# Launch of Teg I Bawb / Fair for All: A Strategic Action Plan to address health inequalities through Primary Care

Primary Care Division, Public Health Wales

11/12/25

# Webinar Agenda

| Item | Who |
|---|---|
| Welcome and introduction to the Webinar | Kerry Bailey, Consultant in Public Health, Public Health Wales |
| **Why this matters?**<br>• Why this matters for sustainable health and wellbeing in Wales & how it is aligned with the Wellbeing of future generations Act<br><br>• Why is this plan needed?<br>○ What is it like to navigate services? - A lived and living experience perspective<br><br>○ What is it like to provide care in a deep end practice? - A GP perspective | Marie Brousseau-Navarro, Deputy Commissioner and Director for Health, Office of the Future Generations Commissioner<br><br>Nicholas Rhead, Chair of Lived Experiences Alliance Forum, Western Bay<br><br>Neil James, GP, Meddygfa Cwm Rhymni Practice and Chair of Deep End Cymru |
| **How we developed the plan?**<br>Introduction to the action plan | Fatima Sayed, Principal Public Health Practitioner, Public Health Wales & Kerry Bailey, Consultant in Public Health, Public Health Wales |
| **What happens next?**<br>Implementing the plan | Fatima Sayed, Principal Public Health Practitioner, Public Health Wales & Kerry Bailey, Consultant in Public Health, Public Health Wales |
| Panel Question & Answer | |
| Closing reflections | |

# Launch of Teg I Bawb / Fair for All: A Strategic Action Plan to address health inequalities through Primary Care

Why this matters for sustainable health and wellbeing in Wales & how it is aligned with the Wellbeing of future generations Act

# Launch of Teg I Bawb / Fair for All: A Strategic Action Plan to address health inequalities through Primary Care

What is it like to navigate services? Expert by Experience

# HEALTH INEQUALITY AND PRIMARY CARE

Neil James, Chair Deep End Cymry
Joanna Watts-Jane, Deputy Chair Deep End Cymru
Kathrin Thomas, Public Health Lead, Deep End Cymru
Rebecca Jenkinson, Training and Education Lead, DEC
Jonny Currie, Policy Lead, DEC

November 2025

# RHYMNEY VALLEY GP

- White Rose Medical Centre
- Tillery Valley
- Victoria Surgery, Rhymney
- The Lawns
- Training practice
- Multiple services

# THE DISPROPORTIONATE EFFECTS OF DEPRIVATION ON WELSH SOCIETY

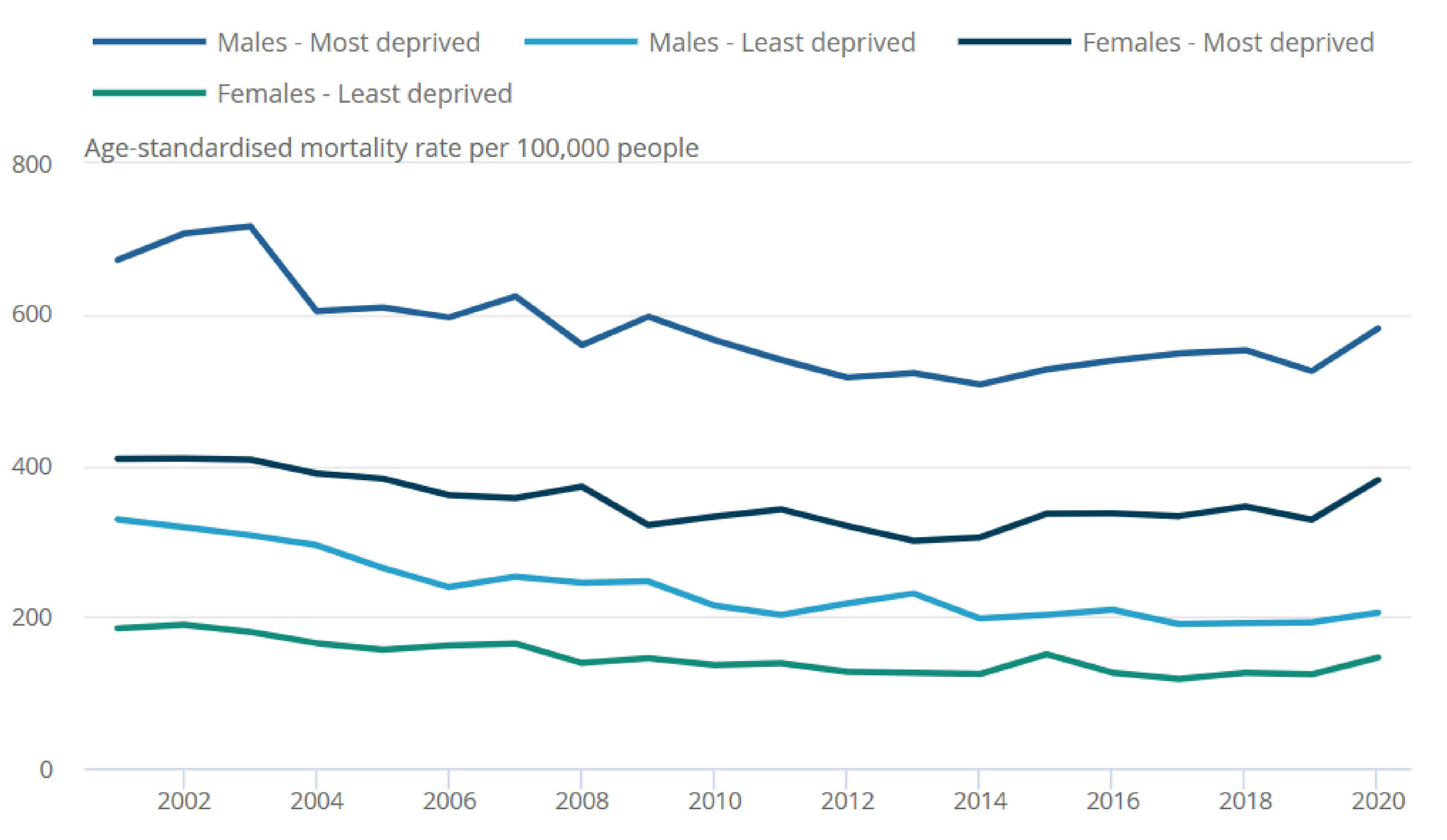
# PRIMARY CARE IN THE TWENTIETH CENTURY

- Health inequality embedded at the outset
- Independent contractor status but no strategy
- Wide variation in practice throughout the country
- Inverse care
- Reactive immigration
- Institutional naivety

# WHERE ARE WE NOW?

- Profound disintegration
- Perpetually naive?
- Slow dawning of awareness?
- Structural collapse

# Avoidable deaths: what the NHS needs to get right




37.0% of all male deaths in the most deprived areas of Wales compared with 18.9% in the least deprived areas in 2020;

