FAIRSTEPS

Building equitable primary care:

A toolkit for practitioners and decision makers

EQUALISE

EXECUTIVE SUMMARY

Inequalities abound across every aspect of society from income and employment to education and health. Primary care is no different, with inequalities in access and experience contributing to inequalities in health outcomes. We've known about many of these inequalities for decades. What can primary care contribute to a fairer society? What does good look like? And how do we get there?

Two academic groups have independently looked at what works to address inequalities in and through primary care. This document brings together these two studies to describe what equitable primary care looks like and provides practical steps to help local decision makers address inequalities in health and healthcare.

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 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.

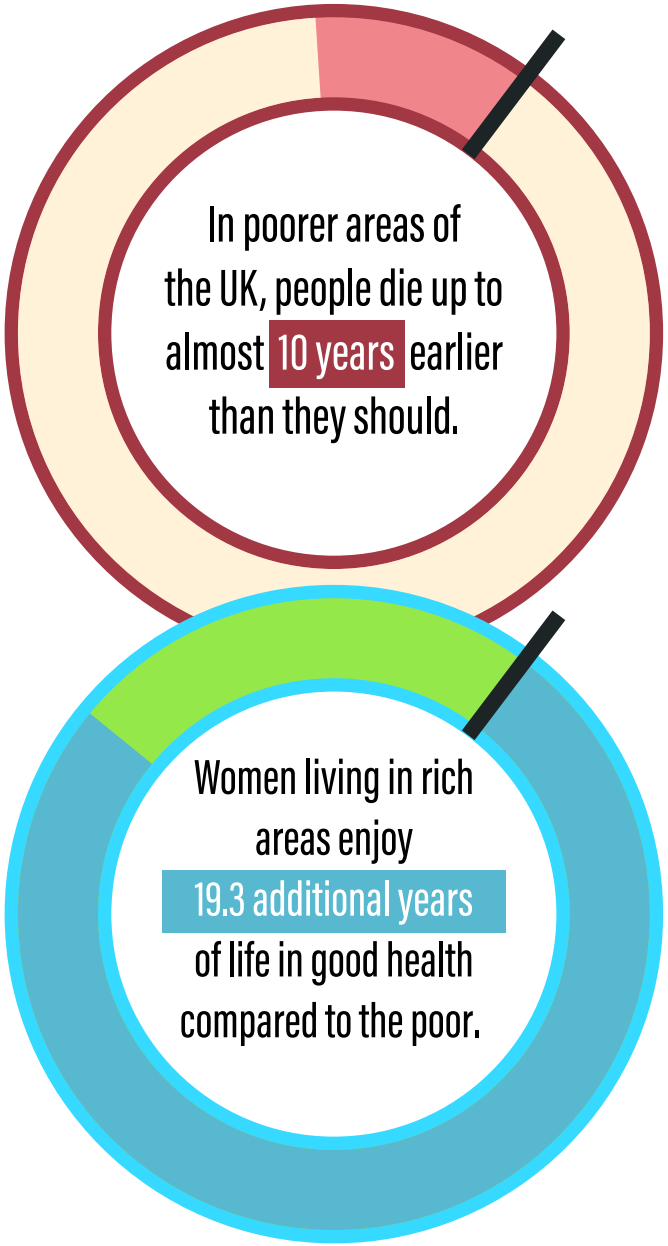
The FAIRSTEPS study provides an evidence-informed framework to guide the commission, design and delivery of interventions in primary care to address health inequities involving four steps.

- **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)

In addition it provides a set of practical examples, prioritised by practitioners and patients of interventions that have been tried and tested.

This toolkit presents a vision for equitable general practice and provides guiding principles to achieve it with practical actions and case studies. Addressing inequalities in general practice is not easy, but it is possible.

CHALLENGES

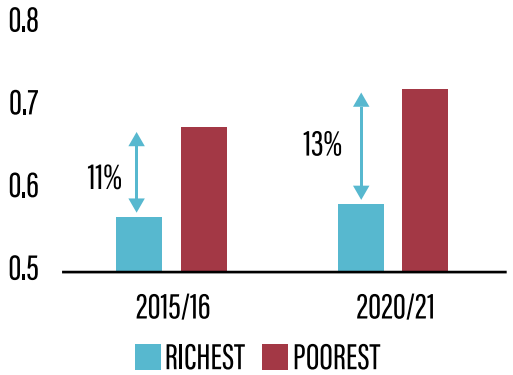


People are dying earlier than they should.

In disadvantaged communities, people typically have to deal with job instability, lower pay, poor housing, lack of access to green space, limited food availability, worse education and healthcare. In such circumstances, stress and exhaustion overstrain their bodies and the lack of support gives little choice in how to cope.

In terms of health, 60-year-olds belonging to Gypsy or Irish Traveller, Bangladeshi, Pakistani, and Arab groups are similar to that of a typical white 80-year-old.

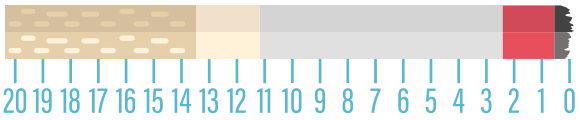
In September 2022, among people who ate less because they couldn't access or afford food, 58% said they were buying less fruit and 48% were buying fewer vegetables.



Inequalities in obesity are widening

Smoking is the single largest driver of health inequalities in England. In 2021,1 in 5 of smoking households in the UK were living below the poverty line.

2 in 20
people smoke in professional jobs.



5 in 20
people smoke in manual and routine jobs.

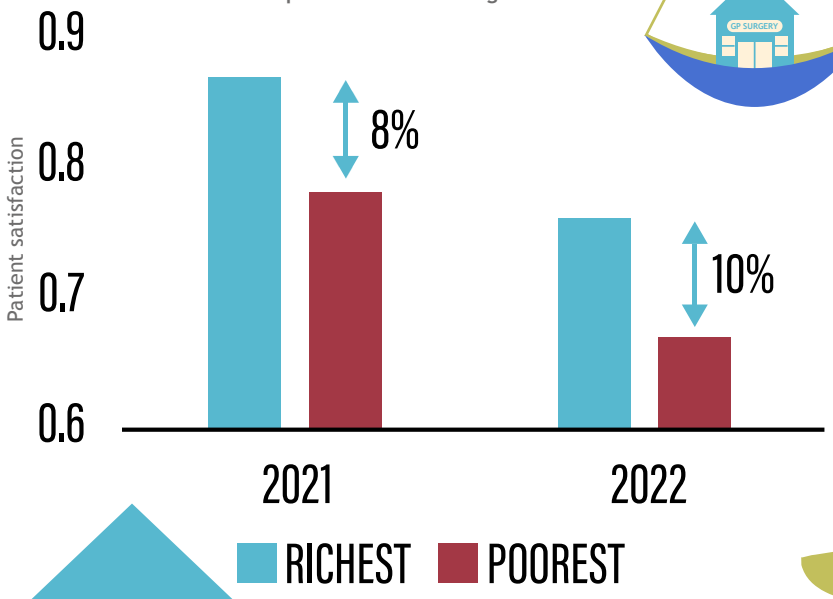
CHALLENGES

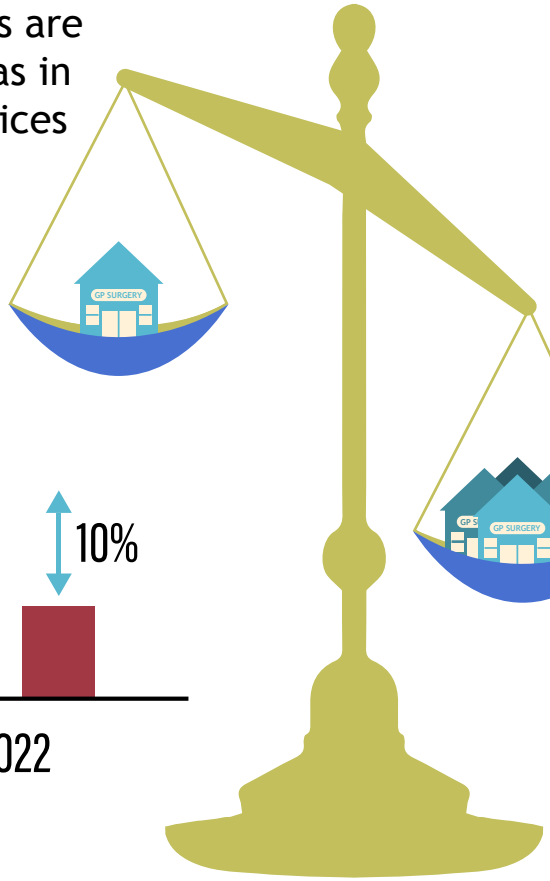
The inverse care law remains active.

