Scottish Borders
Health and Social Care
PARTNERSHIP

NHS
Borders

T.H.I.S BORDERS

Tackling Health Inequalities
in the Scottish Borders

2024 - 2030

CONTENTS

EXECUTIVE SUMMARY

Health inequalities affect all of us across the Scottish Borders, either directly or through the negative consequences on our neighbours, friends and family members. Disparities in health status outcomes and life expectancy between different groups are unfair and rooted in complex social causes.

We are clear that tackling health inequalities is good for everyone: reducing the stark differences in population health not only reduces human suffering but also benefits the health and care system and the wider economy in access to skills and productivity.

Whilst, of course, individuals can promote and strengthen their own health and wellbeing, health inequalities are the systemic result of differing life chances and opportunities within our communities. As this strategy will highlight, from cradle to grave, we observe clear and persistent differences in health outcomes by socio-economic status and geography across our population.

Such deep social causes require concerted effort across partners, both statutory and voluntary, to work together to tackle the fundamental determinants. The same factors that may lead to unfair differences in health outcomes also lead to the attainment gap in schools and differential access to employment thereafter. The cycle is complex and persistent, and prevention is the most important intervention.

We know from the data we observe and in speaking with colleagues and partners, that the last five years have brought new challenges. We find ourselves – having come through a pandemic – in a cost of living crisis that has impacted the poorest in society most profoundly and exacerbated existing differences.

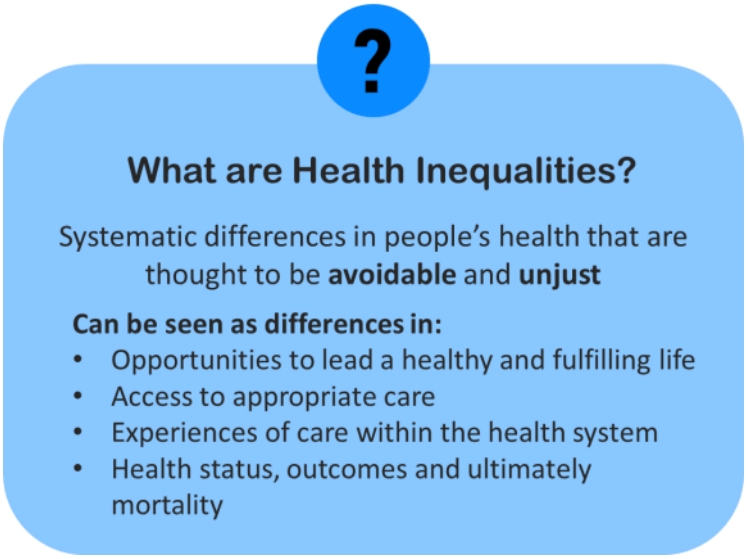
Health inequalities should and need to be on everyone's agenda. They must be considered in all areas of work – from workforce and transport, to education, housing and digital inclusion. Their impact should be at the forefront of the planning of all services within NHS Borders, including within the local authority and third sector.

We are ambitious for what we can achieve together as we seek to Tackle Health Inequalities in the Scottish Borders.

INTRODUCTION

Differences in the conditions in which people are born, live and grow create profound disparities in health status. These differences in health outcomes are stark and enduring. People living in more deprived groups face worse health outcomes throughout their lives and this results in a difference in life expectancy.

Males in the least deprived areas of Scotland had 23 years more life in good health compared to males in the most deprived areas, with the gap being slightly higher for females (24 years). Furthermore, life expectancy also differs even more strikingly amongst other groups within society. For example, those with learning difficulties have a lower life expectancy than the Scottish average [1].



Health inequalities affect all of us. We know that when many people are unable to lead healthy lives that the impact is felt across society, including in education and employment as well as in the NHS and social care. It is thought that the financial losses associated with health inequalities amount to 1.4% of GDP within European countries [2].

There are many wide-ranging reasons why these differences exist, including social deprivation, diet and nutrition, access to support networks, education and employment, time poverty, housing quality and the degree of control an individual has over their lives and circumstances. Other factors such as smoking and harmful drinking and/ or drug use can impact upon some of the inequalities we see. Many of these are established in our childhood and are deep-rooted in our social circumstances.