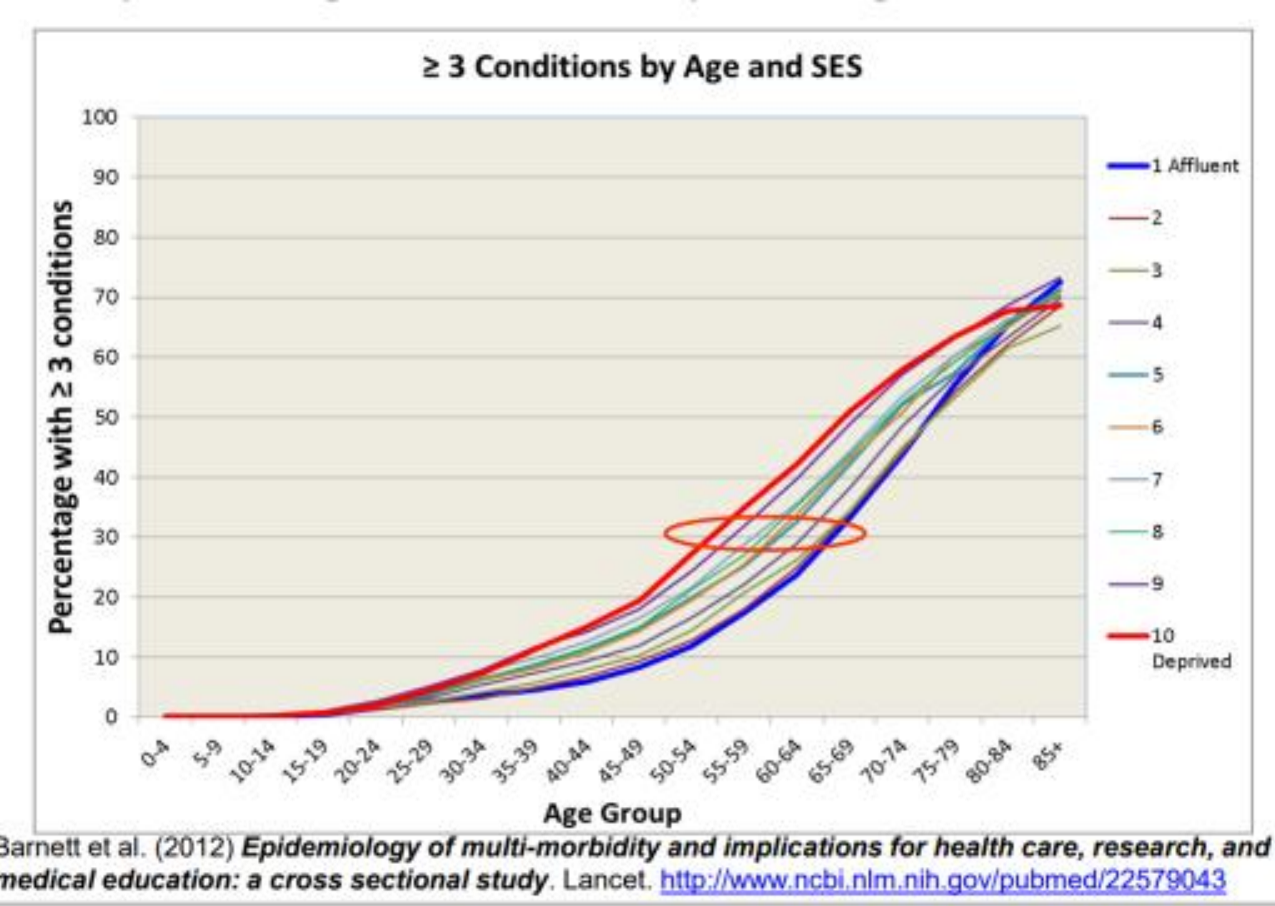
For females it was 25.7% and 14.1% respectively.

Source ONS

# Quality of Life

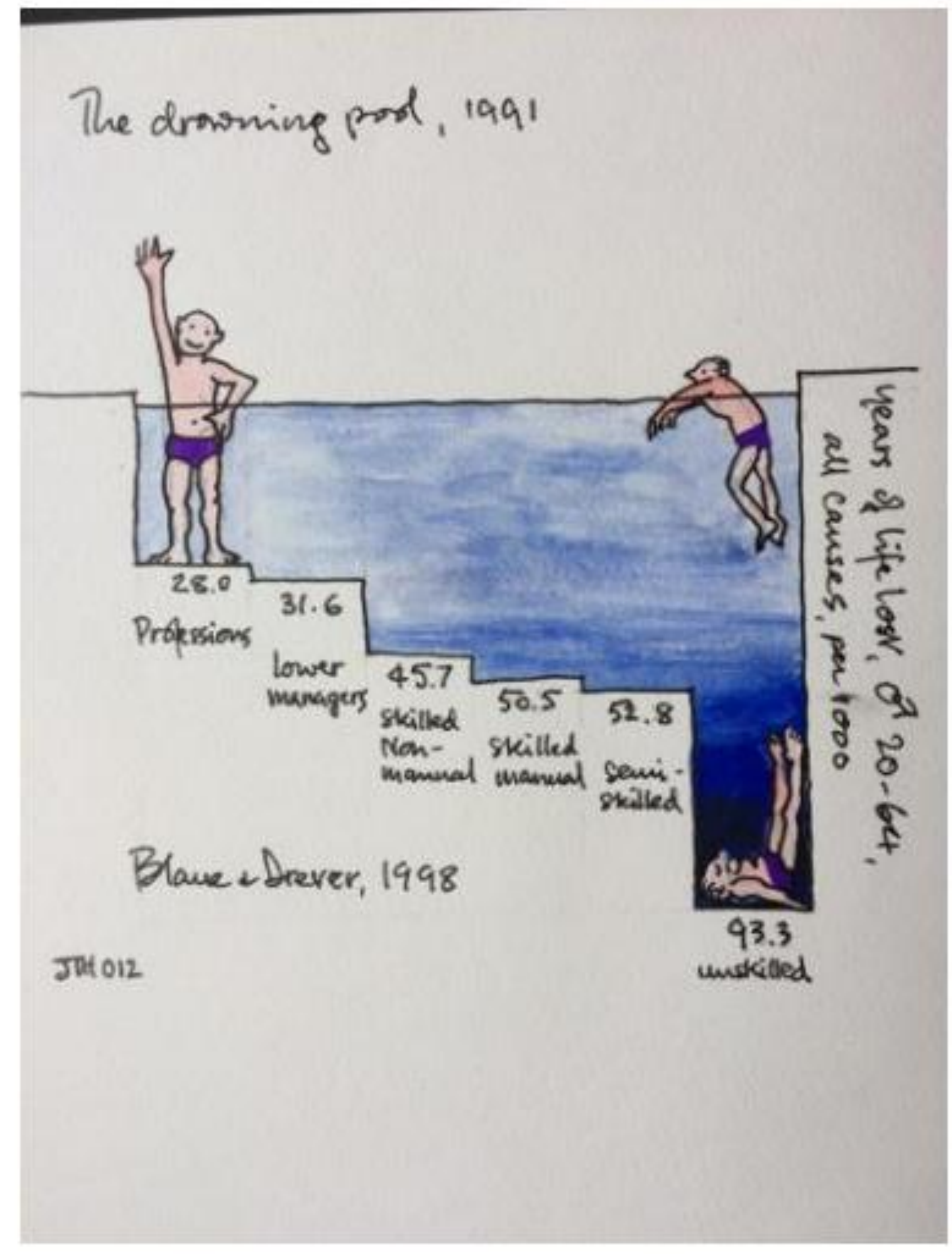
**The poor get more sicknesses at a younger age and for longer**

- Men living in the most deprived communities  spend an average of 13.3 **more** years living in poor health
- Women living in the most deprived communities  spend an average of 16.9  **more** years living in poor health




Barnett et al. (2012) ***Epidemiology of multi-morbidity and implications for health care, research, and medical education: a cross sectional study***. Lancet. http://www.ncbi.nlm.nih.gov/pubmed/22579043

