- How do we get there? and who's role is it?

As a first step to develop an action plan to answer the above and illustrate the impact of primary care, we reviewed existing evidence regarding how others have tackled this issue. What frameworks are available, and what common areas of action have already been identified.

Review Question:

Question 1: What frameworks exist to reduce health inequalities within primary care?

Objectives:

The objectives of this review are to:

- Identify relevant conceptual / or action frameworks aimed at reducing health inequalities within primary care.

- Summarise their key components and identify common themes across identified frameworks to inform potential action areas for primary care in Wales.

Approach to the literature review:

Inclusion Criteria: Grey literature was included if the publications were in the English language and published from the 1st of January 2014 onwards. The rationale for selecting 2014 as the start date for the search was based on the publication of the Fair Society, Healthy Lives: The Marmot Review in 2010. Only those frameworks or reports that recommended a systematic blueprint of

actions that specifically focused on reducing health inequalities in primary care and health and social care were included.

Exclusion Criteria: Literature not available in the English language and/or published before 2014 were excluded. Frameworks not relevant to health and social care or wider determinants of health were also excluded. Frameworks that did not focus on health equality/ inequality and health equity / inequity were excluded.

Search methods: A rapid search for grey literature from government and public health websites within the UK nations, Ireland, and key international organisations (e.g., World Health Organization) was completed. Google and Google Scholar were also searched.

Websites searched: Centre for Disease Control (CDC), Department of Health (Ireland), Department of Health (Northern Ireland), Department of Health and Social Care (UK), Health Equity Evidence Centre, Improvement Cymru Academy, Institute of Public Health (Ireland), Kings Fund, Local Government Association, National Institute for Health and Care Excellence (NICE), NHS England, NHS Confederation, NHS Scotland, NHS Wales, Public Health Agency (PHA), Public Health Scotland, Public Health Wales, Scottish Intercollegiate Guidelines (SIGN), Social Care Institute for Excellence, the Health Foundation, and the World Health Organization.

The key search terms were: Primary care, primary care system, pharmacy, optometry, dentistry, health inequalities, health inequity, reduction or reduce, increase, gap, mortality, morbidity, socio-economic disadvantage, socio- economic disadvantaged groups AND/ OR communities, marginalised groups, socially excluded groups, hard to reach communities. Searches were also performed from the reference list of the eligible literature that were identified to capture other relevant literature that focused on frameworks for reducing health inequalities in health and social care.

Data extraction: Literature that met the inclusion criteria were reviewed and summarised according to key areas of interest including key framework components, recommendations, target audience (e.g., NHS, local government etc), monitoring and evaluation plan and the definitions of health inequalities. Strengths and limitations of each framework were also identified and described. Common themes within the key components of frameworks were highlighted and identified.

Findings:

Our initial search yield 4,623 results, of which 4,603 was excluded at title. The remaining 20 were reviewed in more detail after which ten was excluded following application of further inclusion & exclusion criteria and minded for reference purposes only.

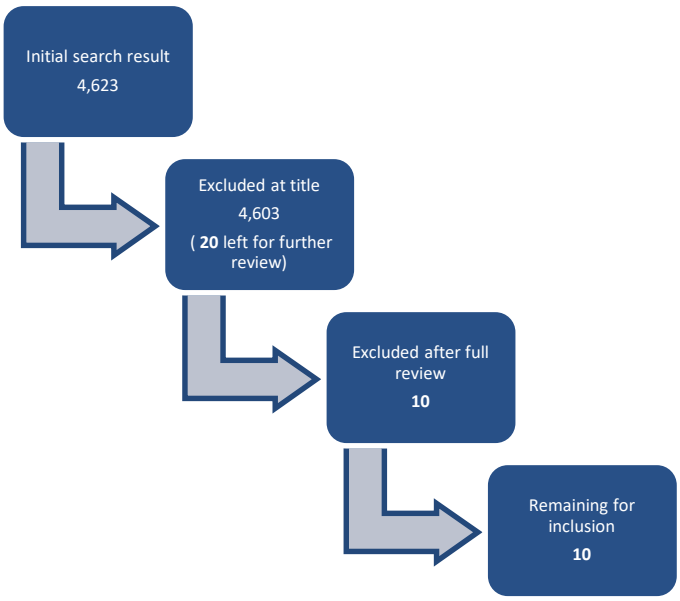


Figure 1 Search results

We categorised the included literature into two categories:

1- Primarily focused on inequalities in primary care

2- Focused on health inequalities within the healthcare system with components relevant to primary care.

1- Focused primarily on addressing inequalities in primary care.

1.1 Building Equitable Primary Care Action Framework[4,5], framework is accompanied by a toolkit for practitioners and decision makers. Two academic groups (Equalise Study & The FAIRSTEPS) have independently looked at what works to address inequalities in and through primary care. The framework combines two studies to describe what equitable primary care looks like and provides some practical steps to help local decision makers address inequalities. The framework is made of the following five guiding principles and four steps to guide the commission, design, and delivery of interventions in primary care.

Guiding Principles:

- Connected: Health inequalities should be addressed through coordinated interventions and services

- Intersectional: To address the diverse impact of services and interventions on patients with multiple disadvantages, care providers should take an intersectional approach.

- An intersectional approach is a way of understanding how different aspects of a person's identity such as race, gender, class, combine to create unique experiences of advantage and

- disadvantage. It highlights that these aspects are all interconnected and can't be examined separately when considering inequalities and or discrimination.

- Flexible: Flexible care delivery should accommodate individual patient needs and preferences, including time, communication, location, and support options.

- Inclusive: We need to cultivate an organisational culture that is less western-centric and normative to ensure that people are not excluded due to wrong assumptions about who they are, what they need, and how they 'should' behave.

- Community Centred: Care should be designed and delivered with input from all stakeholders, including clinical and non-clinical staff, patients, and their networks and communities.

Four steps

- Consider the issue (access, engagement, structure, process of care, patient experiences, staff training and development).