In the last five years we have seen inequalities worsen since the COVID-19 pandemic and the cost of living crisis. Fragile employment and rising household costs have put pressure on households, their support networks, and the services that can offer support. It is an important time to think again about how we address and respond to the growing challenges faced by our communities: we are clear that early intervention and prevention are vital.

Many of us are proud to live in the Scottish Borders, but there are also specific challenges of our geography that can impact health outcomes. This can be due to higher transport costs, poorer digital connectivity, isolation, and the challenge of providing and maintaining services across a large, rural area.

We also know that some of the data we have on socio-economic status are not as reliable as they are in urban areas, which can make it challenging to identify people at need across the whole area. The Scottish Index of Multiple Deprivation (SIMD) is better applied to more densely populated towns and cities so, whilst we are able to demonstrate many stark inequalities, we know that some of the challenges are also hidden. Realistically, we need other ways of measuring deprivation. The link with Adverse Childhood Experiences (ACEs) and individual deprivation are strong [3] and could form a Borders specific approach to viewing the harms from health inequalities.

Engagement with community members and organisations, as well as our staff who work closely with people in the Borders, will be vital in understanding how best we can collectively have impact. We want to see meaningful preventative action being taken to address health inequalities amongst people who live and work here. This strategy seeks to bring together local data alongside the experiences we have gathered from our colleagues and partners.

The need for prevention

Prevention and early intervention are critical because they enable people to have better quality health outcomes, avoiding illness, disease and ultimately premature death. 21.6% of all deaths in the Scottish Borders are deemed avoidable, and this has far reaching consequences for families and the wider community. Across Scotland, whilst we know that the population is expected to fall in the same time period, by 2043 it is estimated that the level of illness will have risen by 21%, putting great strain on health and care services [4].

In the Scottish Borders, there is significant variation observed between the most and least deprived and across different localities in terms of years of life lost. Years of life lost is an expression of the age at which people have died in a population as well as the number of deaths that the population has experienced. If the total number of years of life lost is high, then many people have died prematurely before reaching life expectancy.

Years of life lost by locality in 2023

Locality	Male	Female	Total
Berwickshire	769	857	1626
Cheviot	836	782	1618
Eildon	1419	1138	2557
Teviot and Liddesdale	943	575	1518
Tweeddale	703	659	1362
Total	**4670**	**4011**	**8681**

The table above shows the average number of years of life lost by locality in the Scottish Borders – that is, the number of years people in the Borders have lost before reaching life expectancy (82 years for females and 79 years for males). There is variation by locality and recorded biological sex. Better understanding some of the specific challenges within localities, and why we see such variation, will go some way to addressing inequalities.

The concept of prevention is one of the fundamental pillars of Public Health. In broad terms, the three most discussed types of prevention are primary, secondary and tertiary.

Primary prevention is where action is taken to stop a disease or illness ever occurring within an individual. Examples include immunisation programmes and seatbelt legislation.

Secondary prevention is where action is taken to detect the early signs of a specific disease and intervene before symptoms can develop. The target group are those who have a disease (or precursor to the disease) but are apparently healthy with no symptoms. Examples include screening programmes, controlling blood pressure and managing high cholesterol.

Tertiary prevention is where action is being taken to reduce the impact of a disease that has already been diagnosed to prevent any further deterioration, maintain quality of life, improve function and minimise suffering. The target group are those with an established disease. Examples include regular reviews for people with diabetes, respiratory or cardiac diseases.

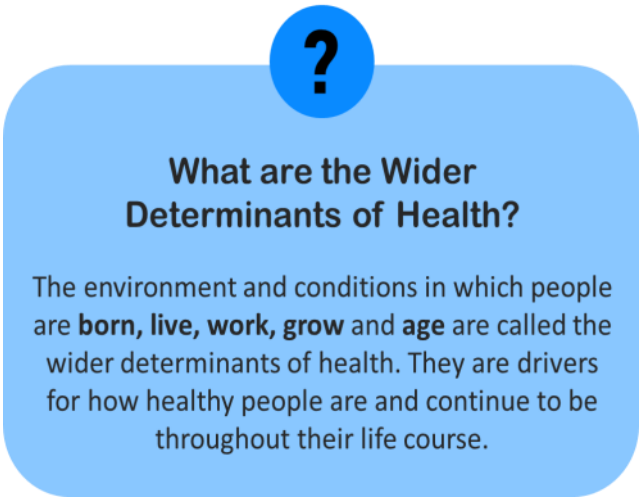
Prevention, of course, can reduce the human suffering of individuals and their families and friends, but there are also important benefits for society as a whole. To improve the sustainability of our health and care services we must look upstream to promote more cost-effective and timely interventions. A study by the University of York aimed to try to quantify the difference in cost per QALY (1 quality-adjusted life year equals 1 year lived in perfect health) for public health interventions versus general NHS treatments. They found that for preventative work, the cost per QALY was £3,800, compared to £13,500 for treatments [4].

