Deep End Report 38

Climate Change and Health Inequalities

On Wed 1 Sept 2021, 10 GP colleagues from a variety of Deep End settings contributed to an online roundtable event to explore the impact of climate change in the context of health inequalities that our patients face. Discussion centred on the various factors that influence Deep End patients and practices in particular, but also explored the urgent need for system-wide solutions to tackle this burden.

November 2021

Executive Summary: Climate Change and Health

The Problem and Our Role

- Deep End GPs are mindful of the **intersectional nature** of the Climate Emergency and Health Inequalities.
- GP teams can **lead by example and advocate for sustainable models of working** that address health inequalities and support teams to build back fairer for a Green Recovery.

Inclusive Change and Patient Empowerment

- **Foreground the voice of patients and communities** - a 'one size fits all' approach does not work.
- GP clusters and primary care networks can build on the potential of **community-oriented primary care teams** to engage with schools, families and communities to improve public health at both wider and local levels.
- GP teams, alongside their patients, can advocate for improvements in living standards that not only address health inequality but also address the climate emergency.

Evidence-Based Practice

- Support the wider roll out of existing resources such as the **[RCGP Greener Impact for Health toolkit.](#)**
- Support engagement with local councils and community groups to advocate for **equitable access to active travel opportunities, green space and non-pharmacological options** to improve health and wellbeing.
- Lobby for **15-minute GP appointments** as standard to facilitate shared decision decision-making and holistic care conversations
- Wider rollout of Community Link Workers, Financial Inclusion workers and Mental Health **workers, embedded within practices.**
- **Health Board formularies** should take the carbon impact of medications into account and promote low carbon options, thus making it easier for patients and clinicians to make sustainable prescribing choices.
- **Patient decision aids** with appropriate levels of health literacy can help with a patient-centred approach to greener, lower carbon health interventions.
- **Ongoing research** to monitor and evaluate the rollout of Realistic Medicine principles, which include **a focus on deprescribing**, where possible and appropriate.
- **Adoption of digital technologies and telemedicine** can reduce healthcare-associated carbon footprint by reducing patient and staff travel, but ongoing evaluation of the inequalities impact of remote consulting on those potentially experiencing digital exclusion is needed.
- **Expansion of Deep End projects** (e.g. **Govan SHIP, Pioneer Scheme, Financial Inclusion workers, Alcohol nurses, Community Links Workers**) where additional resources are embedded in practices, thus reducing reliance on prescription medications as solutions.

Curriculum Shift

- Support **transformative and vertical integration of sustainability themes across all stages** of undergraduate and postgraduate medical curricula and quality improvement work.

- There need to be clear mechanisms for **sharing of sustainable Quality Improvement projects** between practices and clusters.
- We need to create **supported education time and posts for sustainability champions** across all stages of the workforce - medical students, trainees, qualified GPs, those nearing retirement - to help steer and realise this.

Partnerships To Improve Premises and Build Capacity

- **Estates will need to be retro-fitted or rebuilt** and **waste streams will need optimisation** to effect sustainable change at local board level and nationwide.
- Improvement in joined up working will facilitate the roll out of **sustainability assessments** for Primary Care estates and help them NHS net zero aims.
- **Build capacity, funding and infrastructure** for funded roles that support sustainable general practice.
- **Explore existing funding streams** to support early adopters and fund GP led input for sustainable change

THE PROBLEM

The Climate Emergency is now widely accepted as the biggest public health crisis facing us (1)

The world is emerging from a global pandemic and the 26th United Nations Climate Change Conference or COP26 has commenced in Glasgow, the city where a majority (70%) of Scotland's Deep End practices are based.

In this context, General Practitioners of Deep End Scotland welcomed the opportunity to discuss the intersectional nature of climate change and health inequalities, the themes of climate justice and explore how GP teams might lead by example and advocate for sustainable interventions and models of working that help teams address health inequity and build back fairer (2) for a green recovery (3).

To that end, the group organised a roundtable discussion to identify the specific challenges felt more acutely by Deep End practices and patients; the possible barriers to overcome; and discussed solutions and resources that are useful to share. Background reading material was distributed to inform discussions, these are included at the end of the report.