- Ensure key ingredients are included (how and why will it work; what principles need prioritising for it to be transformative)

- Co-design the intervention (involve service users, ensure sensitivity to local context & resources, establish responsibilities, plan evaluation)

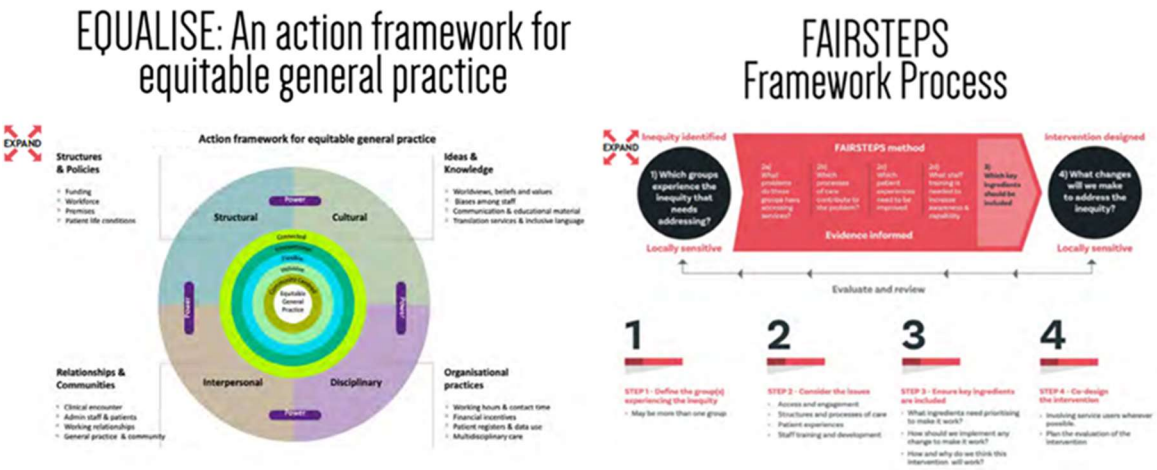


Figure 2- Equalise & fairsteps framework for equitable general practice.

1.2 Doing more for less[6]- Is a mixed method analysis of the experience of primary care networks (PCNs) in socio economically deprived areas in England which was carried out by Kings Fund. The five key recommendations for PCNs and NHS England include:

- Additional funding for PCNs in the areas of high deprivation will help meet the more significant needs of their population.
- Short-term (adjusted for population), all population-based PCN funding and workforce allocations should be based on the PCN-adjusted population. In the long term (change the formula), funding formulas need to be changed to better match PCN allocations to need.
- Greater flexibility for PCNs within the national contract. This could include flexibility in the roles PCNs can recruit, more discretion over PCN spending and more reasonable adaptations of PCN service specifications to fit local contexts.
- Targeted support (with organisational development, management, and data analysis) to the PCNs in the areas of high deprivation.
- Better Policy and Planning must take better account of the areas of higher deprivation.
- Addressing Inverse Care Law, Policymakers should address the inverse care law. An independent review of general practice funding allocations should be conducted.

2- Focused on health inequalities within the healthcare system with components relevant to primary care.

2.1 Core20PLUS5[7] was developed by the Health Inequalities Improvement Team to support NHS Integrated Care Systems (ICSs) to reduce health inequalities. It offers a focused approach to enable prioritisation of focus and resources with a potential larger gain.

Core20 (the most deprived 20% of the national population as identified by National Index of Multiple Deprivation (equivalent of Wales Index of Multiple Deprivation – WIMD).

PLUS (population groups experiencing poorer than average health access, experience and outcomes, but not captured in 'Core20' and inclusion health groups including : minority communities, coastal communities, protected characteristics, people with multiple – morbidities, people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller community, sex workers, people in contact with criminal justice system, victims of modern slavery and other socially excluded groups. This is mainly left for the regions to identify their own PLUS groups.

Five clinical Areas for adults (Maternity, Sever Mental Illness, Chronic Respiratory Disease, Early Cancer Diagnosis and Hypertension case finding)[5] and children (Asthma, Diabetes, Epilepsy, oral health and mental health)[6] were selected based on examining data and evidence from several sources of data including public health profiles and tools from the office for Health and Improvement and Disparities and Global Burden of Disease study, highlighting five clinical areas with potential to make substantial improvements for those experiencing health care inequalities. They also examined and considered policy priorities to understand areas where large gains were possible.

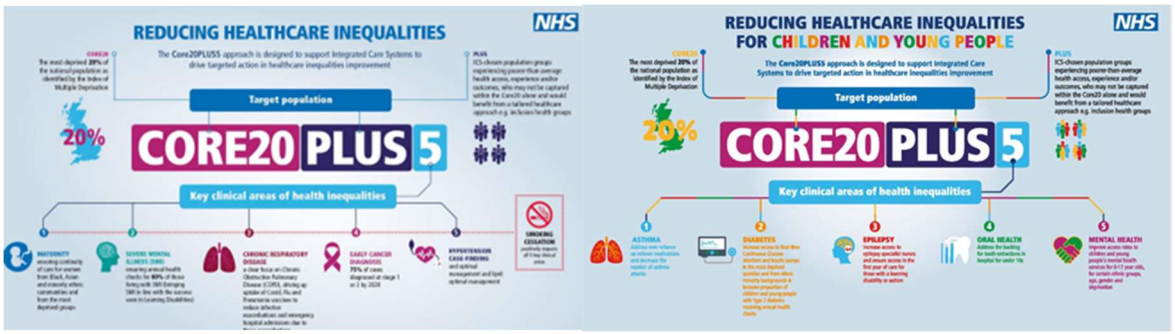


Figure 3- Core20PLUS5 for adult and children

2.2 The following three frameworks had recommendations and focus on specific groups, professionals, or businesses. Whilst the frameworks were not specific to primary care most of the identified components were relevant to primary care too.