It is clear that we need to have a preventive system that is co-ordinated, evidence-driven and able to offer sustainable improvement to the health of the whole Scottish Borders population. We need to work together as individuals and as an organisation to effect change.

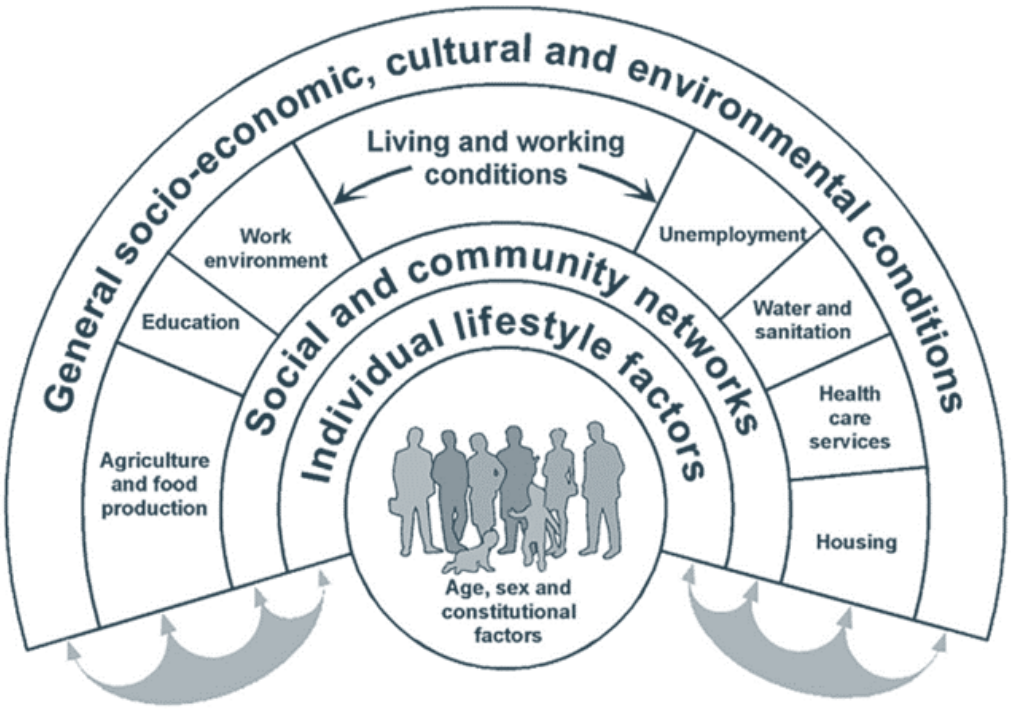
The wider determinants of health

We know that there are many factors that lead to people experiencing worse health than others, and most of the wider determinants of health fall outside the remit of the health service.

Dahlgren and Whitehead [5] developed a model which has been widely accepted as a useful visualisation of these wider determinants at different levels, from the individual to wider societal influences.



Differences in these social factors, most of which are largely outside of individual control, are evidenced to be a major contributor to the health inequalities we see between different groups of the population. People in more socially deprived circumstances are more likely to experience a number of related disadvantages in their housing, employment, and access to health promoting amenities and opportunities. We know that the pandemic and the cost of living crisis have also had a negative impact upon food security and have increased the demand for food banks and emergency food parcels amongst the most vulnerable. Social disadvantages make it far harder for people to make and sustain healthy choices and the patterns of difference we see between the most and least deprived in our community reinforce this observation.



Understanding these wider determinants of health will be vital in addressing how we can better improve the life chances and health outcomes of people living in the Scottish Borders. We recognise that, as an anchor institution, NHS Borders alongside our statutory partners, has a key role to play as employers, procurers and service providers within the Scottish Borders. Understanding the influence we can have on the wider health of the community will form a key element of our health inequalities work plan.