The subsequent report captures various themes from roundtable discussion as well as common themes from the Lothian Deprivation Interest Group meeting, where participants were invited to attend, later that day.

OUR ROLE

"We are not experts"

The discussion opened with a sense from many participants that GPs are "not experts in climate change" but that there was an urgent need for climate justice and action to future-proof and protect the lives of our patients and the services we deliver.

The initial hesitancy was then galvanised into a more confident theme with a strong call to arms. Participants reflected that while GPs may lack specific expertise on climate science, in the words of Henry Sigerist, GPs and their teams *"well know the factors that paralyse efforts. They are not only scientists but also responsible citizens, and if they did not raise their voices, who else should?"* (4)

The group recognised that when our patients are malnourished because of damaging food systems, or when patients struggle with weight, inactivity and chronic respiratory and cardiovascular conditions because of unhealthy transport systems and environments, or when stressed patients use cigarettes, alcohol, drugs and violence to cope with economic and social injustices, these are the drivers of climate change intersecting within the communities we serve.

It was also recognised that these very same themes interweave to create the storm of climate injustice that is damaging the planet on an unprecedented scale. Participants expressed the hope that collective discussion and action will identify ways that teams can build on ongoing efforts to address health inequalities and level up living conditions and life experiences. In doing so, it was felt that GP teams can participate in a ripple effect of actions and interventions that could help offer the co-benefits of improved health as well as action for climate justice.

General practice was recognised as one of the most sustainable components of the NHS - *"by knowing health inequality issues, we know climate change issues"*. Better homes, jobs, food, transport and policies can improve and save patient lives and will safeguard both human and planetary health for future generations.

Individual Change vs Upstream, System-Wide Change

Participants reflected that we can each make changes to shift and encourage sustainable habits and models of care, within ourselves and others - by living by our principles, setting examples, and "planting the seed" to share green learning among practice staff and patients. This in turn impacts upon the wider communities we serve immediately and longer term. Thus the importance of sharing and signposting good ideas and helping to build change was recognised as a crucial factor in building momentum around this.

However, at the very core, it was also agreed that the most effective drivers of change are upstream and that we need to *"apply pressure at a structural and political level"*. Attendees agreed this has been particularly highlighted in the context of the COVID-19 pandemic and COP26. Participants also agreed that we need to demand strategies that shift from *"an unequal, sickness economy"* of unsustainable growth to an economy that builds back fairer for a green recovery - where policies embody the principles of doughnut economics and de-growth to contribute to a wider, more holistic index of wellness.

Recommendation
- *Deep End GPs are mindful of the intersectional nature of the Climate Emergency and Health Inequalities.*
- *GP teams can lead by example and advocate for sustainable models of working that address health inequalities and support teams to build back fairer for a Green Recovery.*

INCLUSIVE CHANGE AND PATIENT EMPOWERMENT

Autonomy and Inclusive Change

Despite the urgent need to act, participants recognised that meaningful progress can only be achieved with genuine inclusivity and collectivism. Participants reflected that a radical shift to policies with a climate action focus can attract negative views.

One participant stated that "*positives of 20-minute liveable neighbourhood communities, active travel, green spaces and better public transport systems are clear*", as is the need to gradually shift the perception of car ownership - and that difficult conversations will need to come into common language to achieve wider change across the system. But participants were also in strong agreement that there is a real risk of leaving people unprepared, disenchanted and disengaged - and that inclusive engagement of stakeholders is crucial.

Participants discussed that one key challenge is the societal markers and definitions of 'success' which have dominated our outlook for generations and continue to do so. Owning and driving a car, being able to afford to fly overseas and buying plentiful gifts for children were among the many common goals that were discussed, and the fact that many of these advantages have been disproportionately enjoyed by the most affluent sections of society. One participant raised the point that globally *"the richest 10% produce half of lifestyle carbon emissions, while the poorest 50% produce only a tenth"*. (5) These can therefore be particularly challenging conversations to have with those who have not necessarily enjoyed these luxuries, and understandably aspire to do so.