- My role in tackling health inequalities[8]: a framework for allied health professionals by Kings Fund
- A national framework for NHS actions on inclusion health[9] – NHS England
- 10 ways businesses can help to reduce health inequalities[10] tackling inequality commission report (Diabetes UK)

Figure 4- three mentioned frameworks for businesses, Allied Health professionals and health inclusion

2.3 Reducing health inequalities: system, scale and sustainability[12] identified 14 common elements in delivering interventions at the service level. It is a symmetrical framework each side has five components and equal consideration should be given to action on both sides of the framework. The two sides of the framework are brought together around a strong central core to ensure structures and processes are in place to lead and coordinate the balance between uptake on and provision of services, to provide adequate resources and their management to avoid bottlenecks and gaps in pathways of provision. While starting at any point on the framework is possible, it is important to complete all the steps. The framework has proven its worth in several ways as a planning tool and as a diagnostic framework[10].

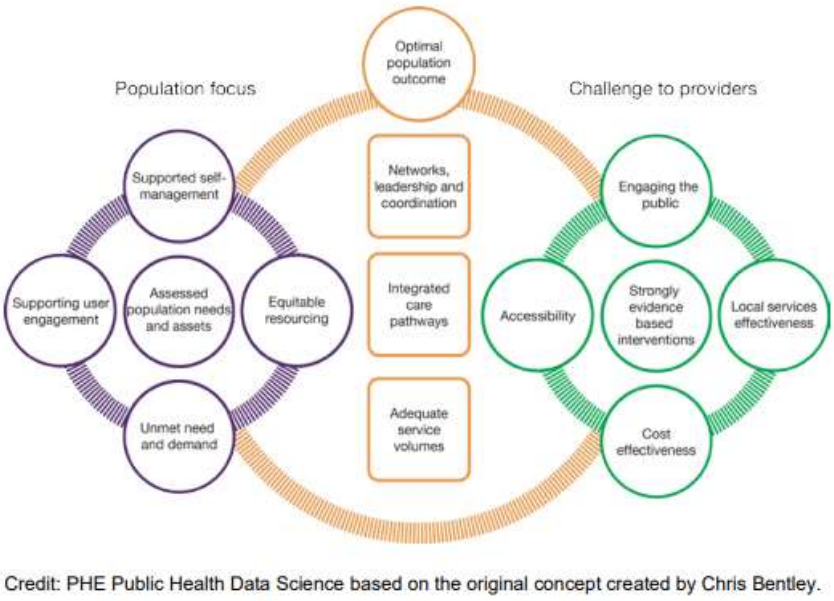


Figure 5- Population Outcome through services framework (POTS)

2.4 Health inequalities: place-based approaches to reduce health inequalities[13] present the population intervention triangle consist of three groups civic level, community centred and service-based interventions. Its structured around four stages of

- scoping (including leadership, joint and collaborative strategic planning and needs assessment, joint priority setting, scoping the whole system)[13.]
- Planning (including select your intervention & be realistic, set your targets & make it locally relevant, and business planning consider health economic case for change)[13.]
- Delivery (including systematic intelligence sharing and programme management to identify who is accountable lead)[13.]
- Evaluation to be built from the outset[13].

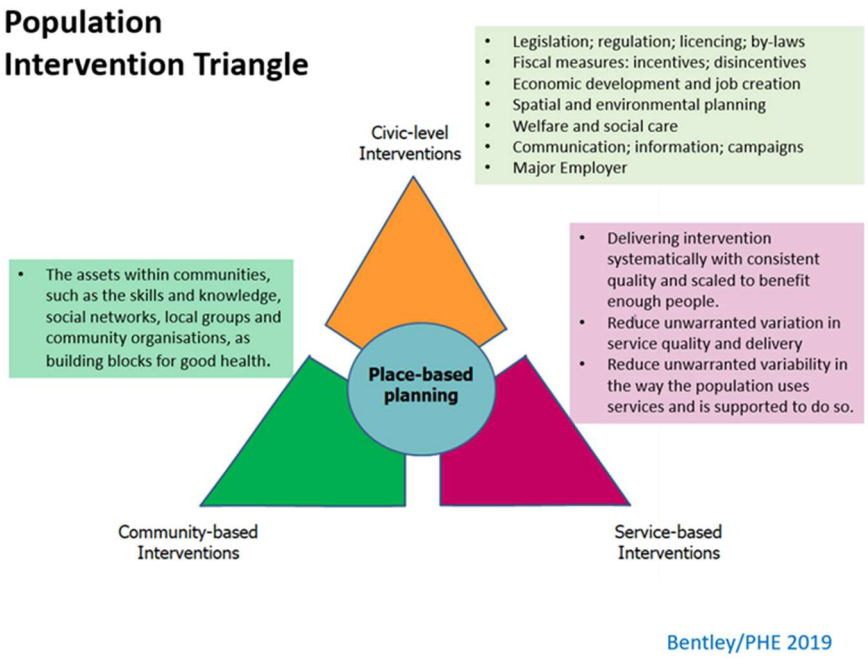


Figure 6- Population Intervention Triangle: PHE Public Health Data Science based on the original concept created by Chris Bentley

2.5 The role of health and social care partnership in reducing health inequalities – NHS Scotland (2018)[14] offers practical actions of good practice as a way of considering health inequalities right from the start of developing plans and priorities. The key action areas include Quality of services, training the workforce, effective partnerships across sectors, mitigation of inequalities through employment, procurement and commissioning process and leadership and advocacy. As part of our discussions with colleagues in Scotland they are in process of updating their health care strategic priorities[14].

2.6 Care Quality Commission[15] rapid evidence review on talking inequalities through the regulation of services and organisations identified key action areas including Collaboration and engagement, leadership, culture and workforce knowledge, capacity and resourcing, data and intelligence including quality and availability of data, and impact[15].