Primary care services in rich areas continue to receive more funding than practices in poor areas. People living in poorer areas, compared with their rich counterparts, are more likely to find it harder to get an appointment at their GP surgery, see a GP, and be less satisfied with the care they receive.

In rich areas, **6 in 10** practices are **rated as outstanding**, whereas in poor areas only **4 in 10** practices are rated outstanding.

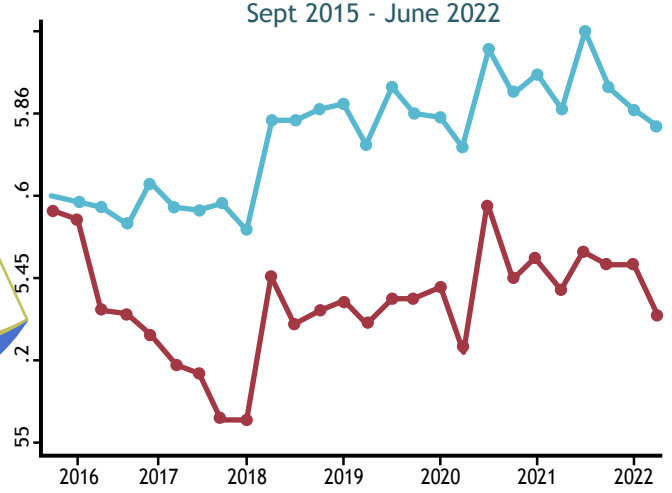
Inequalities in patient satisfaction with general practice is worsening





An average practice of 10,000 patients in a **rich area** has about **2.5 days more GP time** per week than those in the **poorest areas**.

GPs per 10,000 Patients, Decile 1 (blue) vs. Decile 2 (Red)
Sept 2015 - June 2022



Practices in the poorest areas receive about **£10 less per patient** compared to practices in the richest areas.

General practice is still where people, and especially the most disadvantaged, turn to for a range of health and non-health matters. With its expertise and knowledge of local communities, it can play a vital role in reducing health inequalities.

RESEARCH

PROJECTS: EQUALISE >> FAIRSTEPs

EQUALISE: Interventions which increase or decrease inequalities in General Practice

The EQUALISE study was conducted at the University of Cambridge from January 2021 until September 2022. The project was led by Dr John Ford and involved an interdisciplinary team of researchers from the University of Oxford, Newcastle University, and University of Dublin. The team was consistently supported by healthcare professionals from Cambridge CCG and a group of public and patient representatives.

STUDY AIM: To explore which interventions or aspects of routine care increase or decrease inequalities in health and healthcare through general practice.

APPROACH: We built on theories which frame health inequalities as the result of structural arrangements which generate inequalities in power and shape people's lives.

We adopted an intersectional approach to interrogate:

1) the impact of multiple disadvantage (e.g., being an immigrant woman living in a disadvantaged area)

2) how interventions and services have a different effect on people according to their own circumstances

3) inequalities in general practice across four domains of power organisation.

METHODOLOGY:

Realist review based on Pawson's five steps focusing on academic literature published since 2010.

How Things Work: Realist Logic

CONTEXT → MECHANISM → OUTCOME

SEARCH STRATEGY:

7876 REVIEWS SCREENED → 251 INCLUDED

6551 PRIMARY STUDIES SCREENED → 325 INCLUDED

155 IN THE EVIDENCE SYNTHESIS

RESEARCH PROCESS:

CLICK FOR PROCESS

RESEARCH

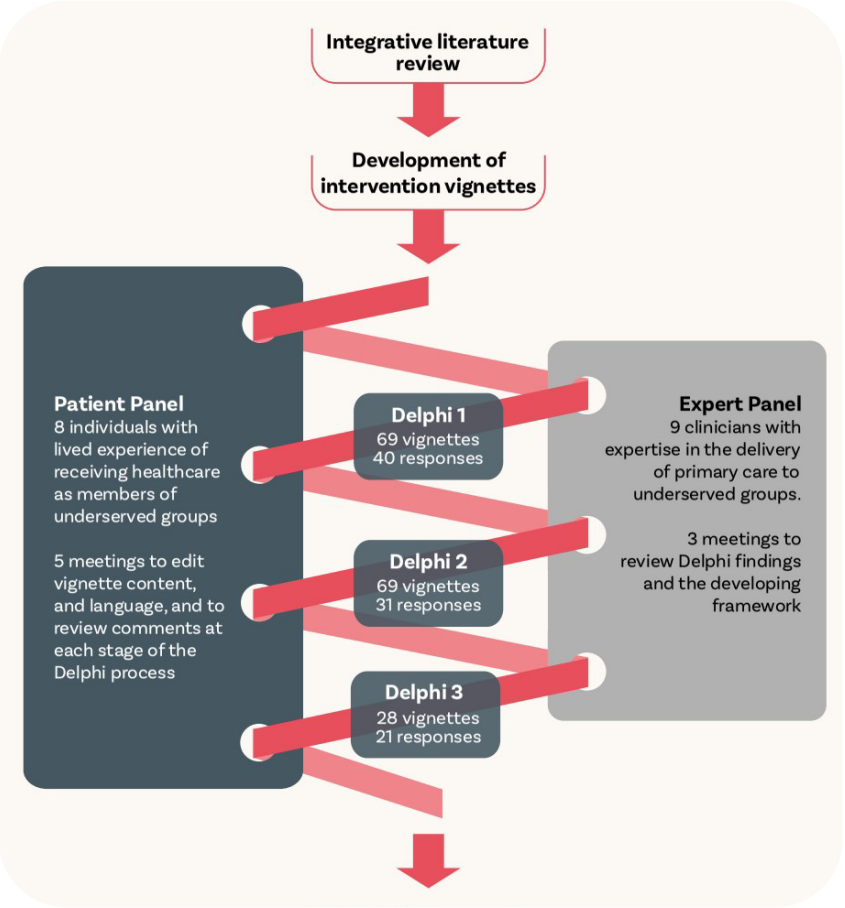
PROJECTS: EQUALISE >> FAIRSTEPs

FAIRSTEPS: Framework Addressing Inequities in pRimary care using STakEholder PerspectiveS

The FAIRSTEPS study was conducted at the University of Sheffield between April 2021 and November 2022, led by Dr Ben Jackson as a collaboration of academic GPs, public health researchers and the Sheffield Deep End Research alliance. The mixed method study involved an integrative literature review, a Delphi survey of primary care clinicians and collaborative patient engagement in study design and outputs.

STUDY AIM

To develop an evidence-informed framework for those wishing to commission, design or deliver actions to address health inequities through primary care service development or education and training.



1. Integrative Review

An integrated review of academic publications, reports and policy documents since 2000 had three outputs

- Interventions that address inequities, including how and why they were expected to work.
- Barriers and facilitators to providing equitable primary care services.
- Example intervention vignettes for use in the Delphi Study.

2. Delphi Study

We asked primary care practitioners to rank interventions according to their usefulness and feasibility, with appropriate support and investment.

- The FAIRSTEPS priority grids provide example interventions to guide strategy, funding, and development of services.