We are also clear that input is required at all levels of society: healthcare, local government, third sector, industry, the community, and individuals themselves. Collaborative working is the only way to correctly address these wider determinants of health.

Within the Scottish Borders, we have looked at some of the factors that may have particular impact upon the health and wellbeing of our local population. Some of these findings have been summarised in the graphics on the next page.

Transport

Transport accounts for 17% of total household expenditure in Borders compared to 14% across Scotland

More monthly income is spent on transport in the Scottish Borders compared to Scotland as a whole, and a quarter of geographical areas (26%) are in the 10% most geographically accessed deprived areas in Scotland. It is important to consider digital access as well – limited access to online services can widen inequalities for those with poor connections or low digital literacy.

Food

8.2% of children in P7 – S6 stated that they always or often went to bed hungry

Access to nutritious, balanced, and affordable food has a significant impact on levels of overweight and obesity as well as other health outcomes. Almost 10% of school children in the Borders reported having a soft drink containing sugar at least daily. Only 40% reported eating fruit or vegetables at least once a day.

Climate change

It is estimated that 11,000 homes and businesses will be at risk of flooding by 2080 in Borders

Climate change is considered as one of the most significant health threats of our current time. It has been observed that the most deprived areas of society contribute the least to climate change but are most likely to experience the impacts of it.

Income

21.7% of people earn less than the living wage in Borders, compared to 14.4% across Scotland

The average income in the Scottish Borders is lower than across Scotland. In 2021, average residence-based weekly wage in our area was 89% of the Scottish average and, in 2022, the gross weekly workplace-based wage in the Borders was £69 less per week than the average for Scotland.

Child poverty

in 2021, 40% of geographical areas in Scottish Borders had high or higher levels of child poverty

Poverty impacts health and wellbeing through poor quality housing, and competing financial pressures for heating, transport, and food. Children living in low-income households in the Scottish Borders has increased from 14.6% in 2021 to 19.7% in 2022.

Employment

In 2021, 19% of households with children under 16 years were considered workless in the Borders compared to 12% across Scotland

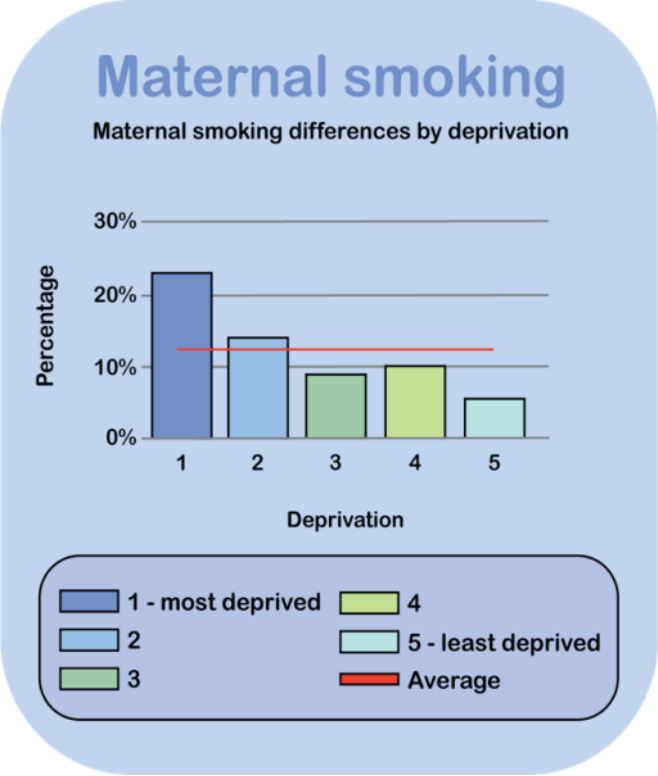
The ratio of total jobs to the working age population in Borders is lower than that of Scotland (0.79 vs 0.81) – meaning that individuals may have to travel for work or have fewer opportunities locally than other areas of the country.

ANALYSIS OF HEALTH INEQUALITIES IN THE SCOTTISH BORDERS

To support our understanding of health inequalities in the Scottish Borders we have undertaken a thorough review of the available data. The purpose of doing so is to highlight the scale of the challenge across the life course and to begin to identify where we can take action.