Data extraction from included frameworks and expert views identified the following commonly cited action areas to address health inequalities:

1. Leadership and culture
2. Workforce
3. Accessible, quality, and integrated services
4. Data, knowledge, and intelligence

5. Investment and funding distribution

6. Community enablement

7. Collaboration

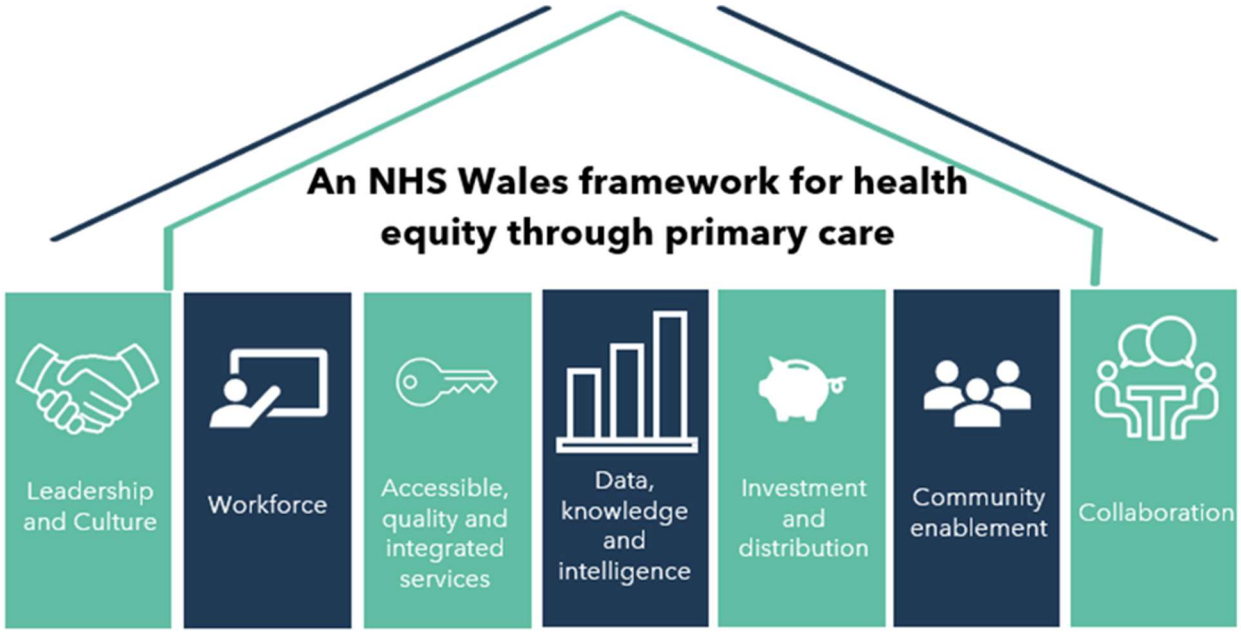


Figure 7: Key action areas to address health inequalities in primary care.

Below, we discuss each component with a more detail:

Leadership & culture – A strong collaborative and inclusive systems leadership and accountability on health inequalities is commonly reported to be a key enabler in addressing health inequalities[4,5,6-16]. There is an emphasis on the need for leaders to explicitly prioritise inequalities in organisational, and teams planning and strategies, communicate this commitment clearly to staff and stakeholders[15], and integrate considerations for inequalities in all regulatory activities to foster a culture that prioritise tackling health inequalities[15,16.] . Examples of identifying inequalities lead and champions within strategic leadership structure and other staff members are included as enablers and good practice to embed inequalities in organisational and teams thinking and culture[15].

A report of the Primary Care Health Inequalities Short- life working Group which was based on the views of primary care professionals and service users lived experience in Scotland strongly recommended strengthening national leadership for health inequalities including considerations for a health inequalities commissioner, and a coordinated cross departments and organisation efforts, led by cross- portfolio leadership and accountability[16].

Workforce - Commonly cited components in relation to the workforce is training, recruitment & retention practices. It is frequently highlighted that organisations should develop schemes to promote the recruitment and retention of local staff especially in disadvantaged areas. The delivery of health equity focused training should be an integral part of undergraduate and postgraduate medical education. Postgraduate health inequalities programs have been shown to

greatly impact professionals' awareness, attitudes, skills, retention, and stress reduction, ultimately strengthening services where needed most[14,15,16]. It has been frequently recommended that the introduction of such program at scale will establish a strong foundation for improving essential services in areas of high need[4]. It is also important for primary care to utilize existing resources like Trauma informed practice to address the widespread lack of trauma-informed practice and care, as frontline leaders often overlook health inequalities amidst competing priorities, leading to stress and burnout[14,15]. This highlights the need for services to be informed about discrimination and trauma, and to work alongside communities to ensure inclusivity and support for those most in need[4,5,8,10,14,15,16].

There is also common emphasis on an employment system that:

- Supports drivers' composition of workforce that reflects the communities they serve, and regular monitoring of the workforce composition[14,15,16].

- Ensure a sustainable workforce planning process that supports progression of existing staff, and creates opportunities for new workforce to enter health, social care, and primary care workforce[14,15,16].

Integration & accessibility - Integrated and accessible services is one of the most cited recommendations. Integration to improve and streamline accessibility to primary care services at local level. Incorporating services within specific locations and cultural communities is vital for focusing on individuals' needs rather than separate services, streamlining efficiency, overcoming barriers, and ensuring financial prudence[4-17]. To normalise integrated working, consistent joint training, shared vision development, and addressing barriers like cultural differences and technical jargon are essential across organisations and professions. It is critical, particularly with health inequalities in mind, that the purpose of the integrating process is to make access of services easier for the end user to enable increased uptake for those who need it most. An important means of achieving this is to engage target communities in consultation throughout the integrating process[5-16].

Data, knowledge, and intelligence – there is common emphasis on the gap in quality and availability of equality data which makes it challenging to identify differences in service provision and its impact. A commonly identified recommendation is to invest in robust, routinely collected data at individual (socio-demographic and health) and population level (e.g., health service and community data on social determinants)[4-16]. Other commonly cited actions for primary care include[4,6,7,9-16]:

- National and local commitment to developing and publishing high-quality data and accessible information on health inequalities[4,6,9,15,16].