3. Collaboration with people with lived experience

The Deep End Research Alliance (DERA) Patient and Public involvement group were actively involved at all stages, from design through to the analysis and interpretation. This embedded collaboration with the public is a novel approach to DELPHI studies which gives the framework and prioritised interventions face validity with the public. Active participatory research to co-produce services is key to reducing inequalities.

VISION

Building an equitable primary care system

5 Key principles

1. **Connected** across the system as coordinated components of a strategy against health inequalities
2. **Intersectional** to account for differences within patient groups
3. **Flexible** to make allowances for different patient needs
4. **Inclusive** of patient worldviews and cultural references
5. **Community-centred** involving communities in design and delivery

4 Action areas

1. **Structures & Policies**
2. **Ideas & Knowledge**
3. **Organisational practices**
4. **Relationships & Communities**

4 Steps

1. **Define the group(s)**
2. **Consider the issues**
3. **Ensure key ingredients**
4. **Co-design the intervention**

EQUALISE: An action framework for equitable general practice

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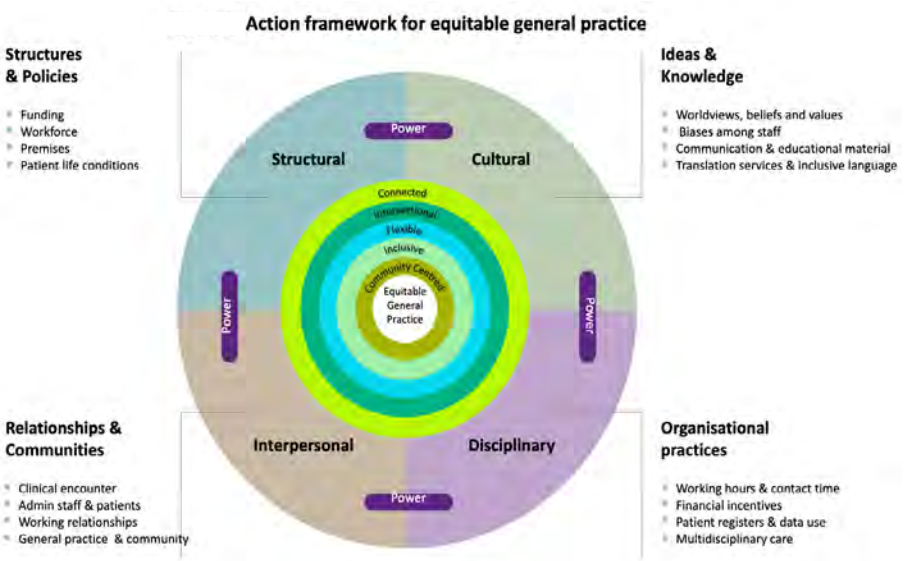

FAIRSTEPS Framework Process

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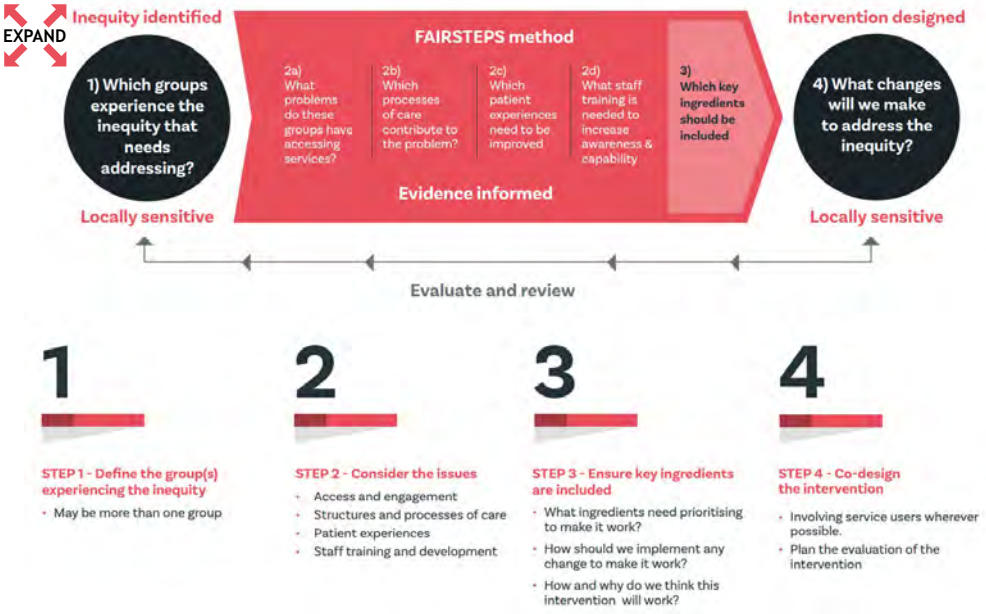
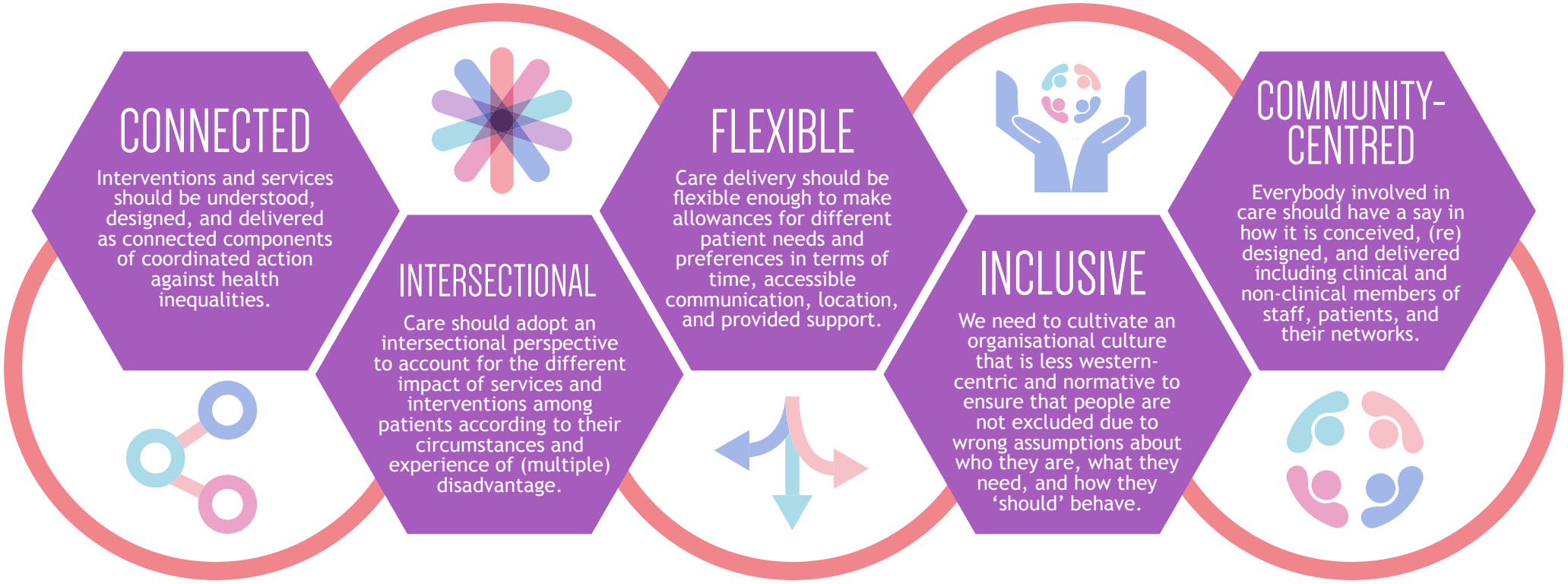


PRINCIPLES

What does equitable care look like?

Focusing on the common qualities of the reviewed interventions, in EQUALISE, we identified **five key principles** of equitable general practice that should inform services, interventions, and initiatives.