**This massive burden of poor health has a HUGE impact on GP workload in more disadvantaged areas.**



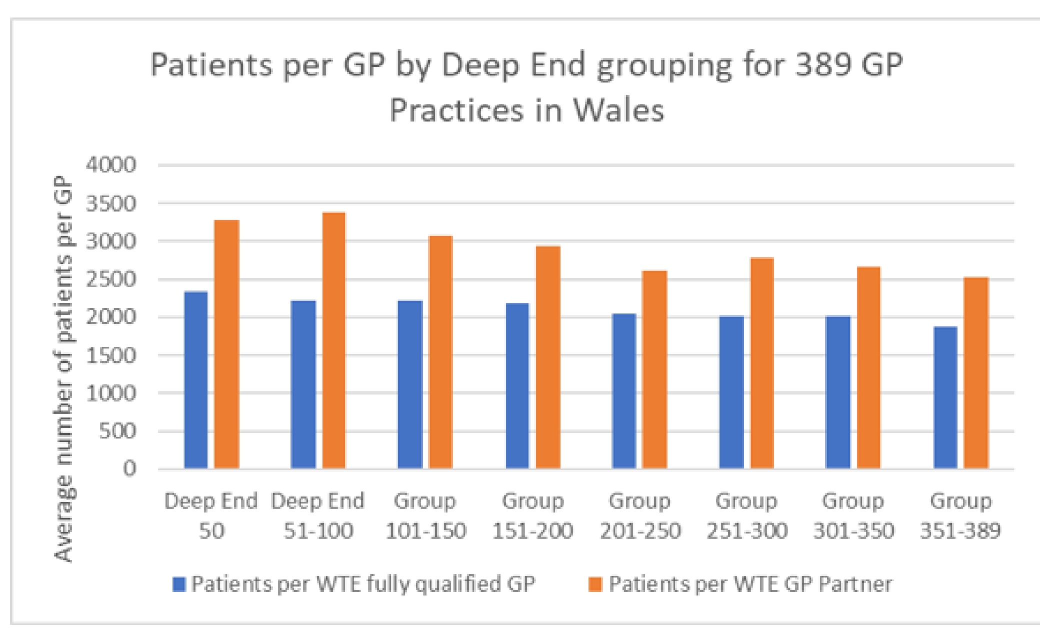

*"The availability of good medical care tends to vary inversely with the need for it in the population served"*

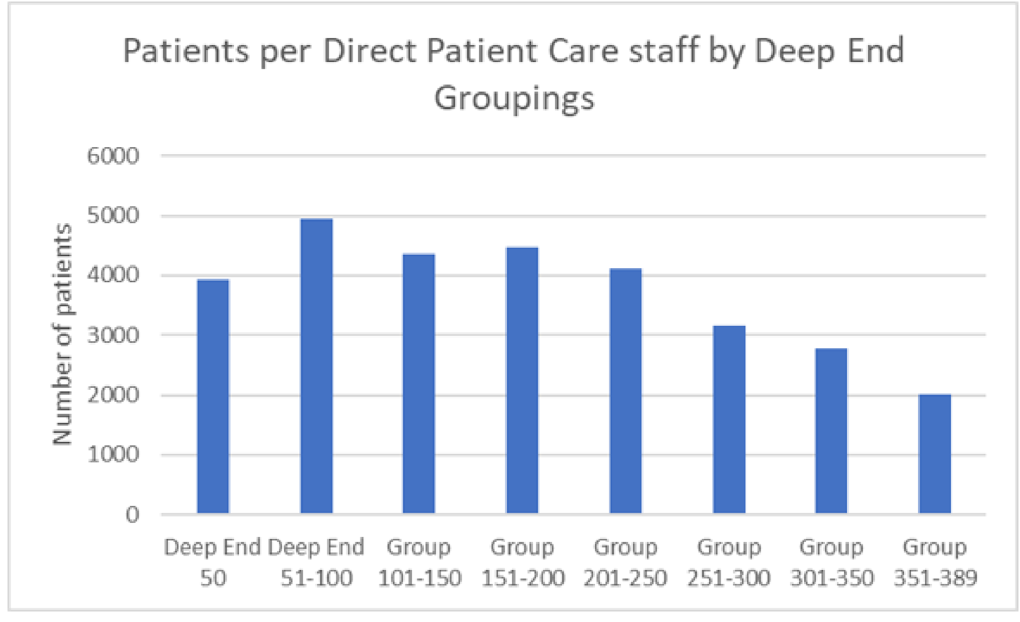
- **Not the difference between good and bad care, but between what general practices *can* do and what they *could* do with resources based on need.**
- **The inverse care law is a policy of the NHS which restricts care in relation to need.**

Dr David Blane, Deep End Scotland

"It's not a neutral situation. There is very solid evidence that the NHS, though free, isn't impartial. It actively favours affluent populations."

Dr Peter Cawson, Founder member of Deep End Scotland




# Inverse Care Law

Deep End GPs have larger list sizes, compared to the 100 Practices with the least proportion of patients in the most deprived areas:

- 266 (13.2%) more patients per fully qualified GP.
- 764 (29.7%) more patients per GP Partner
- 1927 (77.7%) more patients per Direct Patient Care staff

**Different Patients**

- Obesity/ smoking/ alcohol/ substance misuse
- Mental health/post trauma/ personality
- Infectious diseases
- Complexity and multi-morbidity
- Language barriers/ Low health literacy
- Cultural issues
- Non-responder for prevention.
- Chronic illness
- Homelessness
- Walk in patients
- Poor understanding of health care system
- Younger cohort, less funded

**Impact**

- Increased consultation time

- Frequent attendance for even minor ailments
- Disease prevalence difficult to manage with many patients having no medical history
- Safeguarding/ inquests
- Increased security costs
- Difficulty in recruitment and sourcing locums
- Practitioner stress/burnout and steep learning curve for new clinicians
- Difficulty reaching targets
- Need to offer higher sessional rate to deal with additional pressure
- Large amounts of DNA's which waste money despite DNA policy
- Lower income/ less alternative income
- Higher Number of Admin Staff and Reception

Thank you Diolch yn fawr

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# Teg I Bawb – Fair For All

## Lleihau Anghydraddoldebau Iechyd trwy Ofal Sylfaenol: Cynllun Gweithredu Strategol I Cymru

Cyflwynwyr:
Dr Kerry Bailey, Ymgynghorydd Iechyd y Cyhoedd
Fatima Sayed, Prif Ymarferydd Iechyd y Cyhoedd

Diolch i’r tîm Lleihau Anghydraddoldebau Iechyd:
Victoria Tice, Rahul Dalal, Martin Naughton, Eve Salter am eu cefnogaeth a'u cyfraniadau

# Teg I Bawb – Fair For All

## Reducing Health Inequalities in Primary Care; A Strategic Action Plan For Wales

Presenters:
Dr. Kerry Bailey, Consultant in Public Health
Fatima Sayed, Principal Public Health Practitioner

Thanks to Health Inequalities Team:
Victoria Tice, Rahul Dalal, Martin Naughton, Eve Salter for their support and contributions

# Amlinell

# Outline

- Cefndir
- Fframweithiau
- Cynllun ar gyfer ar ôl heddiw

- Background
- Framework
- A plan for after today

# Yr achos dros tegwch iechyd

- Dylai pawb gyrraedd eu potensial llawn ar gyfer iechyd a lles. Cyfiawnder cymdeithasol yw cydraddoldeb iechyd.

- Deddf Cydraddoldeb 2010 a'r Ddyletswydd Economaidd-Gymdeithasol.
- Targed 'Cymru iachach' Cenedlaethau'r Dyfodol: *cynyddu disgwyliad oes iach (blynyddoedd a dreulir mewn iechyd da) a lleihau'r bwlch mewn disgwyliad oes iach rhwng yr ardaloedd mwyaf difreintiedig a'r ardaloedd lleiaf difreintiedig o leiaf 15% erbyn 2050.*

- Mae anghydraddoldebau iechyd yn costio arian i GIG Cymru, amcangyfrifir main o leiaf £322 miliwn y flwyddyn oedd hyn yn 2018/19 .
- Mae anghydraddoldebau iechyd yn disbyddu cynhyrchiant a thwf economaidd.

# The case for health equity

- Everyone should attain their full potential for health and well-being. Health equity is social justice.