- invest in robust, routinely collected data at individual (socio-demographic and health) and population level (e.g., health service and community data on social determinants)[15,16.]
- Look at the ways to incorporate digital access and skills into analysis of inequalities[15,16].

- Look at the ways and approaches to standardise analysing data including both uptake and outcome defined by WIMD, ethnicity, age, sex, employment status etc.[15,16.]

- Commit to identifying models and approaches that work for underserved communities though research and evaluation[15,16].

- Sharing best practice to help services and organisations within primary care system become effective health equity entities[9-16].

- Develop mechanisms for recording, assessing, and reporting unmet primary care health[15,16].

Investment & funding– Recent reports on health inequalities in England and Scotland highlights higher demands on primary care due to higher needs especially in areas of deprivation. The reports suggest that the uneven distribution of general practice funding affects Primary Care in high deprivation areas, putting them at a disadvantage compared to more affluent peers, hindering their ability to invest in new services and develop fully[13,14]. The EQUALISE study recommends that action to reduce health inequalities in primary care should involve structural decisions and policies particularly in relation to resources distribution (funding, workforce, premises & infrastructure) and structural barriers that affect people's lives (e.g., lack of transport options)[5]. The FAIRSTEPs study emphasises that health inequalities interventions need more resources and policy changes to be effective and feasible[5]. Doing more for less report by the king's fund for England recommends that in the short term, all population-based funding and workforce allocations should be based on the adjusted population[6]. In the long term, funding formula should be changed to better match all allocations to need[16]. Building equitable primary care framework also recommends that Primary care policymakers should distribute funding that considers the differences in the needs of served populations[4,5,6]. This can involve integrating patients' socio-economic status and ethnicity into healthcare funding formulae and giving higher patient list weighting for general practices in disadvantaged areas[4,5,15,16-20].

Collaboration- like integration, collaboration, and coordination of efforts to share experience, insight and common goals across organisation and systems is one of the most cited recommendations within the included frameworks and reports. This involves tapping into community assets taking ABCD approach to provide community centred care through working with local authorities, voluntary sector, community groups and social enterprise partners[5-17].

Community enablement – community enablement is another frequently cited component of the identified frameworks and reports. Working closely with community leaders and identifying individuals who face inequalities should involve personalised holistic care, fostering long-term relationships between care teams and the community, locating services near community landmarks, offering transportation options, and conducting targeted home visits and co designing services with communities and service users is reported as effective way to address wider health inequalities and inequity in primary care service provision and access[5-18].

The table 1 in the next page provides a summary of frequently cited actions within each key enabler.

Table 1- summary of frequently cited actions within each enabler

	Leadership and Culture	• A strong collaborative and inclusive systems leadership and accountability on health inequalities[4-5,12,13,14,16,16] • strengthening national leadership for health inequalities including considerations for a health inequalities commissioner, and a coordinated cross departments and organisation efforts, led by cross- portfolio leadership and accountability[16.] • leaders to explicitly prioritise inequalities in organisational, and teams planning and strategies. It should be well communicated to staff[15,16]. • Assign named leaders and champions, giving responsibility to a board, or working group to drive work forward within teams and organisations[11,15.] • **Integrate equity in all regulatory activities to foster a culture that prioritise tackling health inequalities[15,16]**
	Workforce	• Develop schemes to promote the recruitment and retention of local staff especially in disadvantaged areas. Composition of the workforce to ideally reflect the communities they serve & regular monitoring[14,15,16]. • Ensure a sustainable workforce planning process that supports progression of existing staff, and creates opportunities for new workforce to enter health, social care, and primary care workforce[14,15,16]. • Delivery of health equity focused training should be an integral part of undergraduate and postgraduate medical education.[14,15,16.] • **Build a leadership network in primary care to develop skills and generate additional capacity for multi- agency & interdisciplinary working within communities[16]**
	Accessible Quality and Integrated Services	• Incorporate services within specific locations and cultural communities[4-17]. • Normalise integrated working, consistent joint training, and shared vision development[5-17.] • **Addressing barriers like cultural differences and technical jargon are essential across organisations and professions[5-16]**
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	Investment and funding	• Invest time and commitment to review funding and resource distribution[6]. • Give higher patient list weighting for practices in disadvantaged areas[6]. • **Funding allocations in primary care should explicitly consider socio-economic inequalities, rurality, equity of access and unmet needs[6,16].**
	Community enablement	• Foster long term relationship between teams and community such as locating services near community landmarks, offering transportation options, conducting targeted home visit and co designing services with communities and partners[5-17.] • Raise awareness of health care rights and responsibilities[16] • **Develop a network of expert reference group with lived experience to ensure inclusion[16]**
	Collaboration	• Take ABCD approach to provide community centred care through working with local authorities, voluntary sector, community groups and social enterprise partners[5-17].

For the summary of included frameworks, models and reports see table 2 in appendix 1.

Discussion: Our findings echo previous work emphasizing the importance of primary care in reducing health inequalities, improving access, equity, and quality of services, which is also associated with inequalities in service utilisation and care outcomes. We have identified various conceptual and action frameworks related to primary care and inequalities, highlighting the key components including leadership & culture, workforce, integration, investment & funding, collaboration, and community enablement that can be applied to the Welsh context.

From included frameworks in the study two frameworks including building equitable primary care, and Core20PLUS5 seems to offer a more comprehensive yet focused approach on tackling health inequalities at both strategic, structural, operational, and clinical level[7-8]. Further discussions with key stakeholders in Wales will be needed to discuss and agree potential adaptation of these frameworks for Wales to identify and agree actions at the system, structure, and policy level relevant to the Welsh Government, Health Boards and pan cluster planning groups as well as operational / clinical actions for primary care teams, clusters, and professional collaboratives that is aligned with the Primary Care Model for Wales.