There was agreement also that market forces, albeit unsustainable, have made these goals increasingly affordable for individuals and some participants reflected that climate action goals can be viewed as an unfair or moralistic shift in goalposts, or worse still, a loss of autonomous choice, which can provoke tension. Sensitivity and awareness of complexity will need to be a key feature of all discussions and decisions. Participants recognised that factors impacting urban or rural poverty, or food or transport systems are multifaceted - so change would need to be meaningful and holistic. There was agreement that improved knowledge sharing and shared decision tools can help staff and patients to engage in a patient-centred approach for greener, lower carbon health interventions. It was suggested that primary care networks might also help build on the potential of community-oriented primary care teams to engage with schools, families and communities to improve public health at a hyperlocal level.

Patient Empowerment- "Nothing about me, without me"

Participants recognised the psychological impact of the very act of questioning or challenging lifelong aspirations. Accordingly, this section of the discussion highlighted that successful change needs inclusivity and collaborative action - where the patient and community feel empowered, and not victimized by exclusionary or imposed changes.

Participants agreed that it was essential to view all possible solutions through a lens where "*the voice of our patients is in the foreground*" and "*nothing about me* [is decided] *without me*". One participant commented that different issues apply in different settings, for example, in relation to pollution, an inner-city London resident might be worse off than residents in the peripheral housing estates in Scotland, access to green spaces might also vary. There was agreement that decisions and options need to be cognizant of patient dignity and circumstances, so that a well-meaning intervention such as a lifestyle prescription or gym membership paper slip does not dissolve into a dehumanising process that would ultimately fail. Another participant discussed that a 'one size fits all' model of change and social prescribing cannot and should not apply. Collaborative and inclusive decision making with patients was felt to be pivotal to any successful local neighbourhood and system wide changes.

Participants expressed the hope that GP clusters, through their extrinsic influencing roles - as well as primary care networks - might be able to build on the potential of community-oriented primary care teams to engage with schools, families and communities and improve public health on wide and local levels. However, it was also recognised that GP clusters are currently significantly hampered in their efforts because of lack of resource and time to achieve their aims. For individual practices and practitioners, the consensus was that our most effective stance would be to stand side by side with our patients and amplify their voices on issues that are recognised to affect them, and ensure that change is introduced with humility, sensitivity and a sense of collective action and trust in the need for system-wide change. Practical examples of these issues may be improved insulation in housing to reduce fuel poverty, improved active travel options, improved access to green spaces, improved access to technology to facilitate access to health care and other essential services.

Recommendation
- *Foreground the voice of patients and communities - a 'one size fits all' approach does not work.*
- *GP clusters and Primary care networks can build on the potential of community-oriented primary care teams to engage with schools, families and communities to improve public health on both wider and local levels.*
- *GP teams, alongside their patients, can advocate for improvements in living standards that not only address health inequality but also address the climate emergency.*

EVIDENCE BASED PRACTICE

Sustainable General Practice and Focus on wellbeing
Participants were in firm agreement that sustainable general practice at its very core is based on preventative medicine. Discussions recognised that this was no radical shift for Primary Care teams, who have always worked closely with Public Health colleagues to improve the long-term health of the patients and communities they serve. Participants agreed that sustainable practice requires genuine collaboration with our patients and careful stewardship from us as GPs, to provide advice that is *realistic, relevant and applicable to daily life*.

Participants agreed that this needs an environment where patients participate in shared and empowered decision-making with principles of realistic medicine in mind, to gain both "clinical and carbon benefits". There was agreement for the need to reduce healthcare-generated waste and carbon contributions, whilst simultaneously striving to improve the patient experience and outcome, and the need to incorporate the wellbeing approach of *"good for you and good for the planet"* already adopted in many forward-thinking practices.

Attendees of the roundtable meeting also commented that they had found information regarding 'greener medicine' prescribing options hard to find. It was felt that the use of existing resources such as the [RCGP Greener Impact for Health (GIFH) toolkit](#) (6) would ideally be more commonplace to achieve these aims. To that end, participants supported the roll out of existing resources such as the RCGP Greener Impact for Health toolkit.