PRINCIPLES

5 Key principles of equitable care in a real-life example

The FAIRSTEPS study showed that staff development programmes to increase the awareness and capability of staff with respect to challenges in providing equitable services are a useful and feasible way to decrease inequalities in primary care. A closer look to real life examples shows that the EQUALISE principles inform the design and delivery of such programmes.

The 'EQUIP' project: an organisational health equity intervention in Canadian primary care clinics. The Equip Project was implemented between 2013 and 2015 in response to an urgent call for health care organisations to make health equity a strategic priority at all levels from the Institute for Health Care Improvement in Canada. The team delivered staff training to integrate **three key dimensions of equity-based care**: cultural safety; trauma and violence-informed care and tailoring to context.

The project was implemented with four diverse Canadian primary healthcare clinic settings, all providing care for people living in poverty; experiencing homelessness; LGBTQ+ patients; recent migrants; Indigenous peoples and those from ethnic minorities.

PRINCIPLES

5 Key principles of equitable care in a real-life example

The EQUIP intervention improved patient experience and confidence in the received care, which in turn increased confidence in self-management and improved depression and PTSD symptoms, chronic pain and quality of life. On the workforce side, EQUIP **increased awareness and confidence amongst the staff in delivering equity-oriented care**. During the programme, some tensions arose when individual positionality and experiences relating to racism, violence and trauma and substance use were uncovered. The project team responded to these disruptive tensions by focusing on the involvement of all staff disciplines in organisational strategies to combat discrimination, improve the clinical environment and optimise access to harm reduction for suitable patients.

CONNECTED

From its conception 'EQUIP' was based on the idea that the delivery of equity oriented healthcare requires the review of multiple organisational practices and policies. Its implementation revealed that delivering equity oriented care in a consistent and sustainable manner involves leadership, administration and clinical staff. Further, it demonstrated the need for sustainable support to staff experiencing various trauma linked with working closely with people experiencing violence and trauma.

CLICK FOR QUOTE

CLICK FOR QUOTE

INTERSECTIONAL

'EQUIP' was based on understanding the effects of interpersonal (e.g., domestic violence) and structural trauma (e.g., racism) as intersecting and resulting in disadvantaged people experiencing multiple and simultaneous forms of violence. The intervention helped staff and administrative leaders to target certain areas specific to each clinic's context and to the specific populations served.

FLEXIBLE

Staff education and discussions had a flexible structure to fit the context and priorities of the participating practices but also the timeline of the intervention and its evaluation was flexible to be as adaptable as possible to the practices rhythms and activities. Staff education and discussions revealed how routine practice processes were excluding or even stigmatising patients and led to their reconsideration and change.

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INCLUSIVE

Cultural safety was at the core of the guiding framework of EQUIP intervention. The culture of healthcare was rendered as a priority for transformation where care providers should not be concerned about 'cultural differences' but rather create culturally safe environments for patients and staff.

COMMUNITY-CENTRED

EQUIP's focus on inequities including racism and poverty strained dynamics among staff related with professional but also societal hierarchies. It often led to reviewing whose voices among staff were privileged in decision making about care plans and how this affected the served populations.

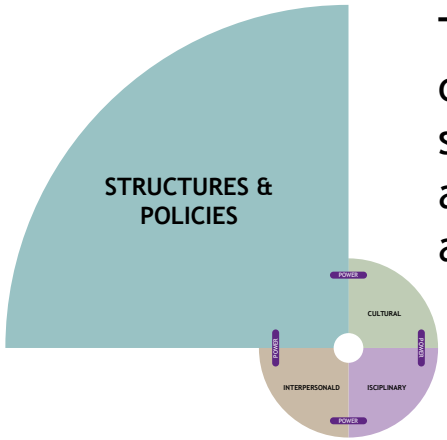
CLICK FOR QUOTE

[Source: Browne AJ, Varcoe C, Ford-Gilboe M, Nadine Wathen C, Smye V, Jackson BE, Wallace B, Pauly B, Herbert CP, Lavoie JG, Wong ST. Disruption as opportunity: Impacts of an organizational health equity intervention in primary care clinics. International Journal for Equity in Health. 2018 Dec;17:1-6.]

AREAS

SUBHEADINGS: STRUCTURES >> IDEAS >> ORGANISATIONAL PRACTICES >> RELATIONSHIPS

Where do we intervene? Structures & Policies



The **EQUALISE** study shows that action to reduce health inequalities in primary care should involve structural decisions and policies especially in relation to resources distribution (premises, funding, workforce) and structural barriers that affect peoples' lives (e.g., lack of transport options). In assessing the importance and usefulness of health inequalities interventions, the **FAIRSTEPs** study highlights that these types of interventions require additional resources and policy change, which when not established, render such interventions less feasible or even useful.

How Things Work

Financial, material, and workforce resources in practices serving disadvantaged groups	Services' capacity + Convenience + Effectiveness	Identification of patients at risk / Increased access / Better condition management

One such real-life example is

The Kirketon Road Centre

The Kirketon Road Centre is a special primary care centre in Sydney which delivers integrated care for at-risk young people, sex workers and intravenous drug users with anonymous registration and non-NHS notes.The Kirketon Road Centre builds on offering high quality healthcare to vulnerable populations using a **non-judgmental approach**.

Where do we intervene? Structures & Policies

The Kirketon Road Centre

It delivers interventions that are based around harm reduction, such as needle exchange, HIV testing, drug and alcohol counselling, women's health checks and assessment and management of general health issues. To encourage attendance, it secures an **inclusive** context with high level of client confidentiality based on anonymous registrations system and discreet not identifiable premises. It advocates for **connected** general practice, drug and alcohol services at the local level, **flexible** drop-in appointment systems and fast-track processes for certain patients depending on the population served, and the adoption of an **intersectional** and **community-centred** approach which focuses on the needs of served populations rather than specific diseases.

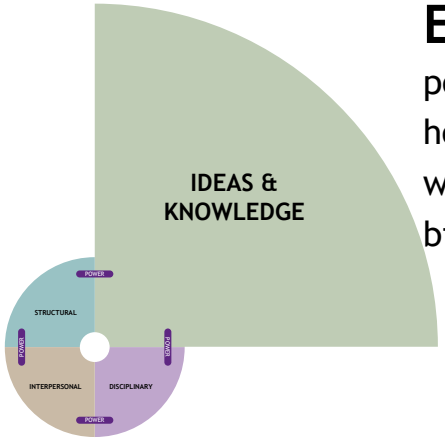
The Kirketon Road Centre has been operating for more than 35 years but this wouldn't have been possible without important action taken in the **structural domain** which provided the **resources** and ensured **organisational flexibility**. It was originally established as part of a policy effort to provide better health services to sex workers and it was the direct result of a **policy recommendation** of the Select Committee of the Legislative Assembly on Prostitution, Parliament of New South Wales. To achieve the desired levels of cultural safety, confidentiality and flexibility that in turn increase attendance among marginalised patients, the centre is allowed to operate **outside** Australia's universal health insurance scheme which has specific protocols when it comes to registration systems and patient information exchange.

[Source: Rodgers C. The Kirketon Road Centre: Improving access to primary care for marginalised populations. Australian family physician. 2012 Apr;41(4):245-7.]

AREAS

SUBHEADINGS: STRUCTURES >> IDEAS >> ORGANISATIONAL PRACTICES >> RELATIONSHIPS

Where do we intervene? Ideas & knowledge



EQUALISE and **FAIRSTEPS** make a strong case for shifting primary care culture away from positivist, Western-centric and heteronormative ways of looking at health, illness, and care to provide holistic, inclusive and equitable services. Developing cultural sensitivity is a multi-component process which requires a deep understanding of patient worldviews and questioning one's own beliefs and biases. Therefore, it often implies a service adaptation that goes far beyond the mere translation of communication material and name-matching. Both studies highlight that cultural understanding is a core ingredient of successful interventions regardless of their aim and format.