Strengths of our scoping is that we examined a range of existing frameworks with diverse designs that still underscore common key elements that can assist the primary care system in addressing inequalities by focusing on the identified key themes. We have also engaged with professionals in England and Scotland to incorporate their perspectives and experiences into our findings. Both England and Scotland have also identified similar priority areas for action on health inequalities within their strategic approach on addressing health inequalities. In England Core20PLUS5 identified five clinical areas for adults including (maternity, sever mental health illness, chronic respiratory disease, Early cancer diagnosis and hypertension case finding and optimal management & lipid optimal management) and five priority areas for children including (asthma, diabetes, epilepsy, oral health, and mental health)[7,8].

Through meetings and attending workshops we understand that Public Health Scotland is in process of drafting their national priorities for health care inequalities and so far, has identified similar key action areas including[18]:

- leadership, systems change, accountability.
- Improving quality of data and evidence
- Empowering and enabling people and communities
- Improving access and experience
- Workforce, culture, and wellbeing
- CVD prevention, taking a QI approach to reducing its risk factors, building the QI infrastructure and interface between primary and secondary care around this priority as a first step to focus on. There is also a strategic focus on 'missingness' supported by[18]:
    - National guidance on a standard approach to analysing patients' appointment Do Not Attend by SIMD (Wales version WIMD) ethnicity, age, and sex.
    - A once for Scotland compassionate DNA policy integrated into waiting times guidance, with proactive identification and follow up of those serially missing from services.

Our findings on key areas for action are also in line with the health and quality standards framework[19]. Another report by the Health Foundation which identifies NHS as an anchor organisation also identified similar themes as ways in which NHS organisations act as an anchor institution. With Primary care being a key building block of the NHS, this gives us confidence that intervention on these priority areas could enable the development of an equitable and high-quality primary care system[20].

We are also aware that several frameworks / models have either been developed or in process of developments within Public Health Wales and Primary Care Division including Prevention Based Health Care Model that has recently been launched and a Health Care Public Health Framework which is under development. Hence, it's important that these findings are shared with our key stakeholders and partners in Wales who have got local knowledge and experience and link to communities they serve to seek their views on the appetite to develop another framework, avoid duplications and framework fever and finally develop an action plan, or model that serves the needs of primary cares system in Wales at all levels. It is also crucial to stress on the fact that taking actions on these key elements will not be possible with one or two entities or organisations. It will be a whole systems effort to address health inequalities across the system.

Although we recognise that some of the identified frameworks have recently been developed, a key insight from our review and consultation was that most of the identified frameworks are informed by evidence rather than being evidence-based. A significant limitation identified in our review was the gap in implementation and evaluation. This serves as an important lesson for Wales that any framework or action plan developed for the Welsh primary care system should be accompanied by an implementation and evaluation strategy.

Conclusion and recommendation:

Our approach examined diverse range frameworks with common key elements to help address inequalities in primary care by focusing on identified themes and incorporating insights from professionals in England and Scotland. Our findings on priority areas for action are consistent with numerous current frameworks in the UK, including the health and quality standards framework, indicating that interventions in these areas could help to establish an equitable and high-quality primary care system. However, how these would look like in practice and who needs to take them forward needs further discussions and consultation with key stakeholders in Wales to co-develop an action framework on inequalities that is relevant to the Welsh primary care context.

Appendix 1 (Table 2- summary of the included frameworks/ reports)

Framework / report title	Aim & approach	Key components	Recommendations and action for practice	How was the framework developed? Evidence base?	Has it been implemented and evaluated?
Building Equitable Primary Care: A toolkit for Practitioners and Decision makers.	This toolkit presents a vision for equitable primary care and provides guiding principles to achieve it with practical actions and case studies.	Based on an 18-month review of published research, the EQUALISE study identified 5 Guiding Principles which mark equitable general practice: Connected: Interventions and services should be understood, designed, and delivered as connected components of coordinated action against health inequalities. Intersectional: Care should adopt an intersectional perspective to account for the different impact of services and interventions among patients according to their circumstances and experience of (multiple) disadvantage. Flexible: Care delivery should be flexible enough to make allowances for different patient needs and preferences in terms of time, accessible	For national policy makers, local health boards and primary care organisations Prioritise the reduction of health inequalities and develop solutions based on intersectionality, long-term planning, integration of services and policies, and involving frontline workers and disadvantaged groups in primary care services. The Population Health Management approach can help identify the groups experiencing inequities. Foster an inclusive organisational culture by leveraging community resources, implementing community-centered care, collaborating with various partners, involving carers and patient representatives, and working with equality and diversity bodies to address discrimination.	Two academic groups, Equalise Study and the FAIRSTEPS, have each investigated methods to tackle inequalities in primary care; this document combines their findings to outline what fair primary care involves and offers practical guidance for local decision-makers to address health disparities. FAIRSTEPS created a framework for those involved in developing, designing, or implementing strategies to address health inequalities in primary care, while Equalise study focused on identifying interventions that either increase or decrease health disparities in general practice.	Monitoring and evaluation of the frameworks is not specified. This is a relatively new tool. There is currently no evidence of its effectiveness; however, it has been developed based on the evidence (systematic literature search, case studies and collaboration and co-production).

		communication, location, and provided support. Inclusive: We need to cultivate an organisational culture that is less western-centric and normative to ensure that people are not excluded due to wrong assumptions about who they are, what they need, and how they 'should' behave. Community-centred: Everybody involved in care should have a say in how it is conceived, (re)designed, and delivered including clinical and non-clinical members of staff, patients, and their networks. The FAIRSTEPS study provides an evidence-informed framework to guide the commission, design, and delivery of interventions in primary care to address health inequities involving four steps. STEP 1: Define the group(s) experiencing inequity (may be more than one group; sensitive to local context and information about population) STEP 2 - Consider the issues (access and engagement; structures and processes of care; patient experiences; staff training and development)			