- Equality Act 2010 and Socio-economic Duty
- Future Generations 'A healthier Wales' target: *to increase healthy life expectancy (years spent in good health) and narrow the gap in healthy life expectancy between the most and least deprived areas by at least 15% by 2050.*

- Health inequalities costs NHS Wales money, estimated to be at least £322 million per year in 2018/19
- Health inequalities drain productivity and economic growth

Mae babi 2x yn fwy tebygol o farw os yw'n Ddu neu Asiaidd o'i gymharu â babi gwyn

Mae oedolion LHDTC+ 2x yn fwy tebygol o adrodd bod ganddynt gyflwr iechyd meddwl hirsefydlog

Mae niferoedd dynion yn yr ardaloedd mwyaf difreintiedig sy'n profi cyfraddau marwolaethau y gellir eu hosgoi hyd at 4.1 gwaith yn uwch na'r rhai yn yr ardaloedd llai difreintiedig

Mae dynion a menywod digartref yn tueddu i fyw am 30-40 mlynedd yn llai na'r boblogaeth gyffredinol

Mae pobl sy'n byw yn yr ardaloedd mwyaf difreintiedig bron 2x yn fwy tebygol o aros > 1 flwyddyn am driniaeth o gymharu â'r ardaloedd lleiaf difreintiedig

Mae ardaloedd gwledig yn profi ffurfiau cudd o amddifadedd. Maent yn aml yn cael trafferth gydag incwm isel, diffyg cyfleoedd cyflogaeth, a thlodi tanwydd, allgáu digidol, mynediad gwael at wasanaethau.

**Ffynonellau:** Swyddfa Ystadegau Gwladol (ONS)/ Dangosyddion cenedlaethol Llesiant Cymru 2022 (LlC)/ Iechyd a gofal gwledig Cymru/ Gwasanaeth Ymchwil Cynulliad Cenedlaethol Cymru (Llyw.Cymru)

A baby is 2x more likely to die if they are Black or Asian compared to a White baby

LGBTQ plus adults are 2x likely to report having a longstanding mental health condition

Men in the most deprived areas experiencing avoidable mortality rates up to 4.1 times higher than those in the least deprived areas

People experiencing homelessness live 30-40 years shorter than general population

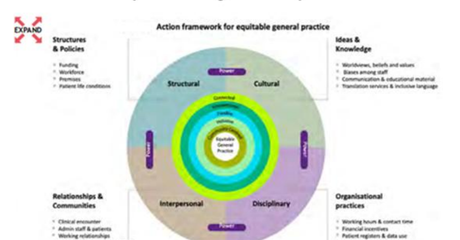
People living in the most deprived areas are nearly 2x as likely to wait > 1 year for treatment compared to the least deprived areas

Rural areas experience hidden forms of deprivation. They often struggle with low incomes, lack of employment opportunities, and fuel poverty, digital exclusion, poor access to services.

**Sources:** Office for National Statistics (ONS)/ Wellbeing of Wales National indicators 2022 (WG)/ Rural health and care Wales/ National Assembly for Wales Research Service (Gov.Wales)

# Sut wnaethom gyrraedd yma?  How we got here?

EQUALISE: An action framework for equitable general practice

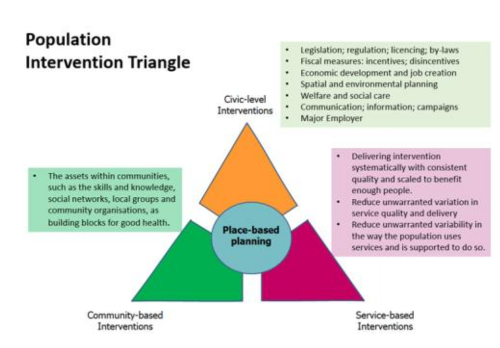



FAIRSTEPS Framework Process

1 2 3 4

10 WAYS BUSINESSES CAN HELP TO REDUCE HEALTH INEQUALITIES

england.healthinequalities@nhs.net



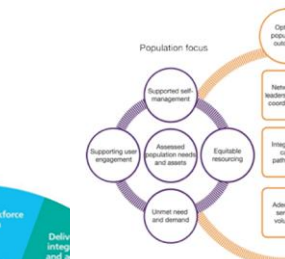

PREVENTION-BASED HEALTH & CARE

A framework to embed prevention in the health and care system in Wales

ACHIEVING HEALTH & MENTAL HEALTH EQUITY AT EVERY LEVEL

Transforming the conditions in which people are BORN, GROW, LIVE, WORK and AGE for optimal health, mental health & well-being.

HEALTHY PEOPLE · HEALTHY COMMUNITY · HEALTHY ENVIRONMENT · HEALTHY SOCIETY



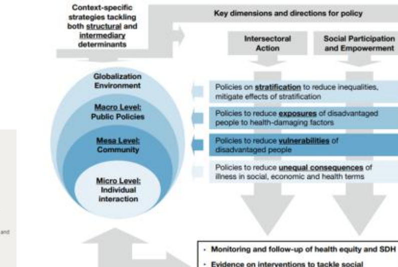

Credit: PHE Public Health Data Science based on the original concept created by Chris Bentley.

Inclusion health principles

1 Commit to action on inclusion health
2 Understand the characteristics and needs of people in inclusion health groups
3 Develop the workforce for inclusion health
4
5 Demonstrate impact and improvement through action on inclusion health

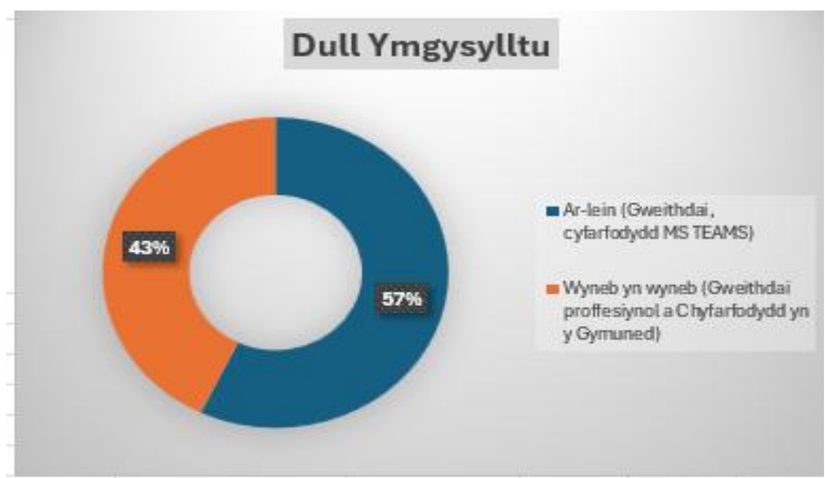
ETR's Health Equity Framework.