The shift in focus to sustainability and wellbeing at Scottish Government and Local Authority levels was also welcomed during discussions. It was recognised that both in Scotland (7) and UK-wide (8), higher air pollution rates exist in less affluent areas, despite lower levels of vehicle ownership in less affluent areas. Participants agreed that joined up working with councils and local grassroots groups could help to improve the safety of pedestrianised and cycling networks surrounding GP practices and the local community, thereby encouraging active travel amongst staff and patients. Subsequent changes in communities in terms of active travel structures and green space availability were recognised as outcomes to aspire to. It was also recognised that increased advocacy of active travel, equitable access to green space, and non-pharmacological methods of improving health and wellbeing by primary care teams empowers patients toward better health, while also reducing the collective climate footprint. Alongside this, participants favoured longer GP appointments with the opportunity for patients to work with embedded support workers, thus prioritising social wellbeing, financial wellbeing, mental health and personalised, holistic care (9).

Participants also discussed that GP teams have the huge benefit of knowing their communities well and can shift from the single disease model to advocating for holistic patient and community health. It was recognised that a caring culture of stewardship, community engagement and stakeholder consultation can help to implement solutions that are agile and realistic, creating equitable access to opportunities that improve patient health and wellbeing and shift health behaviours in the longer term.

Recommendation
- *Support wider rollout of existing resources such as the RCGP Greener Impact for Health toolkit.*
- *Support engagement with local councils and community groups to advocate for equitable access to active travel opportunities, green space and non-pharmacological options to improve health and wellbeing.*
- *Lobby for 15-minute GP appointments as standard to facilitate shared decision decision-making and holistic care conversations*

- *Wider rollout of Community Link Workers, Financial Inclusion workers and Mental Health workers, embedded within practices.*

Prescribing and Deprescribing

It was recognised that prescribing has the single largest carbon impact in general practice, and is where the vast majority of NHS prescribing takes place.

Participants discussed the merits of embracing the principles of non-pharmacological approaches to health and wellbeing, and rationalising and deprescribing where appropriate.

In particular, participants discussed that inhaler prescriptions alone accounted for approximately 13% of the carbon footprint of General Practice (10) and the prescribing of inhalers within General Practice is the medicine group with highest carbon impact. There was agreement that GP teams can help reduce the impact of climate change by working on this to identify safe, personalised ways to make a switch, where appropriate.

Careful work to switch from carbon-intense Metered Dose Inhalers (MDIs) to Dry Powder Inhaler (DPI) alternatives is already being carried out in practices, but it was agreed that this work requires coherent and widespread dissemination with consistent support from health boards (11-12). Participants felt that added support would greatly assist teams in daily clinical practice and improve diagnostic accuracy, improve familiarity with environmentally safer DPIs and result in more inhaler recycling. This in turn could achieve more focused care with careful and personalised reduction of environmentally costly MDIs where appropriate.

There was an accompanying call for wider steps to be taken at Health Board formulary level for the carbon impact of medicines to be taken into account and for sustainable prescribing to be promoted via formularies and toolkits with the carbon cost of medications outlined - as is already happening in Glasgow[1].

Similarly, when focusing on lifestyle interventions, participants discussed how carefully designed decision aids[2] can help both patients and clinicians to choose more sustainable choices to treat numerous conditions including but not limited to cardiovascular and respiratory health, mental health and chronic pain management. It was felt that this could improve engagement and compliance with medications too. Participants commented that ongoing research will help monitor and evaluate the rollout of Realistic Medicine principles (13) which include a focus on deprescribing where possible and appropriate.

Recommendation
- *Health Board formularies should take the carbon impact of medications into account and promote low carbon options, thus making it easier for patients and clinicians to make sustainable prescribing choices.*
- *Patient decision aids with appropriate levels of health literacy can help with a patient-centred approach to greener, lower carbon health interventions.*
- *Ongoing research to monitor and evaluate the rollout of Realistic Medicine principles, which include a focus on deprescribing, where possible and appropriate.*

Digital Inclusion

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[1] An excellent inhaler toolkit is available at https://www.nhsggc.org.uk/media/269811/inhaler-toolkit-final.pdf
[2] Recommended resources include https://cvdcalculator.com/ and https://movingmedicine.ac.uk/