How Things Work

Cultural understanding, Deep structural adaptation of services, Questioning stereotypes in decision making

Culturally aligned services + Patient engagement + Effective assessment

Improved care quality / Behaviour change / Accurate and timely diagnosis

One such real-life example is
The North Dublin City Training Programme

This is a structured three-year GP training programme developed in North Dublin to equip trainees with primary care experience in socio-economically disadvantaged settings.

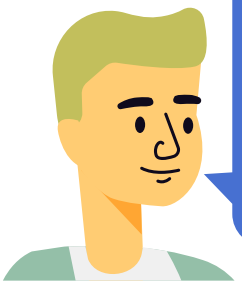
AREAS

SUBHEADINGS: STRUCTURES >> IDEAS >> ORGANISATIONAL PRACTICES >> RELATIONSHIPS

Where do we intervene? Ideas & knowledge

The North Dublin City Training Programme

Primary care access and health outcomes are worse in these populations and recruitment of GPs is more challenging, creating additional pressure on those already in post. GP trainees are traditionally placed in more affluent areas which makes it hard to transition after training. The programme has a variety of components. Trainees rotate through different practices and settings providing patient care to underserved communities. Educational activities specifically focus on the social context when delivering care and developing the skills required to navigate the complexities. In parallel, trainees are encouraged to access a variety of self-care activities which help to foster resilience for their future careers. An evaluation survey of programme graduates showed that 97% continued to work in these communities and the training had increased their commitment, confidence, skills and knowledge to work with marginalised/underserved communities.



"In my view the programme opened the minds of people who previously would not have worked with disadvantaged groups to how needed and rewarding this work could be, while breaking down fears and prejudices that they may have had."

(Trainee 32)

"I think amongst GPs in general there can be a sense of caution or fear towards these groups that stems from a lack of exposure. In contrast, my colleagues from the NDCGP and I are completely at ease [with these population groups]."

(Trainee 7)

[Source: A. O Carroll & F. O'Reilly (2019) Medicine on the margins. An innovative GP training programme prepares GPs for work with underserved communities, Education for Primary Care, 30:6, 375-380, DOI: 10.1080/14739879.2019.1670738]

AREAS

Where do we intervene? Organisational practices

EQUALISE shows that beyond the availability of services, the way services are delivered can involve 'cracks' that let disadvantaged people fall through. Practices involved in the casual delivery of care that have to do with working hours and contact time, the implementation of financial incentives and quality assessment processes, patient registers, data collection and use, and the integration or lack of multidisciplinary care teams are all crucial for the achievement of equitable primary care. In addition, **FAIRSTEPS** shows that, when addressing health inequities, expanding or extending available services to underserved groups through simple and comprehensible steps should be prioritised. Such interventions include intensive case management for homeless and low-income people, who may also have mental health problems or lack health care and social support.

How Things Work

Updated patient registers for those in precarious housing. Timely follow-up	Easy contact + Effective communication + Continuity	Increased service update / Effective targeting of services / Improved quality of care
Continuity, Multidisciplinary and diverse care teams	Improved understanding of patient needs + Increased support across range of issues	Patient satisfaction / Better self-management / Improved quality of care

One such real-life example is

The CATCH-Homeless Initiative

People experiencing homelessness face extensive barriers to primary care access. Their transitory situation and the fragmentation of services make continuity of care difficult to achieve, despite it being more integral to effective care in this population than most others.

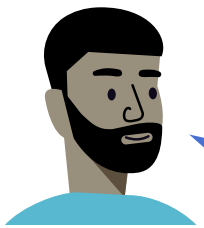
Where do we intervene? Organisational practices

The CATCH-Homeless Initiative

This intervention, developed in an urban Canadian setting, provides intensive multi-disciplinary case management for people experiencing homelessness over the 6-month period immediately following their discharge from hospital. The overarching goal is to establish continuity of health and social care through:

- low-barrier access
- responsive services
- individualised support
- interdisciplinary models
- service coordination

Initially, case managers conduct a needs assessment via outreach/home visits and design a bespoke support package involving an array of team members (psychiatrist, mental health nurse, GP/nurse practitioner, dietician etc) and involvement of local services. Service users can access healthcare via a weekly specialised clinic until a long term primary care provider is in place. Monthly multi-disciplinary team meetings review cases and ensure crisis plans are kept up-to-date. The intervention has been found to significantly increase continuity of care for homeless people with complex needs.



"I can't believe how quickly I got in to see the rheumatologist ... It's best to get it done really quickly, so I don't have to worry about it."

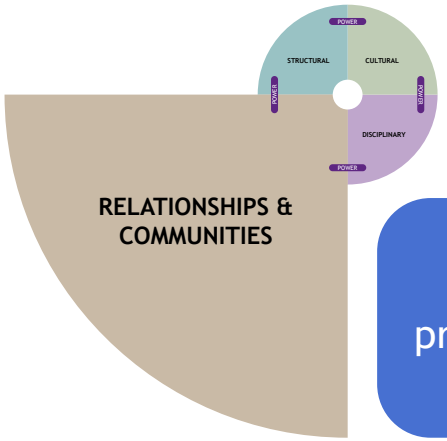
(Service User 21)

Lamanna, D. et al. (2018) 'Promoting continuity of care for homeless adults with unmet health needs: The role of brief interventions', Health and Social Care in the Community, 26(1), pp. 56–64. doi: 10.1111/hsc.12461

AREAS

SUBHEADINGS: STRUCTURES >> IDEAS >> ORGANISATIONAL PRACTICES >> RELATIONSHIPS

Where do we intervene? Relationships with patients and communities



Both **EQUALISE** and **FAIRSTEPS** insist on how cultivating supportive relationships and trust between healthcare professionals and patients is key for the success of any initiative against health inequalities. Both studies highlight how these relationships are shaped within the context of ethnicity, gender, socio-economic and other hierarchies and that healthcare professionals need to consistently work on their interpersonal skills and interrogate their own place within these hierarchies to deliver care within a safe environment for everyone.

Supportive relationships and trust can be achieved with the adoption of an empathetic and holistic approach in care. They are based on healthcare professionals' understanding of the complexity of people's lives and the different ways in which people experience social disadvantage.

How Things Work >>

Empathetic holistic approach, Personalised communication, Familiar environments → Trust + Care plans aligned with service user goals → Increased attendance / Better self-management / Behaviour change / Better clinical outcomes

In the case of the EQUIP project:

trauma-informed care and **cultural safety** were among the pillars of the education programme provided to healthcare professionals to enable them to provide equity focused care.

In the case of Kirketon Road Centre:

ensuring confidentiality and adopting a non-judgemental attitude in care have been at the heart of the initiative which aims to offer high quality care to homeless people with multiple vulnerabilities. **Confidentiality and open-mindedness** are the backbone of trusting relationships between healthcare professionals and patients especially when patients come from communities which are often stigmatised and excluded within healthcare settings.

The evaluation of the CATCH-Homeless initiative:

showed that **supportive relationships, friendliness, respectfulness and an understanding of the realities of homelessness** were key ingredients for the development of personalised care plans and the active engagement of patients with their care.

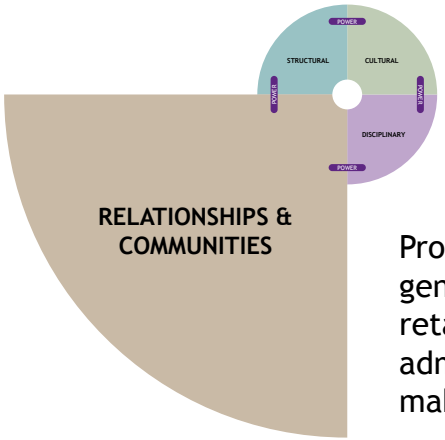
"[CATCH Case Manager] really listened to my needs. At detox, they just always have the same solution, which is, put the person in a recovery home for a year or two ... that's what they do, right? It's not about, 'what does this person as an individual need?' ... She was open to what my needs were in the moment."