Early years and childhood

Within the Scottish Borders, just less than 20% of the population is under 18 years old. Health inequalities begin early in childhood and by the time a child is in school, there are measurable differences in various indicators of good health. The early years are a critical window to influence and promote lifelong health yet we know from data collected in maternity services that there has been an increase in expectant parents experiencing material deprivation as well as mental health concerns.

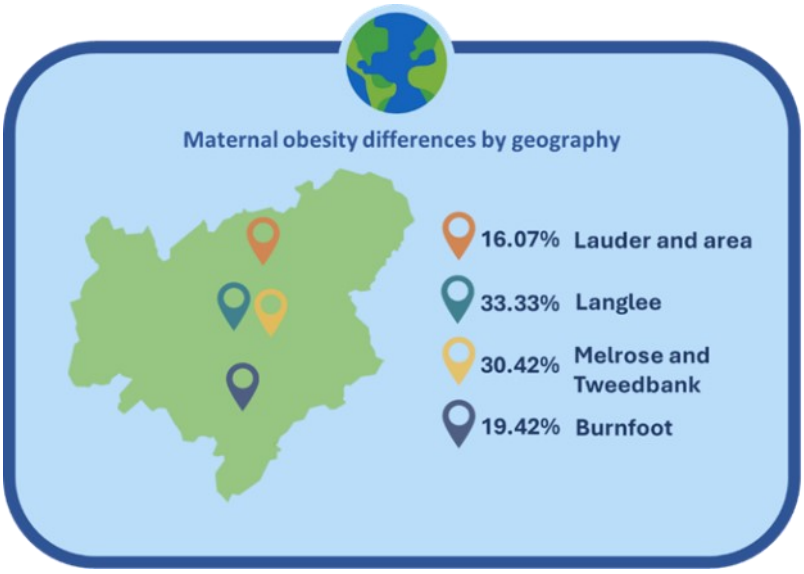


Data collected by NHS Borders shows the sizeable differences in maternal smoking rate by deprivation quintile. Smoking amongst pregnant mothers has decreased in general but the trend shows that expectant mothers in **the most deprived areas are more than 4 times as likely to be smoking**. Smoking in pregnancy can have many lifelong health consequences for a developing baby and supporting mothers to stop smoking is a cost-effective solution to preventing many ill-effects.

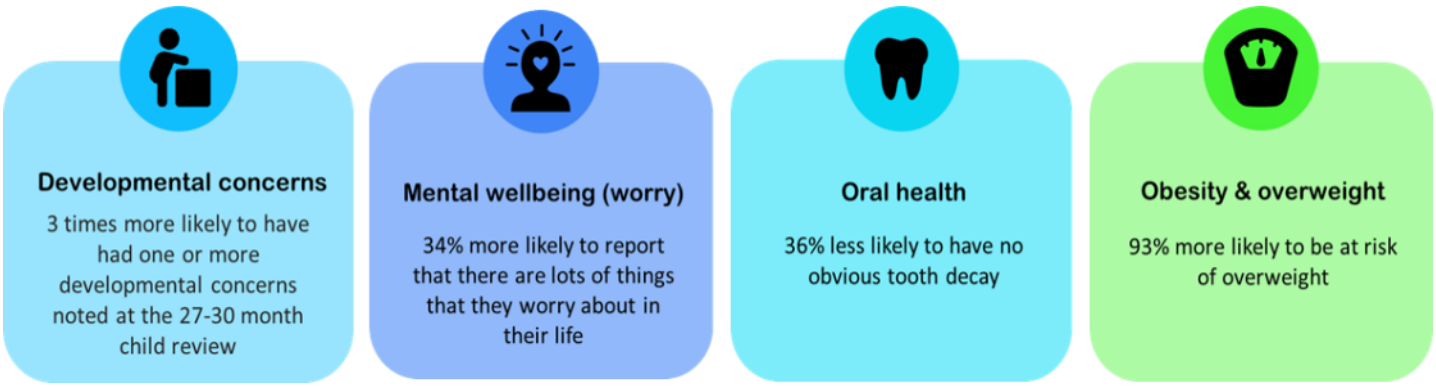
Engagement with community midwives in NHS Borders has highlighted the growing trend of vaping in pregnancy. Similar concerns have been expressed by colleagues working with children and young people. The use of vapes in schools in the Scottish Borders presents a growing problem that many children, parents, teachers and school nurses have expressed concerns about. It is important that we do not promote the conditions for young people who have never smoked to start vaping.