Much has been discussed in the media on the potential of telemedicine and remote consulting, even before the COVID-19 pandemic. Participants recognised that the use of digital technology and telemonitoring by health care teams is an exciting opportunity and will have a huge role to play in saving patient or clinician travel miles and associated carbon and can foster a better sense of health literacy, ownership and engagement. However, it was also recognised that decision makers will need to be mindful of unintended widening of health gaps. Without digital inclusivity, digital technologies may well fail in the essential feature of the NHS - to "allow access to all parts of healthcare delivery" for all in need. So while innovations were felt to be a necessary tool in this journey, participants expressed the hope for this to be done carefully, with due consideration to how these might translate into reality, affordability and the very real risk of unintended widening of Health Inequalities. More digital research, such as Professor Trish Greenhalgh work at the University of Oxford in conjunction with early adopters in Deep End practices in Glasgow, will add to the body of evidence but there is an ongoing need for more information and data on this subject.

Recommendation
- *Adoption of digital technologies and telemedicine may reduce healthcare-associated carbon footprint by reducing patient and staff travel, but ongoing evaluation of the inequalities impact of remote consulting is needed.*

Expanding Existing Deep End Projects

On the theme of sustainability of Primary Care, there was agreement across participants that the hallmarks that characterise sustainable primary care are also notable in previous work carried out by the Deep End group to reduce the impact of Health Inequalities on our patients.

Previous projects (details of which can be found on the Deep End website[3]) including the Govan SHIP, Community Links Workers Programme, and the Pioneer Scheme, all upheld the aims of strengthening existing communities at their heart, and addressing the unmet need of the patients, by freeing up GP time for more targeted interventions. These projects allowed GP teams to embed into local community work, build stronger ties with local third sector organisations and in turn support patients to improve health and wellbeing through non-pharmacological means. The extra time for clinicians was then used in higher quality consultations to tackle the added burden of illness in deprived communities as *"any good quality consultation seems to overrun"*.

The same was true of interventions when Financial Inclusion advice workers, Mental Health and Specialised Alcohol Nurses were embedded in practices - the practice population and staff enjoyed a boost in positive community engagement, wellbeing and morale. The positive outcomes were welcomed by patients and health care professionals alike. These valued MDT colleagues can also help address the many social determinants of health and their impacts, and reduce long term need for prescriptions of medications and the associated carbon emissions and other costs. At the roundtable discussion there was a clear ask for opportunities to fund *'protected time to develop and research greener practice policies'* and to help understand, record and apply evidence-based principles of deprescribing and realistic medicine to our everyday workload.

Recommendation

- *Expansion of Deep End projects (such as Govan SHIP, Pioneer Scheme, Financial Inclusion workers, Alcohol nurses, Community Links Workers, Mental Health workers) where additional resources are*

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[3] https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/

embedded in practices, thus patients and communities are empowered and less reliant on prescription medications as solutions.

CURRICULUM SHIFT

Attendees of the roundtable discussions were all in agreement that sustainability should be part of teaching and training at all levels. Chris Williams and David Shackles, the Joint Chairs of RCGP council announced that a key priority during their three year tenure is sustainability in primary care. This was welcomed, and the Deep End Group are keen to work collaboratively with the RCGP on this common aim.

Participants believed that the impact of this priority should be felt across undergraduate teaching, including time medical students spend in GP practices, as well as in postgraduate core training, the GP training curriculum and beyond. There was a sense that increasing awareness of issues of Climate Change and Health should be considered at national as well as regional levels with responsible undergraduate university departments integrating themes of sustainable healthcare vertically across the breadth of the curriculum. Participants noted that initiatives such as a project led by medical students to highlight disparities in the teaching of planetary health at various medical schools has led to the creation of an initiative called the 'Planetary Health Report Card'[4] which compares how medical schools organize around planetary health at the institutional level, and implement sustainable practices and aims to increase awareness and encourage planetary health teaching at institutional level.