(Service User 21)

AREAS

SUBHEADINGS: STRUCTURES >> IDEAS >> ORGANISATIONAL PRACTICES >> RELATIONSHIPS

Where do we intervene? Relationships among primary care staff



Equitable primary care also requires relationships of mutual support and respect among staff.

Professional hierarchies within primary care are not independent from hierarchies across socio-economic status, gender and ethnicity. Thus, general practices in socio-economically disadvantaged areas struggle to attract and retain GPs, while ethnic minority women are over-represented among nurses, healthcare assistants and administration staff. Despite their everyday engagement with patients, they are often excluded from decision making about care plans and services strategy.

How Things Work >>

Mutual respect among staff, Trust in everyone's leadership skills → Care coordination + Cultural understanding → Patient engagement / Better self-management / Better clinical outcomes

EQUALISE found that effective teamwork involves mutual trust between practitioners, and respect for the expertise and leadership skills of the non-physician members of staff which can often make general practices more **inclusive and community-centred.**

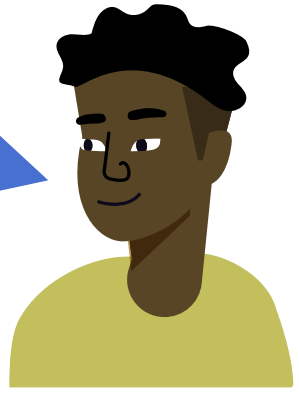
"I used to hate it. I mean hate it because it was always about what I couldn't do but now we [the nurse and the participant] talk about what I can do within the circumstances I have. / My vision is bad and then it was a bad winter but having the nurse through the computer well I didn't have to go nowhere to get the care and advice I need. / I would never have all that time with my doctor. Never. Ten minutes and I'm out."

(Participants in an online diabetes self-management intervention for a sample of inner-city African Americans with diabetes)

FAIRSTEPS found that equity focused care can create tensions among staff as some people may challenge the status quo and others resist such challenges. The EQUIP project highlights how such tensions can emerge and why it is important to adopt an **intersectional** lens in primary care. Integrating intersectionality in everyday practice enables people involved in primary care to understand their own role in challenging or sustaining the power dynamics that generate inequalities.

"It's not education as much as helping to develop a culture, a culture where staff are open to sometimes examining themselves, but also of feeling everybody has a voice to some degree within that, within the organisation. So it's a style of leadership, but the style of leadership also perhaps develops the culture."

(leader administration in EQUIP project)



Sources: Carter EL, Nunlee-Bland G, Callender C. A patient-centric, provider-assisted diabetes telehealth self-management intervention for urban minorities. Perspectives in health information management/AHIMA, American health information management association. 2011;8(Winter)
Browne AJ, Varcoe C, Ford-Gilboe M, Nadine Wathen C, Smye V, Jackson BE, Wallace B, Pauly B, Herbert CP, Lavoie JG, Wong ST. Disruption as opportunity: Impacts of an organizational health equity intervention in primary care clinics. International Journal for Equity in Health. 2018 Dec;17:1-6.]

STEPS

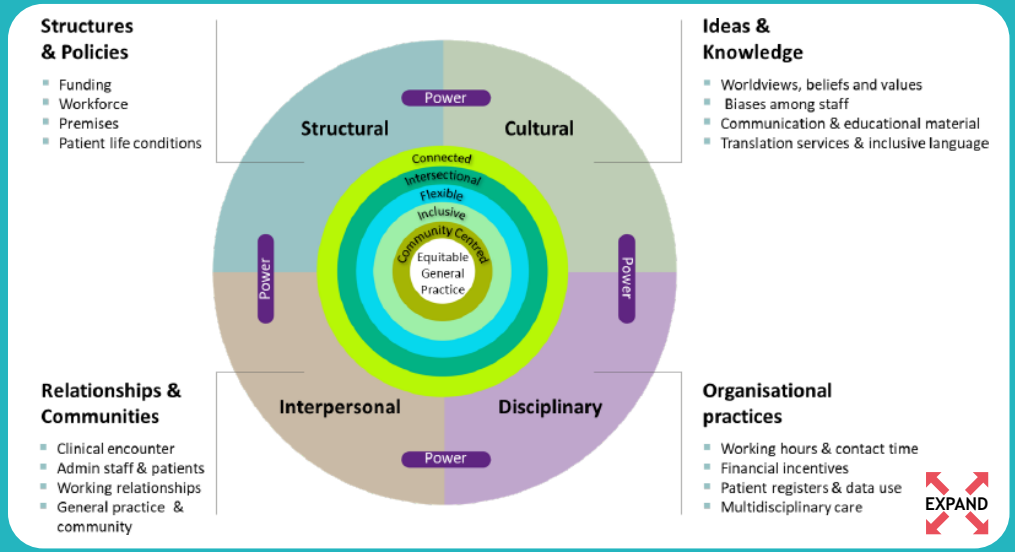
Reducing health inequalities in 4 steps: FAIRSTEPS & EQUALISE in action

The FAIRSTEPS framework

describes an evidence informed, **four-steps process** through which we can develop or commission locally sensitive action that will effectively address health inequities identified in specific contexts.

EQUALISE

describes **5-key principles** which should inform these steps and identifies the action areas they should cover.



STEPS

An Example: The Safe Surgeries Toolkit

Safe Surgeries provides a toolkit for general practices who want to provide a welcoming environment for everyone in their community and an equitable service for all of their patients. It has been developed by Doctors of the World UK with the aim of addressing the particular barriers to primary care faced by **migrants in vulnerable circumstances, including refugees and survivors of trafficking.**

EQUALISE SYMBOL KEY: INTERSECTIONAL FLEXIBLE INCLUSIVE CONNECTED COMMUNITY-CENTRED STRUCTURAL CULTURAL DISCIPLINARY INTERPERSONAL

STEP 1: Define the group(s) experiencing the inequity

A locally sensitive approach is required so that each practice can identify which are the specific migrant groups affected in their catchment area; which are their characteristics, languages spoken, health and social needs.

More than one group might be affected

STEP 2: Consider the issues

Migrants in vulnerable circumstances are often denied registration with general practices because they cannot provide proof of address and/or proof of identification, although this is against the general NHS guideline that promotes registration for all patients.

Specific issues might be more relevant for some groups than for others.

Until recently, primary care records were being used for immigration enforcement without patient or GP knowledge or consent. While this policy has changed, data sharing can still take place if patients access secondary care. This creates a climate of mistrust which makes migrants reluctant to share their personal and contact information with their practice because they are afraid that these will be shared with the Home Office. Additionally, vulnerable migrants are likely to have an increased difficulty in communicating with healthcare staff in English and they are not always aware of their healthcare entitlements.

ISSUES

- **ACCESS**: Information about, and mistrust of, healthcare services
- **PROCESSES:** requests for ID, registration, appointments, visits
- **EXPERIENCES:** interactions with administration, reception, and clinical staff, lack of interpreter availability
- **STAFF TRAINING NEEDED:** Healthcare entitlement and supporting vulnerable patients.