		STEP 3 - Ensure key ingredients are included (how and why will it work; what principles need prioritising for it to be transformative) **STEP 4** - Co-design the intervention (involve service users, ensure sensitivity to local context & resources, establish responsibilities, plan evaluation)			
Core20PLUS5 (adults & children) – an approach to reducing healthcare inequalities	Developed by NHS England and NHS Improvement (NHSESI). A national NHS England approach to inform action to reduce healthcare inequalities at both the national and system level. The tool offers ICSs a focused approach to enable prioritisation of resources to the areas where large gains are possible.	**Core 20** – Most deprived 20% of our population. **PLUS** – Other population groups as identified by local population health data e.g. ethnic minority communities. **Five clinical areas of focus- Adults:** 1. Maternity 2. Severe Mental Illness (SMI) 3. Chronic Respiratory Disease 4. Early Cancer Diagnosis 5. **Hypertension Case-Finding and optimal management and lipid optimal management.** **Five Clinical areas of focus- Children:** 1. Asthma 2. Diabetes 3. Epilepsy 4. Oral Health 5. Mental Health	**Key features of the delivery model include:** Resources and guidance Quality improvement Partnership working Accountability Funding & resources Monitoring	To inform the development of this framework, several different sources of data and evidence were examined including **public health profiles and tools from the office for Health Improvement and Disparities** and **The Global Burden of Disease study**, highlighting five clinical areas with potential to make substantial improvements for those experiencing healthcare inequalities. **Policy priorities** were also considered to understand areas where large gains were possible	Relatively new framework, currently there is no evidence of effectiveness however monitoring systems for the framework is being developed.
Health inequalities: place-based approaches to	A guidance that provides a practical framework Provide a practical framework and tools for places to reduce health	PBA uses the Population Intervention Triangle to describe how health inequalities can be addressed at scale through systematic collaborative leadership and action – drawing	Strategic and system level: The toolkit recommends the following, which might be suitable at pan cluster or	Framework was developed following an internal review of existing frameworks.	Monitoring and evaluation of the tool and framework is not specified however

reduce inequalities	inequalities. This work is intended for use by local parts of the healthcare and public health system, including: local authorities (LA), Clinical Commissioning Groups (CCGs), Sustainability and Transformation Partnerships (STPs), Integrated Care Systems (ICSs)the voluntary, community and social enterprise (VCSE) sector.	together civic activity (for example, local authorities), services (such as the NHS), and community-centred approaches, in a way that is sensitive to local needs. The population intervention triangle encompasses essential elements for effective place-based working. It consists of three groups: 1-civic-level interventions, 2-community-centred interventions, 3-service-based interventions Each group can bring about population-level change. Place-based planning, built on quality characteristics and partnerships, can drive measurable change by combining the impact of the individual groups. Effective planning can also enhance impact by focusing on group interfaces. Creative working can make the whole more significant than the sum of its parts. Each local area will have different causes of health inequalities and existing solutions.	higher strategic level groups in four stages: **Scoping:** Make sure leadership is in place and fully committed to Health Inequalities goals. Undertake Joint Strategic Needs Assessment: bottom up and top – down. Joint Priority setting: needs to be balanced across partners. Scoping whole system: make sure full range of contribution from across the system is considered. **Planning:** Select your intervention be realistic about the system and scale. Set your targets: make it locally relevant and meaningful. Business Planning: consider health economic case for change.		evaluation is an integral part of the recommendations within the tool.

			Delivery: Information governance: systematic intelligence sharing. Programme management: identify who is accountable. **Evaluation:** build in your assessment from the start.		
10 Ways Businesses Can Help to Reduce Health Inequalities: **Tackling inequality commission report (Diabetes UK 2023)**	A report by Diabetes UK that provides a framework that addresses health inequalities related to diabetes. Whilst it's aimed at businesses it provides recommendations into four categories of responsibility Health and Social Care System or Regulator Organisations •Governments • Individual	**Four Principals:** 1. **Context:** Remember the wider social, environmental, and economic factors that impact on health. 2. **Curiosity:** Understand your data and communities around you. 3. **Collaboration:** Coordinate and share insights and efforts to reach different communities across organisations and systems. 4. **Commitment:** Create long-term – embedded fundings, not one-off projects.	**Seven calls to action:** Anti-racism – be bold. Address deprivation – be proactive. Environments – be supportive. Data and insights – be specific. Representation – be diverse. Co-creation – be inclusive. Sustainability – be persistent: Each call has several actions for each of the four categories of responsibility,	Mixed methods of seeking views of a wide range of stakeholders (including people with lived experience) through surveys, interviews, focus groups and online workshops.	We could not find any follow up on the impact of the recommendations and their implementation

			some of which focus specifically on diabetes. 10 ways businesses can help to reduce health inequalities: Fair recruitment practices and good working conditions Supporting employees with their health and wellbeing Outsourcing ethically and to those with good social values Becoming greener and more sustainable Supporting digital inclusion Working in partnership with communities to design products and services. Working in partnership with the NHS and Integrated Care Systems Making corporate social responsibility meaningful		

			Embedding health inequalities into strategy and operations Using shareholder influence to drive action		
My role in tackling health inequalities A framework for allied health professionals	This framework aims to support Allied Health Professionals in tackling health inequalities.	The framework is based on three A (**Awareness, Action, Advocacy**) at five levels: Self Patients Clinical teams, pathways, and service groups Community networks System Nurturing the Future	There is no set of explicit recommendations; however, essential actions are detailed in each key theme of Awareness, advocacy and action.	This framework was created in collaboration with AHPs from across the 14 professional groups based on their insight and experience. PHE commissioned the King's Fund to undertake this qualitative work.	
The role of Health and Social Care Partnerships in reducing health inequalities. NHS Scotland, 2018.	The purpose of this resource is to offer practical actions of good practice as a way of considering health inequalities right from the start of developing plans and priorities.	The practical actions are built based on the theory of causation: **Undo**, the fundamental causes. **Prevent** the harmful wider environmental influences. **Mitigate** the negative impact on individuals.	**Key action areas:** Quality services with allocation of resources proportionate to need. Training the workforce to understand their role in reducing inequalities.	It was developed in partnership with key stakeholders	We couldn't find an evaluation report on the implementation of this plan