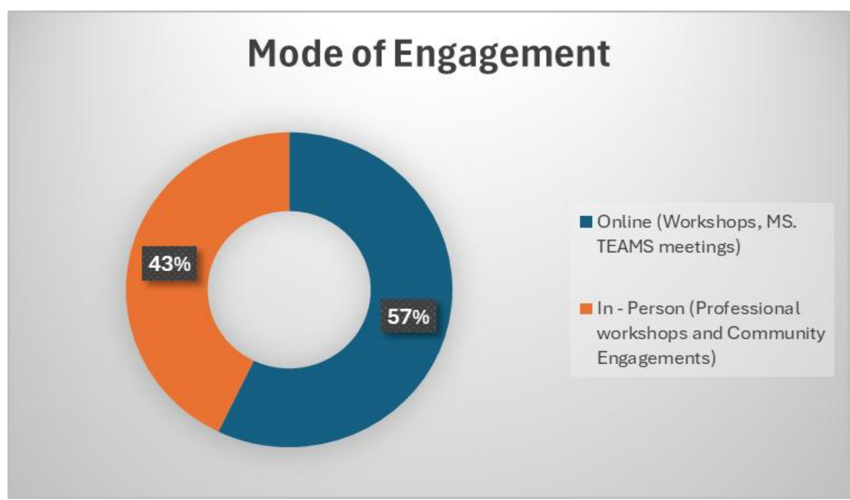
Health and Education Outcomes

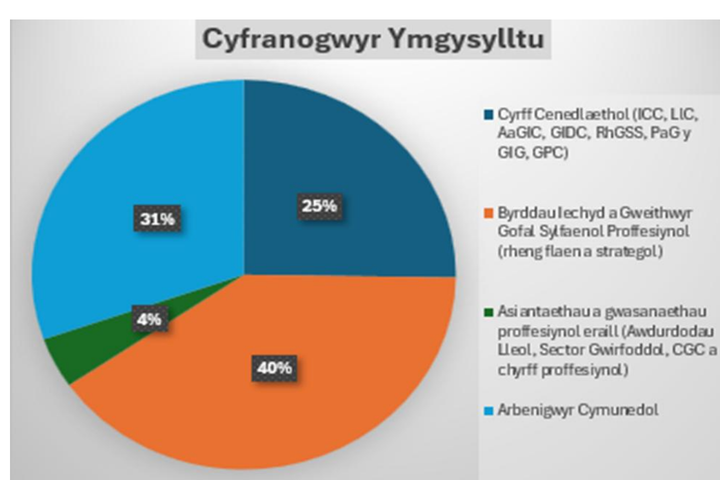


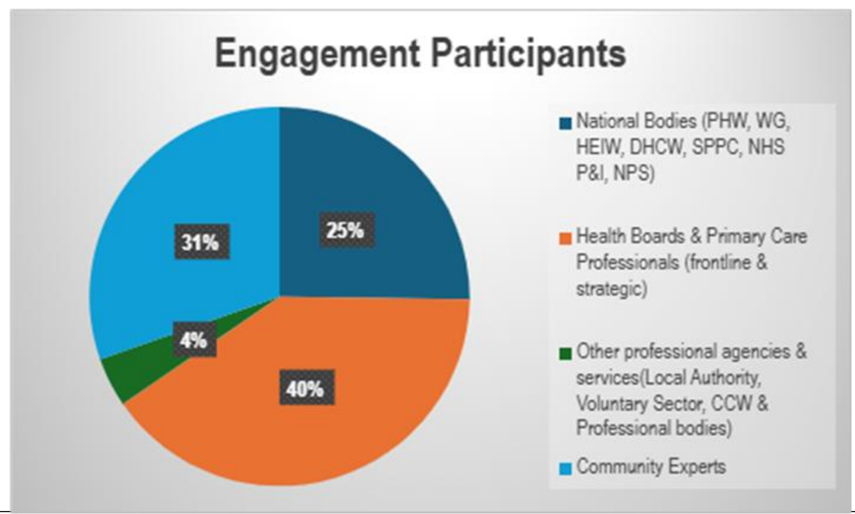
# Cyfranogwyr

# Participants



# Beth ddywedodd pobl? What did people say?

Efallai na fydd fframweithiau presennol i leihau anghydraddoldebau iechyd yn cyd-fynd yn llwyr ag anghenion a chyd-destun penodol Cymru.

Existing frameworks to reduce health inequalities may not fully align with the specific needs and context of Wales.

Roedd rhanddeiliaid eisiau camau gweithredu ymarferol ar gyfer pob rhan o'r system gofal sylfaenol, yn hytrach na fframwaith cysyniadol newydd.

Stakeholders wanted practical actions for each part of the primary care system, rather than a new conceptual framework.

Blaenoriaethu pum prif conglfaen a'u cymhwyso i'r meysydd clinigol sy'n cael yr effaith fwyaf ar anghydraddoldebau iechyd.

Prioritise five key pillars and apply them to the clinical areas with highest impact on health inequalities

Cyflogi mwy o staff gofal iechyd i leihau'r amseroedd aros.

Employ more healthcare staff to reduce wait times.

Sicrhau parhad gofal — gweld yr un gweithiwr proffesiynol lle bo modd.

Ensure continuity of care – seeing the same professional where possible.

Gwella'r cyfathrebu, yn enwedig o ran hawliau cleifion ac argaeledd gwasanaethau.

Hyfforddi staff mewn empathi a chymhwysedd diwylliannol, gan gynnwys yr angen am ddulliau anfeirniadol sy'n ystyriol o drawma.

Train staff in empathy and cultural competence, including a need for non- judgmental, trauma-informed approaches.

**Gweledigaeth:** Cymru iachach a thecach lle mae Gofal Sylfaenol yn lleihau anghydraddoldebau iechyd yn weithredol drwy gamau cydgysylltiedig, sy'n cael eu llywio gan y gymuned ac sy'n seiliedig ar ddata.

Isod mae camau gweithredu diffiniedig a nodwyd drwy grynhoi tystiolaeth, ac ymgynghoriadau ag arbenigwyr trwy brofiad ac arbenigwyr yn ôl proffesiwn ledled Cymru. Rhoddwyd amserlenni dangosol i'r camau gweithredu hyn, a bydd yn rhaid i bob sefydliad ddatblygu ei gynllun gweithredu ei hun yn unol â phob cam gweithredu.

| MEWNBYNNAU | | Arweinyddiaeth a Diwylliant | Rheoli Data ac Iechyd y Boblogaeth | Cyllid ac Adnoddau | Y Gweithlu | Cynnwys y Gymuned |
|---|---|---|---|---|---|---|
| CAMAU GWEITHREDU | Camau Gweithredu Tymor Byr i'r Tymor Canolig Blwyddyn 1 – 5 | Penodi arweinwyr atebol ar draws sefydliadau a thimau.<br>Arweinwyr a benodwyd i ddechrau dylanwadu ar y diwylliant a'r arferion. | Dadgyfuno metrigau fesul oedran, rhyw ac amddifadedd.<br>Gwella metrigau anghydraddoldeb eraill yn cynnwys ethnigrwydd, iechyd cynhwysiant ac allgáau digidol.<br>Defnyddio dulliau iechyd y boblogaeth ar gyfer cynllunio a chyflenwi. | Adolygu modelau ariannu.<br>Cynnal gwerthusiad opsiynau o fodelau ariannu.<br>Buddsoddi sy'n canolbwyntio ar degwch a dosbarthu gwasanaethau gorfodol. | Datblygu modelau a phecynnau hyfforddiant tegwch ar gyfer gwahanol rolau.<br>Trefnu bod cyfleoedd ar gyfer dysgu yn y swydd a systemau dan arweiniad cyfoedion ar waith mewn meysydd y mae eu hangen yn fawr.<br>Blaenoriaethu prentisiaethau uwch mewn gofal iechyd. | Datblygu a chyhoeddi canllawiau ar ymgysylltu â chymunedau ac unigolion sydd â phrofiad bywyd.<br>Cynnwys arbenigwyr trwy brofiad a lleisiau'r gymuned wrth gynllunio, darparu a gwella gwasanaethau.<br>Datblygu gwasanaethau mwy integredig yn yr ardaloedd lle mae'r angen mwyaf. |
| | ...mau gweithredu ...mor Canolig i'r Hirdymor ...wyddyn 5 – 10 | Penodi arweinwyr i wreiddio tegwch mewn gwaith cynllunio a chomisiynu ac yn niwylliant y sefydliad. | Pob metrig gwasanaeth a chanlyniad wedi'i ddadgyfuno fesul amddifadedd, rhywedd, daearyddiaeth, ethnigrwydd a mynediad digidol.<br>Metrigau tegwch iechyd wedi'u | Dosbarthu cyllid ac adnoddau yn adlewyrchu amddifadedd ac anghenion y boblogaeth.<br>Prif ffrydio pob menter arloesol a ariennir y profwyd | Rhoi hyfforddiant i'r gweithlu Gofal Sylfaenol ar degwch a chydraddoldeb.<br>Datblygu modelau recriwtio a chadw gweithlu cynhwysol, a'u | Gwreiddio profiad bywyd ac ymgysylltiad cymunedol mewn dylunio a darparu gwasanaethau.<br>Normaleiddio darparu |

**Vision:** A fairer, healthier Wales where Primary Care actively reduces health inequalities through coordinated, community-informed, and data-driven actions.