STEPS

An Example: The Safe Surgeries Toolkit

EQUALISE SYMBOL KEY: INTERSECTIONAL FLEXIBLE INCLUSIVE CONNECTED COMMUNITY-CENTRED STRUCTURAL CULTURAL DISCIPLINARY INTERPERSONAL

STEP 3: Key ingredients to be included

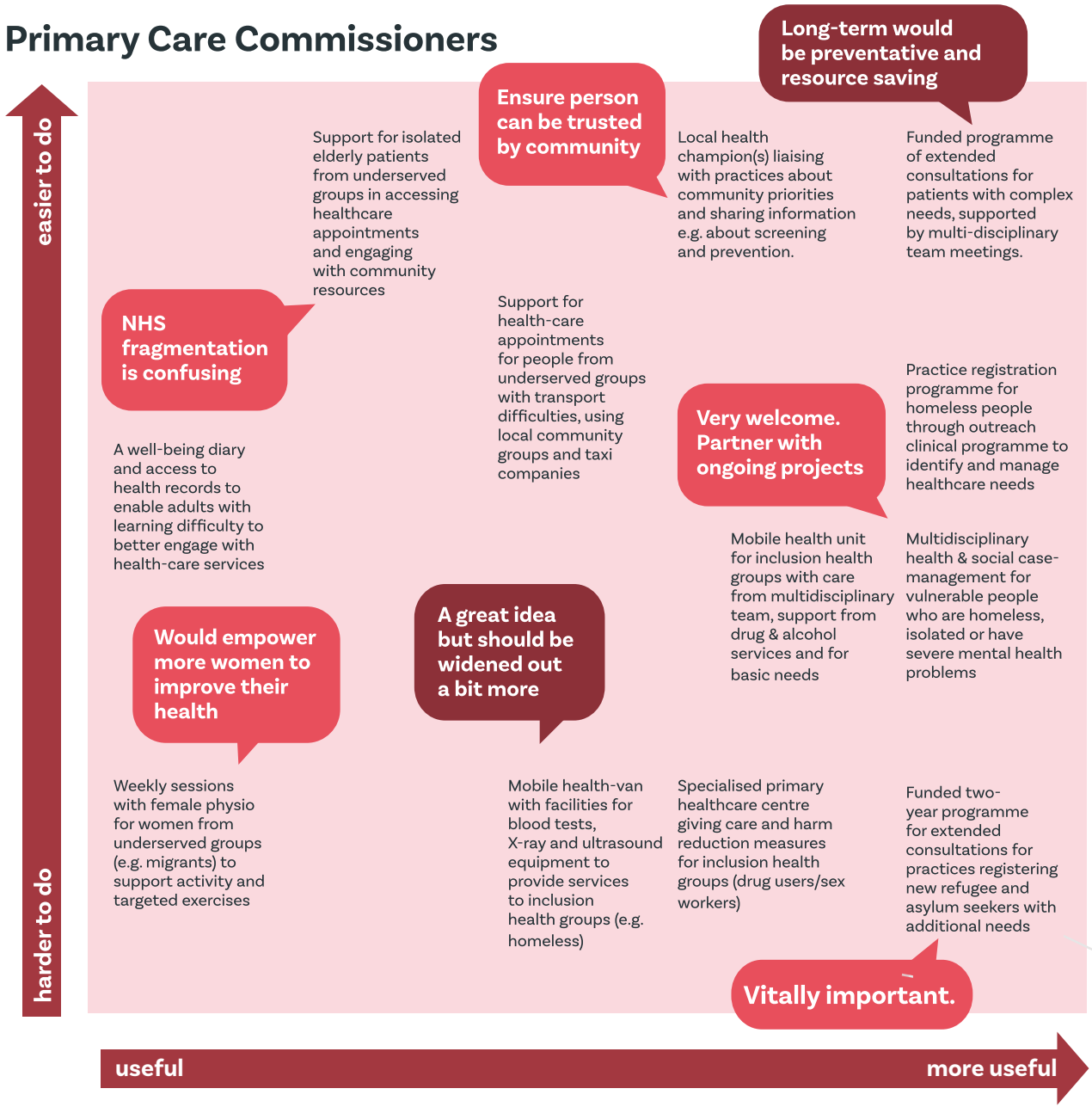
- alternative registration pathways
- translation services, safe environment, information about healthcare entitlements
- Clinical and administration staff should be trained around barriers in access for vulnerable migrants and provide consistent and uninterrupted support.
- Changes should be co-designed with patients (e.g.,information exchange and registration pathways)

STEP 4: Changes to address the inequity

- Don’t ask for proof of identification, address, and/or immigration status.
- Understand patients’ concerns about safety and suggest that they are registered with an alternative address e.g., you can use the address of the practice, a community space, a mosque or a church.
- Ensure vulnerable patients that their information is safe with you.
- Use ‘on-line’ translation services and provide interpreters to make the communication with patients more effective.
- Make sure that you provide interpretation services tailored to patient needs (and not based on assumptions about broader migrant groups) and that the interpreter effectively shares what the patient wants to share.
- Provide posters with information about healthcare entitlement and available services in visible places in the surgery and in different languages.
- Empower clinical and administration staff with training about the barriers that vulnerable migrants face and effective ways to reduce them.

RECOMMENDATIONS

Primary Care Commissioners



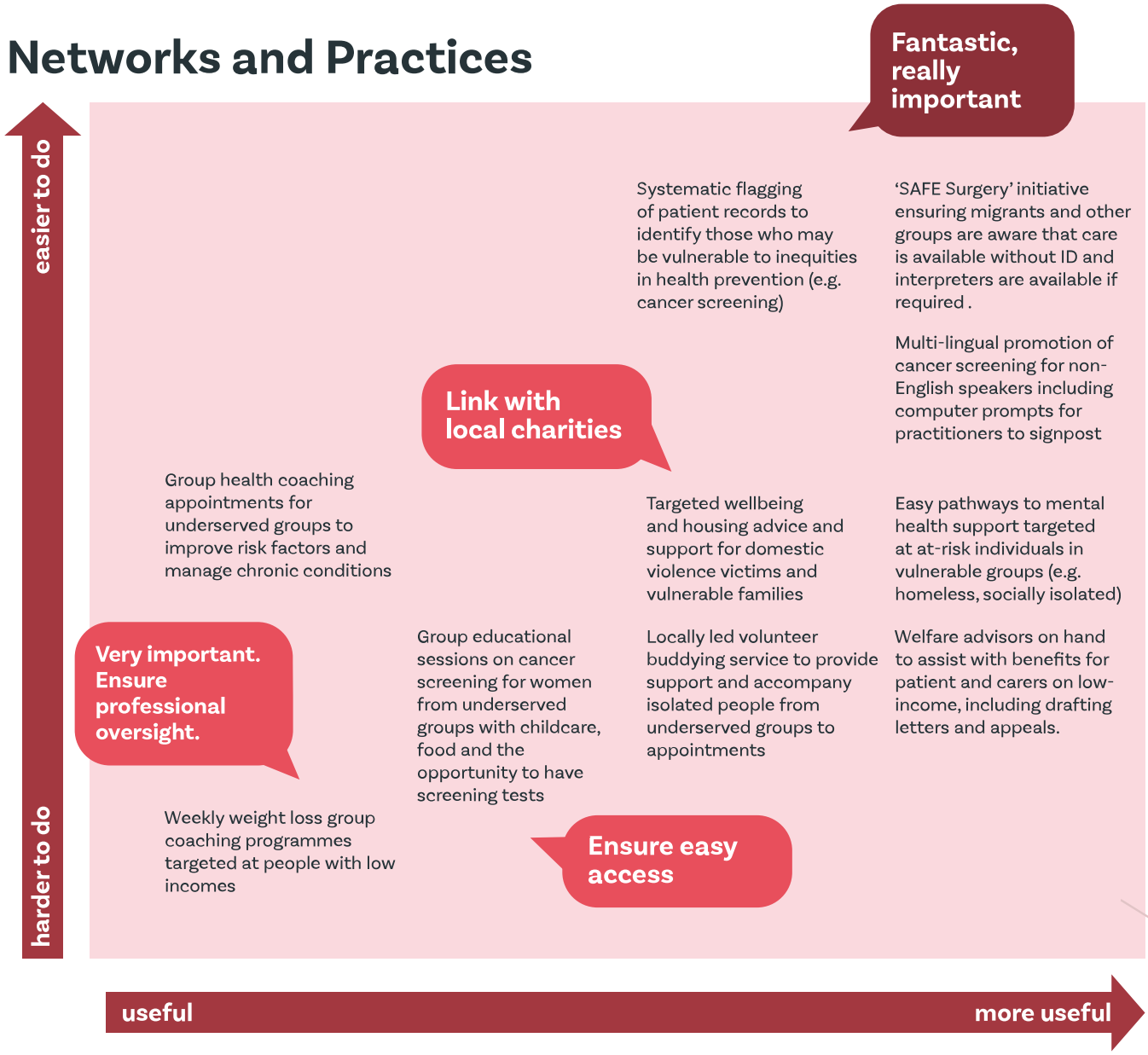
FAIRSTEPS prioritised interventions for **primary care commissioners** help them identify where and when to target investment at networks or practices or at specialised commissioned services. They comprise of three main groups:

1. Interventions that require targeted investment that enhance generalist care through current primary care services (enhanced services that address the inverse care law).
2. Interventions that make access to current services easier for underserved groups.
3. Interventions that require new specialised inclusion health services.