Attendees of the round table who work closely with medical students advocated for increasing links and collaborative working with medical undergraduates to help GP teams achieve sustainability goals. There was a sense that students have *"passion, energy and knowledge"* for the subject of climate change and could be valued resources for individual practices in making greener changes. This could include students undertaking Quality Improvement (QI) projects with a sustainability focus during practice placements or during 'Student Selected Components' (SSCs). Postgraduate GP Specialty training or GPST is overseen by NHS National Education for Scotland (NES), with curricula set by the General Medical Council and the Royal College of General Practitioners. Attendees recommended that there is scope for climate change and sustainability to be incorporated within GPST learning events and going further, attendees advocated for NES to ensure any research or QI project is routinely sense-checked through a sustainability lens to consider any unintended consequences that may negatively impact on greener changes, and to *"push for this to be the norm"*. Participants reported that while practices are familiar with QI work, projects with a sustainability focus may be a new area of focus - hence targeted support will help practices take on these projects more readily. Attendees also advocated for better mechanisms for sharing QI project ideas across practices and clusters, again to help facilitate better uptake and implementation of projects.

Overall, it was felt that organisations such as the RCGP and RCGP's Green Impact For Health (GIFH) toolkit (6), Greener Practice (11) and SusQI framework[5] already share extensive resources. Better visibility of these will be of assistance. These can help existing and future clinicians to factor in and monitor the carbon and global impact of interventions and account for them. There was also a strong sense that interventions that make time and resource available for clinicians to upskill and learn about sustainability, as well as the creation of roles where GPs of all career stages can lead and scale up sustainable practice, can help individual practices and wider primary care networks achieve meaningful, long lasting greener changes.

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[4] This is available online at https://phreportcard.org
[5] This framework tool for designing sustainable QI projects is available at https://www.susqi.org/

- *Support transformative and vertical integration of sustainability themes across all stages of undergraduate and postgraduate medical curricula and quality improvement work.*
- *Clear mechanisms for sharing of sustainable QI projects between practices and clusters.*
- *Supported education time and posts for sustainability champions across all stages of the workforce (medical students, trainees, qualified GPs, those nearing retirement) to help steer and realise this.*

FIT-FOR-PURPOSE PREMISES

Participants recognised that much positive work is already being done at NHS Health Board level across estates and to increase electrification of vehicle fleets. There was agreement regarding the ongoing need to focus on the physical places in which we work in primary care, and the subsequent carbon footprint of our working lives. In particular, for NHS Scotland to achieve the Net Zero target of 2045, participants agreed that primary care must be included in key decision making on how to minimise waste and emissions from estates.

It was widely recognised that estates will need to be retrofitted and rebuilt, and waste streams will need optimisation to effect change at local board level and nationwide (14). While a degree of independence in estate management exists amongst GP teams, the conversations also highlighted a significant need for sustainability assessments to be rolled out consistently and collectively, and for skilled teams to examine building energy supplies, insulation and waste management streams as well as carry out detailed data collection.

Participants recognised the considerable time commitment needed to gather energy data and building data and to implement best practice from the RCGP Green Impact For Health (GIFH) toolkit. They commented on the inevitable time conflict for GP and practice managers who "*need to prioritise patient care, not look at energy arrangements and bills*". There was a sense that tasks to improve premises cannot and should not sit within GP teams alone, as they necessarily have the care of patients as the primary focus, and are dealing with exceptionally high workloads at the current time, so workload from this would be unfeasible and inappropriate for general practice teams to coordinate. Meaningful results cannot be achieved by good will alone so this large volume of work requires formal infrastructure and strategic input. The participants therefore supported and recommended investment in clear policies and toolkits that improve joined up partnership working.

Recommendation

- *Estates will need to be retrofitted or rebuilt and waste streams will need optimisation to effect sustainable change at local board level and nationwide*
- *Improvement in joined up working will facilitate the roll out of sustainability assessments for Primary Care estates and help meet NHS net zero aims.*

IMPROVED MULTI-PROFESSIONAL PARTNERSHIP WORKING

In this section, participants recognised the need for clear guidelines, governance and steering input to make the efforts towards NHS Net Zero in deep end GP teams a reality. It was suggested that while cluster groups will be interested in taking on this work, they are already overwhelmed. More *'boots on the ground'* would help to

identify routes by which sustainable practice can be embedded into routine practice, as well as to provide the necessary follow-up to overcome difficulties when encountered.