Below are focused actions identified through the synthesis of evidence, and consultations with experts by both experience and profession across Wales. These actions have been given indicative timeframes, and it will be for each organisation to develop their own implementation plan in alignment with each action.

| INPUTS | | Leadership & Culture | Data & Population Health Management | Finance & Resources | Workforce | Community Involvement |
|---|---|---|---|---|---|---|
| ACTIONS | Short to Medium Term Actions Year 1 - 5 | Appoint accountable leaders across organisations and teams.<br>Appointed leaders to begin to influence culture and practices. | Disaggregation of metrics by age, gender and deprivation.<br>Improve other inequality metrics including ethnicity, inclusion health, and digital exclusion.<br>Use population health approaches for planning and delivery. | Review funding models.<br>Undertake options appraisal of funding models.<br>Equity focused investment and distribution of services mandated. | Develop equity training models and packages for different roles.<br>On the job learning opportunities and peer-led systems are in place in areas of high need.<br>Higher apprenticeships in healthcare are prioritised. | Develop and publish guidance on engagement with communities and individuals with lived experience.<br>Include experts by experience and community voices in service planning, delivery and improvement.<br>Develop more integrated services in the areas of highest need. |
| | Medium to Long Term Actions Year 5 - 10 | Appointed leaders to embed equity in planning, commissioning and organisational culture. | All service and outcome metrics are disaggregated by deprivation, gender, geography, ethnicity and digital access.<br>Health equity metrics are embedded in all monitoring and evaluation activities. | Funding and resource distribution reflect deprivation and population need.<br>All funded innovations proven to reduce health inequalities are mainstreamed. | Train Primary Care workforce in equity and equality.<br>Inclusive workforce recruitment and retention models developed and actively monitored. | Embed lived experience and community engagement into service design and delivery.<br>Normalise integrated service delivery. |
| VISION | | A culture of leadership grounded in equity. | Easily accessible equity data to enable embedding of population health approaches. | Finance and resource allocation is transparent and based on need. | An inclusive and equity-informed Primary Care workforce. | Routine inclusion of community engagement and lived experience as standard practice. |

| INPUTS | | Leadership & Culture | Data & Population Health Management | Finance & Resources | Workforce | Community Involvement |
|---|---|---|---|---|---|---|
| ACTIONS | Short to Medium-Term Actions Year 1 - 3 | Appoint accountable leaders across organisations and teams.<br>Appointed leaders to begin to influence culture and practices. | Disaggregation of metrics by age, gender and deprivation.<br>Improve other inequality metrics including ethnicity, inclusion health, and digital exclusion.<br>Use population health approaches for planning and delivery. | Review funding models.<br>Undertake options appraisal of funding models.<br>Equity focused investment and distribution | Develop equity training models and packages for different roles.<br>On the job learning opportunities and peer-led systems are in place in areas of high need.<br>Higher apprenticeships in healthcare are prioritised. | Develop and publish guidance on engagement with communities and individuals with lived experience.<br>Include experts by experience and community voices in service planning, delivery and improvement.<br>Develop more integrated services in the areas of highest need. |
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# Welsh Government

| INPUTS | Leadership & Culture | Data & Population Health Management | Finance & Resources | Workforce | Community Involvement |
|---|---|---|---|---|---|
| ACTIONS | • Appoint accountable leaders to embed equity across the Primary Care system.<br>• Clearly articulate the role of the NHS in health inequalities.<br>• Promote a culture of inclusion and involving all voices.<br>• Embed equity in all planning, governance, accountability and statutory contracts. | • Disaggregate all performance metrics by inequality dimensions.<br>• Use data for action, not just for monitoring.<br>• Implement a national Health Inequalities Dashboard.<br>• Ensure enablers such as governance, data sharing, and legislation are in place, and the National Data Resource includes Primary Care. | • Publish data for Primary Care funding and deprivation.<br>• Mandate equity-focused investment through a national funding code of practice.<br>• Reform funding formulae to reflect deprivation and population need.<br>• Mainstream innovation funding for programmes proven to reduce inequalities. | • Establish equity-related targets for workforce recruitment and retention.<br>• Prioritise initiatives such as apprenticeships for both non-clinical and clinical roles. | • Lead by example, by including communities and experts by experience in policy development.<br>• Include community engagement activities in contracts.<br>• Work with the Future Generations Commissioner and demonstrate the involvement of community in health planning and evaluation.<br>• Ensure Primary Care Quality Improvement (QI) projects include an explicit equity focus. |

# National Bodies

| INPUTS | Leadership & Culture | Data & Population Health Management | Finance & Resources | Workforce | Community Involvement |
|---|---|---|---|---|---|
| ACTIONS | • **All National Bodies:** Ensure board-level leadership is accountable for embedding equity into strategy and delivery.<br>• **NHS Performance and Improvement (NHS P&I):** Appoint a designated equity lead within cardiometabolic and respiratory networks, with the aim of expanding this role across all clinical networks over time.<br>• **Public Health Wales (PHW):** Produce and deliver leadership development programmes and training to support equity-focused planning and service delivery.<br>• **PHW / Health Education and Improvement Wales (HEIW):** Provide development for leaders in health boards and primary care, including clusters, to strengthen skills on population health approaches and equity culture. | • **NHS P&I:** Ensure all cardiometabolic and respiratory programme data are disaggregated and monitored through a health equity lens.<br>• **PHW:** Lead in identifying and promoting best practices for data disaggregation, evidence use, and evaluation of effective equity-focused interventions.<br>• **PHW:** Coordinate and develop an evaluation framework for the implementation of this action plan.<br>• **Digital Health and Care Wales (DHCW) / PHW / HEIW:** Prioritise improved analysis of existing datasets over the collection of new data. | • **PHW:** Build the evidence base for financial and social return on equity-focused investments, and support strategies for more equitable funding allocation. | • **PHW / HEIW / Academic Partners:** Review and provide appropriate options on health inequalities training for undergraduate and postgraduate health professional training curricula, CPD, and both clinical and non-clinical new starter training.<br>• **All National Bodies:** Embed population health approach and skills for all involved in planning Primary Care services.<br>• **All National Bodies:** Foster a population health approach within the culture of all those involved in planning Primary Care services. | • **NHS P&I:** Embed structured community engagement, including lived experience, into strategy development processes.<br>• **PHW / NHS P&I:** Promote a unified, clear definition of primary care to community, to support engagement.<br>• **PHW:** Provide leadership and toolkits enabling community and experts by experience to be involved in planning and evaluation. |

# Health Boards

| INPUTS | Leadership & Culture | Data & Population Health Management | Finance & Resources | Workforce | Community Involvement |
| --- | --- | --- | --- | --- | --- |
| ACTIONS | • Appoint senior leaders in planning, finance, and operations responsible for driving health equity.<br>• Senior Primary Care leaders to use Health Equity and Health Impact Assessments in planning and delivery.<br>• Collaborate with Clusters and Pan Cluster Planning Groups to embed equity in the annual planning cycle.<br>• Introduce quarterly Health Equity Reviews to assess progress across all key outcomes and deliverables. | • Apply Population Health approaches to identify and respond to unmet Primary Care needs across population groups.<br>• Develop systems that integrate actual patient experience into data collection and analysis.<br>• Embed actual patient experience with service use data to influence planning.<br>• Prioritise research, evaluation, and innovation in high-need areas (e.g. 'Deep End' practices).<br>• Ensure local data-sharing agreements with key stakeholders, including local authorities and third sector, to enable collaborative and informed service planning and evaluation. | • Apply Health and Equality Impact Assessments systematically in all funding decisions.<br>• Allocate resources in alignment with population health needs, including populations with multiple overlapping needs.<br>• Direct funding to reduce health inequalities as a core organisational objective. | Support CPD training on health inequalities for clinical and non-clinical staff.<br>• Embed health inequalities training into all induction programmes and ensure availability for existing staff at all levels.<br>• Expand and diversify apprenticeship programmes across Health Boards, prioritising recruitment from underserved communities.<br>• Utilise apprenticeships to strengthen local workforce pipelines and support inclusive recruitment practices.<br>• Establish systems to continuously evaluate workforce planning, recruitment, and retention strategies for improvement.<br>• Implement structured initiatives such as rotational placements, mentoring, and peer support to attract and retain staff in underserved areas.<br>• Identify, support, and scale successful voluntary sector workforce partnership models (e.g. Helpforce Cymru, Public Health Wales). | • Work with partners to embed assertive outreach and integrated models of care delivery in areas of high need.<br>• Identify and utilise alternative, community-based settings for care delivery in collaboration with local partners and voluntary sector.<br>• Ensure accessible, inclusive communication by embedding equity and accessibility in all health promotion and public information materials.<br>• Normalise the routine inclusion of community engagement and lived experience as part of standard practice. |