Speech bubbles indicate summaries of comments from members of our public participation group.

RECOMMENDATIONS

Networks and Practices



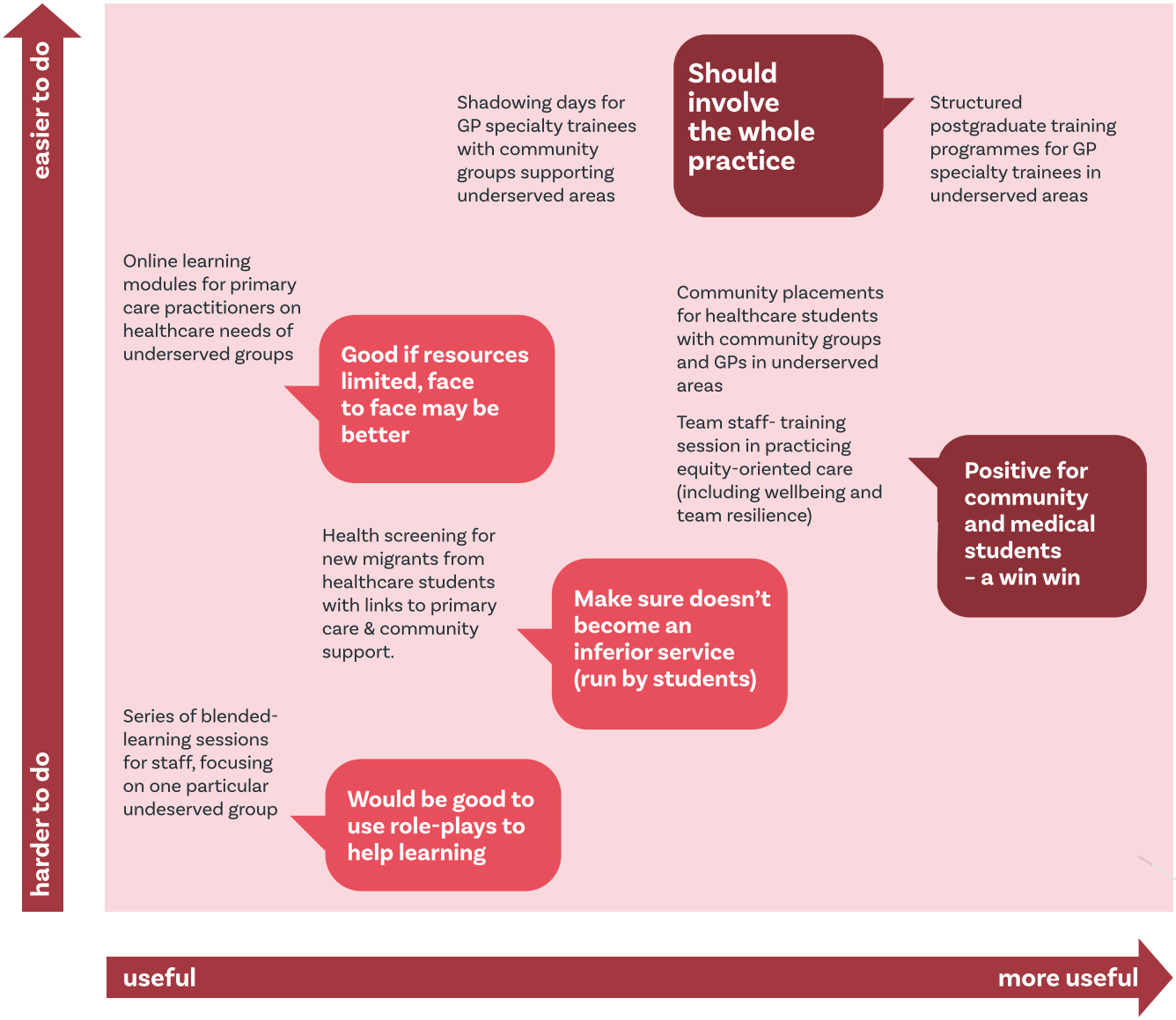
FAIRSTEPS Prioritised interventions for **networks and practices** fall into three groups:

1. Ways in which practices could alter their systems and processes more independently.
2. Collaborative interventions involving others such as patient groups, charity or community groups (potentially provided across a connected network of practices).
3. A group of targeted interventions to help patients support their own wellbeing.

Speech bubbles indicate summaries of comments from members of our public participation group.

RECOMMENDATIONS

Education and Training Providers



FAIRSTEPS prioritised interventions for **education and training providers**, which had a number of characteristics that appeared to be important:

1. Educational interventions should start as early as possible in the training pathway of health practitioners to establish a professional narrative.
2. Interventions that provided engaged experiential learning were more likely to be more useful and effective than other forms of learning, though less easy to implement.
3. Continuing professional development for teams that recognised the intersectionality of inequities and challenged attitudes to under-served groups were seen to be particularly important.

Speech bubbles indicate summaries of comments from members of our public participation group.

RECOMMENDATIONS

Key recommendations for national policy makers, local health systems and primary care organisations

1. National policy makers should keep the reduction of health inequalities high on their agenda and plan solutions building on intersectionality, a long-term perspective, integration of different services and policy domains, and the engagement of primary care services front-line workers and disadvantaged groups. Population Health Management approach could be utilised to define the groups facing inequities.

2. Regional commissioning organisations and local primary care providers should cultivate an inclusive organisational culture from top to bottom. This involves: tapping into community assets and taking an ABCD approach to provide community centred care; working with local authorities, voluntary, community and social enterprise partners to provide inclusive integrated care; engaging with carers and patient representatives; working closely with equality, diversity, and inclusion bodies to tackle structural racism, sexism, ableism, homophobia and transphobia.

3. Workforce, training and education organisations should develop schemes and medical school placements to promote the recruitment and retention of local staff in disadvantaged areas. These would promote community building and involve financial or training incentives, especially to less experienced employees.

4. National and regional primary care policy makers should distribute funding to account better for differences in need of served populations. Building on intersectionality and flexibility, this can involve integrating patient socio-economic status and ethnicity in healthcare funding formulae and higher patient list weighting for general practices in disadvantaged areas.

RECOMMENDATIONS

Key recommendations for national policy makers, local health systems and primary care organisations

Workforce, training and education commissioners and providers should consider the delivery of health equity focused training as an integral part of the undergraduate and postgraduate medical education.

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Local primary care providers should strengthen the continuity and diversity of services building on community. This should start with identifying the people experiencing inequalities in their local area and work closely with community leaders. It should involve personalised holistic care with "what matters to you" conversations, long-term relationships between care teams and local communities, the (co)-location of services close to community landmarks (e.g., schools, libraries), the provision of community transport options, and targeted home visits.

Local primary care providers should collect patient socio-demographic information and integrate it in care and care evaluation. Such initiatives involve inclusive risk calculation algorithms, IT resources, up-to-date patient registers, allocating data collection to specific staff members, and training on data collection tools and data sharing policies.

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For a detailed account of the EQUALISE study and our findings please visit: https://www.sciencedirect.com/science/article/pii/S2468266723000932?via%3Dihub

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