			Effective partnership across sectors to help reduce health inequalities. Mitigation of inequalities through employment processes. Mitigation of inequalities through procurement and commissioning process. Leadership and advocating to reduce health inequalities		
Reducing health inequalities: System, Scale, and sustainability	This resource has been created to assist local efforts in addressing health inequalities by supporting local partners in identifying effective interventions. It is an updated version of the original DH Health Inequalities National Support Team (HINST) publication focused on systematically addressing health inequalities.	The framework identifies 14 common elements involved in delivering interventions at the Service level. The framework is symmetrical. Each side has five components, and equal consideration should be given to action on both sides of the framework. The two sides of the framework are brought together around a strong central core to ensure structures and processes are in place to lead and coordinate the balance between uptake on and provision of services, to provide adequate resources and their management to avoid bottlenecks and gaps in pathways of provision. While starting at any point on the framework is possible, it is important to complete all the steps. The framework has proven its worth in	I) Intervention at different levels of risk, the model is developed based on Labonate 14 and sets out how risk conditions, psycho-social risks and behavioural risk factors are interconnected at three levels (Attributable risks, Causes, Causes of the cause). II) Intervening for impact over time, this model illustrates that input types will impact differently over different periods. For each substantial population-level outcome, it is essential to know realistic timescales for measurable impact. A comprehensive goal of reducing inequalities should	This was a Review and refresh the original DH Health Inequalities National Support Team publication. The updated version was produced based on the review of the previous frameworks, collaboration with partners and learning from good practice.	There is an acknowledgement that the resources and the frameworks included in the review need to be formally evaluated;

		several ways as a planning tool and as a diagnostic framework.	have interventions across all three areas: A) substantial impact in 12-15 years of work and skills B) Substantial impacts in 8-10 years, tobacco, alcohol harm, obesity management C) Substantial impact in 3-5 years, manage HTN, CHD, diabetes, and cancer III) Intervention across the life course, and action areas across all policy domains as identified in the Marmot report. IV) Making Impact at the population level: Population Intervention Triangle suggests actions at Civic, community and Service Based		
A national framework for NHS – action on inclusion health	Developed by NHS England in collaboration with a wide range of partners including: • Office for Health Improvement and Disparities (OHID)	Commit to action on inclusion health. Understand the characteristics and needs of people in inclusion health groups. Develop the workforce for inclusion health.	Within each principle, they have identified useful actions, including: 1. Ensure the ICB has a named lead for inclusion health to ensure ICP strategies and ICB plans tackle inequalities of access, experience, and outcomes	NHS England ran several workshops with people with lived experience of inclusion health to understand challenges that individuals experienced. Learnings from their experience informed the development of this framework alongside	No evaluation report link to its impact & implementation

	• UK Health Security Agency (UKHSA) • Voluntary, community and social enterprise (VCSE) organisations • Integrated Care Systems (ICS) • National and regional teams • Inclusion Health Network	Deliver integrated and accessible services for inclusion health. Demonstrate impact and improvement through action on inclusion health	for people in inclusion health groups. 2. Proactively improve data and insights on the needs of people in inclusion health in your population. Use this to drive improvement. 3. Develop the workforce so all staff understand inclusion health and trauma-informed practice. Develop specialists in inclusion. Support employment of people in inclusion groups as NHS anchor organisations. 4. Use best practice to commission sufficient specialist services for inclusion health groups. Raise the quality of all services to ensure equitable access, experience, and outcomes for all. 5. Evaluate the impact of changes made. Ensure people with lived experience inform improvement and evaluation. They also provide specific actions for the various national, regional, and local system groups.	available best-evidence on inclusion health.	

Doing more for less? A mixed-methods analysis of the experience of primary care networks in socioeconomically deprived areas	This analysis puts forward recommendations for national policy makers and local leaders about how Primary Care Networks in areas of high deprivation could be better supported to function effectively	1- Additional funding 2- Greater flexibility 3- Targeted Support 4- Better Policy and Planning 5- Addressing Inverse Care Law	Additional funding for PCNs in the areas of high deprivation will help meet the more significant needs of their population. Short-term (adjusted for population), all population-based PCN funding and workforce allocations should be based on the PCN-adjusted population. In the long term (change the formula), funding formulas need to be changed to better match PCN allocations to need. Greater flexibility for PCNs within the national contract. This could include flexibility in the roles PCNs can recruit, more discretion over PCN spending and more reasonable adaptations of PCN service specifications to fit local contexts. Targeted support (with organisational development, management and data analysis) to the PCNs in the areas of high deprivation. Policy and Planning must take better account of the areas of higher deprivation. Addressing Inverse Care Law, Policymakers should address the inverse care law.	The report and recommendations were developed based on, Policy analysis of Primary Care Networks (PCN) contracting, and guidance issued by NHS England between 2019-2023.Quantative Analysis of PCN payments and workforce Qualitative interviews with primary care network leaders and integrated system commissioners.	Not applicable

			An independent review of general practice funding allocations should be conducted.		
Rapid evidence reviews: **Tackling inequalities through the regulation of services and organisations.**	This review was commissioned by Care Quality Commission (CQC) and looks at how health and care regulators can tackle inequalities experienced by service users.	Common approaches identified nine core themes: Working with partners Working with service users Supporting accessibility Effective use of data and evidence Contributing to evidence base Allocation of responsibility for equality with regulators Using regulatory mechanisms Assessing the impact of activities Assessing specific inequalities	Key recommendations focused on the following enablers and barriers: Leadership, culture, and workforce knowledge Collaboration and engagement Capacity and resourcing Quality and availability of data	A rapid evidence reviews, supported by the King's fund library service and Dr. Tammy Boyce.	Not applicable

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Gweithio gyda'n gilydd i greu Cymru iachach

Working together for a healthier Wales