# Regional Partnerships

| INPUTS | Leadership & Culture | Data & Population Health Management | Finance & Resources | Workforce | Community Involvement |
|---|---|---|---|---|---|
| ACTIONS | • Appoint a Health Equity Champion to lead and advocate in regional planning and delivery on the broader determinants as well as direct actions. | • Embed equity, equality, and inclusion health in Population Needs Assessments, well-being assessments and Regional Area Plans, to identify the most significant inequalities in their populations and target action to reduce inequities. | • Coordinate funding across local authorities, the third sector, and other partners to target investment in areas of greatest need.<br>• Ensure funding mechanisms are aligned with the Well-being of Future Generations (Wales) Act, enabling joint investment approaches that support sustainable improvements in high-need communities. | • Advocate for and raise awareness of available equity training for member organisations. | • Collaborate with Clusters to identify and implement place-based approaches within Regional Area Plans to address health inequalities, ensuring community needs and assets are central to regional decision-making.<br>• Ensure Primary Care has an active representation at Board level. |

# PCPG, Clusters and Professional Collaboratives

| | | | | | |
|---|---|---|---|---|---|
| **INPUTS** | **Leadership & Culture** | **Data & Population Health Management** | **Finance & Resources** | **Workforce** | **Community Involvement** |
| **ACTIONS** | • Introduce Health Equity Champions at **all levels** to promote equitable, inclusive, culturally competent, and trauma-informed planning and care.<br>• Primary care leaders advocate for integrated community, mental health, social care, housing and support services to support vulnerable groups and meet patient needs.<br>• Embed equity assessment as a core requirement in **PCPG** and **Cluster** annual planning cycles.<br>• Introduce quarterly Health Equity Reviews to monitor performance across all key outcomes and deliverables.<br>• Regularly report on how changes in planning and service delivery have contributed to measurable improvements in health equity. | • Apply Population Health approaches to identify and address unmet needs within local populations.<br>• Embed actual patient experience with service use data to influence planning.<br>• Develop data systems to reflect patient journeys, including lived experience and patterns of service use.<br>• Establish local data-sharing agreements with key partners – including local authorities and the third sector – to support coordinated service planning and delivery.<br>• Develop a **Cluster** plan for improving equity in cardiometabolic, respiratory, and cancer care. | • Apply Health and Equality Impact Assessments (HEIAs) in all **PCPG** and **Cluster** funding decisions.<br>• Allocate resources based on population health needs, with a focus on underserved communities.<br>• Direct cluster-level funding toward projects and initiatives that address health inequalities. | • Promote health equity training for all frontline clinical and non-clinical staff.<br>• Allocate protected CPD time for staff for equity-focused development.<br>• Embed training on health inequalities into all induction programmes.<br>• Implement structured incentives – such as rotational placements, mentoring, and peer support programmes – to support workforce attraction and retention.<br>• Identify, support, and scale effective workforce partnerships with voluntary sector organisations. | • Normalise local place-based approaches to reduce health inequalities.<br>• Embed collaboration and integrated working with community partners, prioritising areas with the greatest need first.<br>• Make diverse community engagement and lived experience contributions routine in planning, delivery and evaluation of services.<br>• Establish Community Health Equity Panels** in PCPGs or Clusters with clear governance.<br>• Partner with local organisations to deliver services in community settings.<br>• Establish peer-review and lived experience-review mechanisms in Clusters to respond to feedback and to share best practice.<br>• Use national resources such as Primary Care One to support equity in Cluster planning. |

# General Practice, Pharmacy, Optometry and Dentistry

| INPUTS | Leadership & Culture | Data & Population Health Management | Finance & Resources | Workforce | Community Involvement |
|---|---|---|---|---|---|
| ACTIONS | • Appoint a Health Equity Champion to drive action on reducing health inequalities and promote inclusive, culturally competent, and trauma-informed care.<br>• Promote a culture that enables trusted non-judgmental relationships between patients and health care professionals.<br>• Identify approaches to appointments which support continuity of care and access. | • Audit and identify patients with missing key indicators for CHD and diabetes (e.g., HbA1c, blood pressure, cholesterol, smoking status, BMI).<br>• Strengthen vaccination programmes for the most vulnerable – including children in supported housing.<br>• Standardise and improve equality data recording.<br>• Disaggregate or audit by health inequality measures (e.g. minimum deprivation, ethnicity), to inform cluster discussions and to support targeted interventions.<br>• Use community knowledge to develop ideas of 'missingness' in data and patients.<br>• Focus quality improvement projects on the conditions which contribute most to health inequalities and in which there are evidence of impact. | • Identify and pursue joint funding opportunities with local authorities, third sector partners, and communities.<br>• Coordinate funding across sectors to enhance resource impact.<br>• Ensure funding approaches are aligned with the Well-being of Future Generations (Wales) Act, enabling joint investment models that support long-term equity outcomes. | • Protect learning time for inequalities training (including Teg I Bawb, Making Every Contact Count (MECC)) for all clinical and non-clinical staff.<br>• Require all new starters to complete training that can help reduce health inequalities, including Teg I Bawb and MECC.<br>• Continue to build staff awareness of trauma, trauma informed care and re-traumatisation.<br>• Collaborate with partners across the Cluster to identify opportunities for local recruitment and apprenticeships within Primary Care.<br>• Create an empowering environment where staff are supported to act on:<br>- ensuring continuity of care when and where needed.<br>- proactive follow up appointments made during patient contacts.<br>- offering alternative mode and time of consultations and DNA follow up.<br>- engaging with support workers and voluntary sector partners to identify and deploy workforce support where appropriate. | • Establish ways to routinely incorporate patient feedback into day-to-day practice including from seldom heard voices.<br>• Develop and implement feedback mechanisms to capture patient experience related to access, discrimination, and unmet needs.<br>• Ensure multiple access routes to services, and varied modes of delivery, including in-person, phone, app, web and outreach.<br>• Co-develop services with local partners and patients to improve access to care.<br>• Where appropriate co-deliver outreach services such as mobile health clinics with local partners to improve access for vulnerable populations.<br>• Use Teg I Bawb resources to inform your practice policies relating to accessibility and inclusion. |

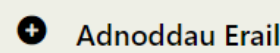
# Adnoddau/ Resources

https://gofalsylfaenolun.gig.cymru/files/rhaglen-cynhwysiad-iechyd-cymru-pdf/

https://gofalsylfaenolun.gig.cymru/pynciau/rhannu-ymarfer/gwasanaeth-cynhwysiant-iechyd-caerdydd-astudiaeth-achos-pdf/

Cyfeiriadur Addysg a Hyfforddiant ar gyfer Gweithwyr Iechyd Proffesiynol - Gofal Sylfaenol Un (gig.cymru)

Lleihau Anghydraddoldebau Iechyd drwy Ofal Sylfaenol - Gofal Sylfaenol Un (gig.cymru)




## Ardal Bwrdd Iechyd:

**Bwrdd Iechyd Prifysgol Aneurin Bevan**
- Data Iechyd Cynhwysiant

**Bwrdd Iechyd Prifysgol Betsi Cadwaladr**
- Data Iechyd Cynhwysiant

**Bwrdd Iechyd Prifysgol Caerdydd a'r Fro**
- Data Iechyd Cynhwysiant

**Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg**
- Data Iechyd Cynhwysiant

**Bwrdd Iechyd Prifysgol Hywel Dda**
- Data Iechyd Cynhwysiant

**Bwrdd Iechyd Addysgu Powys**
- Data Iechyd Cynhwysiant

**Bwrdd Iechyd Prifysgol Bae Abertawe**
- Data Iechyd Cynhwysiant

Cynllunio Cymorth ac Adnoddau - Gofal Sylfaenol Un (gig.cymru))