To that end, participants observed that although sustainability governance groups are being set up within Health Boards, there is often a secondary care focus and even then, the teams are spread remarkably thin. In Glasgow, GGC Health Board Sustainable Communities group have "*hit a brick wall of no funding for GP time or LMC attendance*". Participants agreed that unless mechanisms were in place to facilitate GP teams being included frequently and actively in the process of decision making, change will be fragmented and slow. One example cited was when HSCP Health Improvement leads were unable to push the RCGP Green Impact For Health (GIFH) toolkit off the ground initially (14) because of the possible root causes of timing and investment.

One participant explained that, to establish a baseline and implement RCGP GIFH Toolkit *"can end up being an unpaid session per week for small practices"* and retrofitting premises is a big task, needing investment, incentives and resources where "u*nfunded work discredits the importance of the topic"*. If this work is to be viewed as an important priority it cannot rely on altruism and passion of individuals; a more sustainable model is needed to embed and sustain change.

Participants also felt that sharing resources and skills across primary care teams, Local Health Boards (LHB), Health and Social Care Partnerships (HSCP) and Integration Joint Boards (IJB), as well as third sector organisations would help save time and bring change faster. HSCPs might be particularly well placed to share knowledge and skills and furthermore, participants recognised that the Local Medical Committees (LMCs) can be instrumental in pushing through on sticking points. Therefore, building in partnership infrastructure with these agencies will be crucial, where input is not based solely on goodwill.

A suggestion at the roundtable meeting was to explore the option for each Health Board to fund 1 session/week for a Primary Care Lead for Climate Change and Sustainability, funded and supported via Public Health for example. There was also a call to support early adopters; attract funding for GP led input and governance for sustainable changes; and for networks to disseminate good practice, via clusters and medical forums for example. In terms of funding mechanisms, potential sources of funding may become available via funding streams such as the Quality Improvement Scottish Enhanced Services Programme (QI SESP) or other existing funding streams as outlined above. It was recognised that there is a move away from creating new enhanced services to resource additional work for core general medical services. However, it was suggested that the existing national patient safety programme might be a viable mechanism, with the theme of safety of patients and safety of the planet as the driving forces.

Recommendation
- *Build capacity, funding and infrastructure for funded roles that support sustainable general practice.*
- *Explore existing funding streams to support early adopters and fund GP-led input for sustainable change*

CONCLUSION AND NEXT STEPS

The Scottish Deep End Group hopes that the discussion of the roundtable event included in this report will increase awareness of the specific impact of climate change on the most vulnerable in our society and the practices that serve our most deprived communities. We hope the contents will influence decision makers during the ongoing restructure of wider health and social care structures so that we can Build Back Fairer for a green recovery and mitigate these effects through proportionate and equitable resourcing.

Next steps include connecting with various organisations including the RCGP, LMCs, Health Boards, Integration Authorities and grassroot organisations to amplify these priorities and lobby and advocate for strategies to tackle the linked issues of health inequalities and climate change. We hope to feed into further conversations and events at the United Nations Climate Change Conference (COP26) being held in Glasgow in November and beyond, to identify practical and meaningful strategies for general practice to address this issue.

CONTRIBUTORS

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BACKGROUND READING

We circulated and referred to the following links

- [Greener Practice UK wide resources](#)
- [Greener Practice Planetary Health – Practice Leaflet](#)
- [RCGP Climate & Sustainability paper](#)
- Greener Practice Glasgow [briefing paper](#)
- NHS Lothian [Sustainable Development Framework and Action Plan](#)
- [St Triduana Practice's Sustainability poster](#)

GLOSSARY / ABBREVIATIONS

COP26 = 26th Conference of the Parties
GGC HB = Greater Glasgow and Clyde Health Board
GIFH = Greener Impact For Health toolkit
Govan SHIP = Govan Social & Health Integration Project
GP = General Practice
GPST = GP Speciality Training
HSCP = Health and Social Care Partnership
LMC = Local Medical Committees
NES = National Education for Scotland
QI = Quality Improvement
QI SESP = Quality improvement Scottish Enhanced Service Payment,
RCGP = Royal College of General Practitioners
SSC = Student Selected Components
UNCCC = United Nations Climate Change Conference