# Avoidable Mortality

Measure: EASR per 100,000

Quintile: All

Primary Care Cluster: All

*1 = Most Deprived, 5 = Least Deprived*

Avoidable mortality | Preventable mortality | Treatable mortality

***Tile only affects line graph**

Total Avoidable mortality by Quintile and Year (EASR per 100,000)

Using cluster quintiles from 2024

**Quintile** 1 2 3 4 5

0, 100, 200, 300, 400

2005, 2010, 2015, 2020

Period

Avoidable mortalities by Cause and Quintile (EASR per 100,000) 2020-2022

**Quintile** 1 2 3 4 5

Cancers

Diseases of the circulatory system

Ischaemic heart disease

Diseases of the respiratory system

Alcohol-related and drug-related deaths

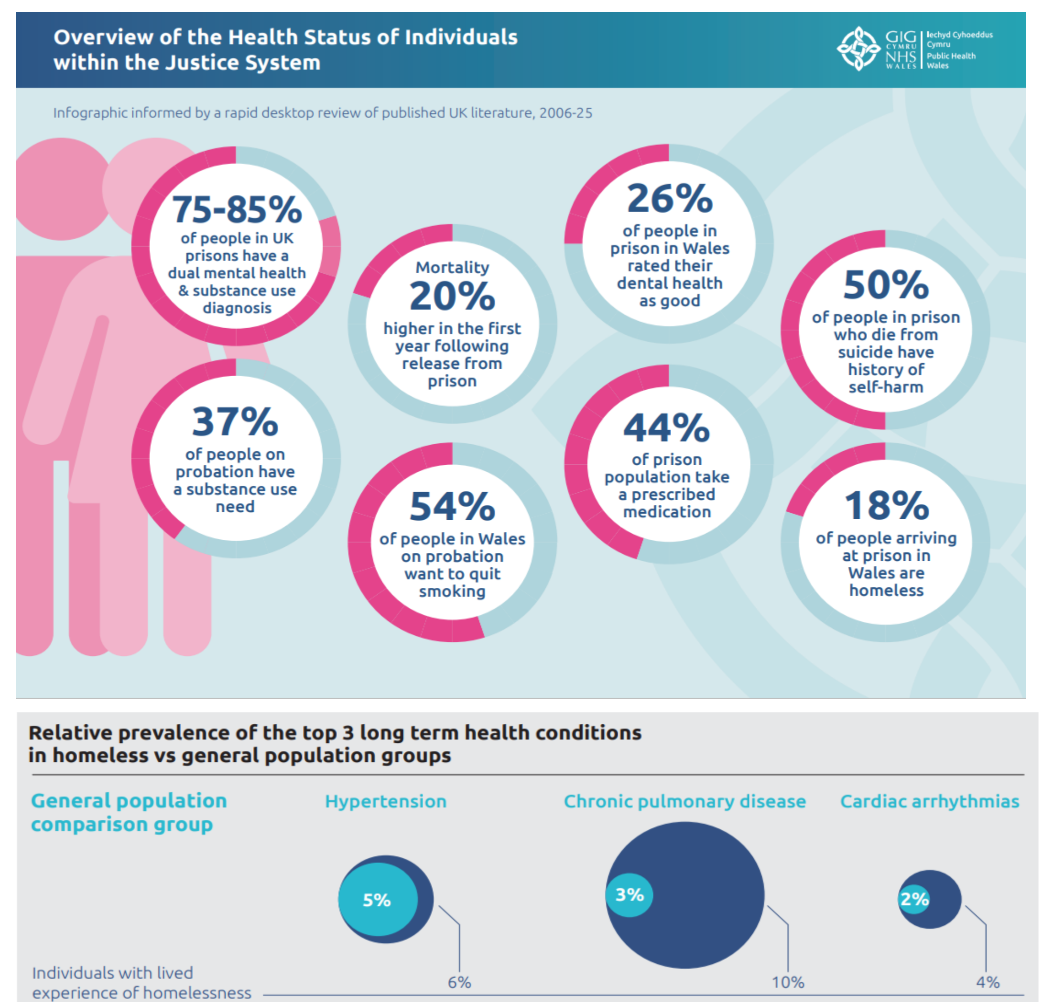
Injuries

Cerebrovascular disease

0, 100

Avoidable Mortalities

# Understanding Health Needs



## Evidence Summaries

Developed to summarise the health and wellbeing needs and experiences of vulnerable population groups in Wales.

A suite of resources

# Teg I Bawb hyfforddi / Fair for All training

## Tegwch i Bawb

Hyfforddiant ar gyfer Staff Anghlinigol, sy'n Wynebu Cleifion ac yn Gweithio mewn Gofal Sylfaenol yng Nghymru

**Nod:** I Wneud Gofal Sylfaenol yng Nghymru yn Deg, yn gynhwysol ac yn groesawgar i Bawb

**Pwy Fyddai'n Elwa?**

- Staff gweinyddol neu dderbynfa sy'n wynebu cleifion ac unrhyw rôl arall sy'n wynebu cleifion mewn gofal sylfaenol

**Manylion yr Hyfforddiant:**

- Sesiwn 45 munud – 1 awr
- Gellir ei gyflwyno wyneb yn wyneb neu o bell dros Teams i bractisau neu glystyrau unigol

**Sut mae hyn yn effeithio ar staff:**

- Yn meithrin hyder o fewn gofal sylfaenol i weithredu arferion gofal iechyd cynhwysol ym mhob rôl -

Mae'r hyfforddiant hwn yn canolbwyntio ar gamau gweithredu syml i sicrhau bod mynediad at wasanaethau yn deg, yn hawdd , a bod gofal yn cael ei ddarparu â charedigrwydd.

Yr Hyn y Fyddwch Chi'n ei Ddysgu:

- Iechyd cynhwysol
- Grwpiau cleifion sy'n wynebu anghydraddoldebau iechyd difrifol
- Sut mae stigma, rhwystrau strwythurol a rhagfarn yn effeithio ar unigolion wrth gael mynediad at ofal .Sut y gall pob aelod o dimau gofal sylfaenol wneud eu hymarfer yn gynhwysol ac yn groesawgar i bob grŵp o gleifion

Wedi'i Lywio gan Brofiad Byw

Ystyriol o Drawma

Cyd-gynhyrchwyd gyda Chydweithwyr Gofal Sylfaenol a'r Trydydd Sector

**Am fwy o Wybodaeth neu i Gofrestru Diddordeb, Anfonwch E-bost at - PrimaryCare.One@wales.nhs.uk neu HEIW.PrimaryCareWFP@wales.nhs.uk**

## Têg i Bawb | Fair for All

Training for Non-clinical Patient Facing Staff Working in Primary Care in Wales

**Aim:** To Make Primary Care in Wales Fair, Inclusive and Welcoming for All

**Who Would Benefit?**

- Patient facing admin or reception staff & any other patient facing role in primary care

**Detail of the Training:**

- 45 minute – 1 hour session
- Can be delivered in person or remotely over Teams to individual practices or clusters

**How this Impacts Staff:**

- Builds confidence within primary care to implement inclusive healthcare practices within all roles -

This training focuses on simple actions to make sure access to services is equitable, easy for all, and that care is provided with kindness.

What you Will Learn:

- Inclusion health
- Patient groups facing severe and multiple health inequalities
- How stigma, structural barriers and bias impact individuals in accessing care
- How every member of primary care teams can make their practice inclusive and welcoming to all patient groups

Informed by Lived Experience

Trauma Informed

Co-produced with Colleagues in Primary Care and Third Sector

**To Find Out More or Register Interest, Please Email - PrimaryCare.One@wales.nhs.uk or HEIW.PrimaryCareWFP@wales.nhs.uk**

# Shifting the Narrative

From……..To………

## WHAT WE HEAR NOW

- Too difficult, too busy
- Someone else's problem
- As an add on – nice to have
- Describing the problem
- Data not good enough

## TOGETHER WE CAN

- Focus on simple actions
- Focus on what is in our control
- Embed in all we do
- Move to action
- Data good enough to start

# Diolch / Thank you

Gweithio gyda'n gilydd
i greu Cymru iachach

Working together
for a healthier Wales