Rates of maternal obesity are increasing and there are differences in the rates observed across different areas of the Borders. Local data reveals that Langlee as well as Melrose and Tweedbank have almost twice the rate of maternal obesity compared to Lauder. There are many complex causes of obesity, for both children and adults, including access to nutritious food, time available

to prepare food, a lack of access to health promoting environments and access to physical activity. NHS Borders and Scottish Borders Council are working together on the development of a Good Food Nation Plan and a key theme of that will be considering how we address the underlying causes of inequalities that we see in overweight and obesity as well as under-nutrition.



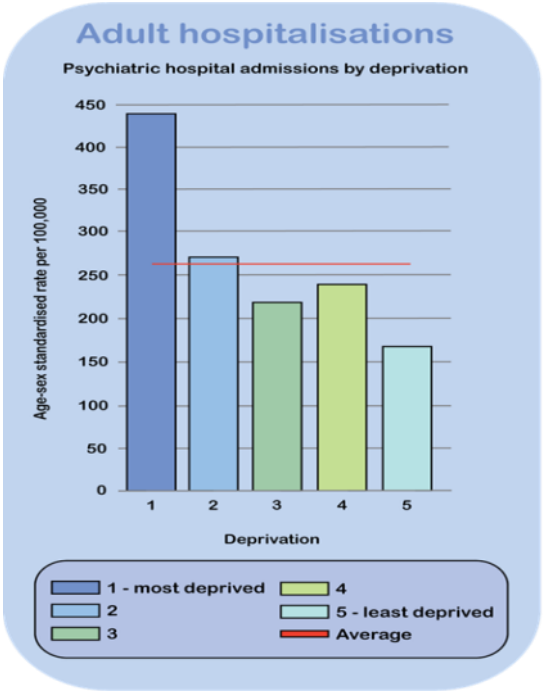
Throughout childhood, across almost all health indicators, we continue to see differences between the most and least deprived. In the Scottish Borders specifically, we observe that, compared to the least deprived group, children living in the most deprived areas are:



Supporting children to have the best start in life can have a significant impact on their long term health and wellbeing, which in turn impacts a child's ability to attend and enjoy school. The links are well established between, for example, oral health and a child's mental health and wellbeing, as well as their diet and general health.

The early years represent a critical window to address health inequalities throughout the life course. We can do a lot to alter the life chances of children, and we rightly focus on the first 5 years of life when the brain is most plastic. Puberty is another time of great neuroplasticity, and we need to focus more on how we can support young adults to develop better life chances. Supporting the health of the whole family is critical to addressing inequalities in physical and mental health that begin in childhood and continue to impact throughout life.

Working age adults



By adulthood, the inequalities we see in childhood are enduring and there are significant differences in use of health and care services as a result. **People in the most deprived groups of the Scottish Borders are 60% more likely to be prescribed drugs for anxiety, depression or psychosis** and are significantly more likely to be have a psychiatric admission to hospital.

Additionally, comparing the most deprived group in the Borders to the least deprived reveals **higher rates of admissions as a result of asthma (2 to 3 times higher), alcohol related incidents (2 to 3 times higher) and drug use (4 times higher) amongst the adult population**.

In addition to emergency hospital admissions, access to services continues to represent a significant inequality in this group. In general, data collected about scheduled appointments in the Borders General Hospital indicate that the group most affected by health inequalities is **1.5 times more likely to miss a hospital appointment** (DNA rate). Additionally, the same group is **23% less likely to have visited a dentist** within the last 2 years if they are registered with an NHS dentist.

Inequalities in screening – an important opportunity to detect cancers or serious illness early – are evident both across Scotland and in the Borders. Across all of our local screening programmes, uptake is higher amongst the least deprived groups and lowest amongst the most. We know there is also less uptake amongst people with learning disabilities. This leads to notable differences in early detection rates and survival outcomes, despite more cancers being diagnosed in general in the most deprived areas. In the Scottish Borders, compared to the least deprived, people living in the most deprived groups experience:

Cancer diagnosis

20% higher likelihood of having a cancer diagnosis

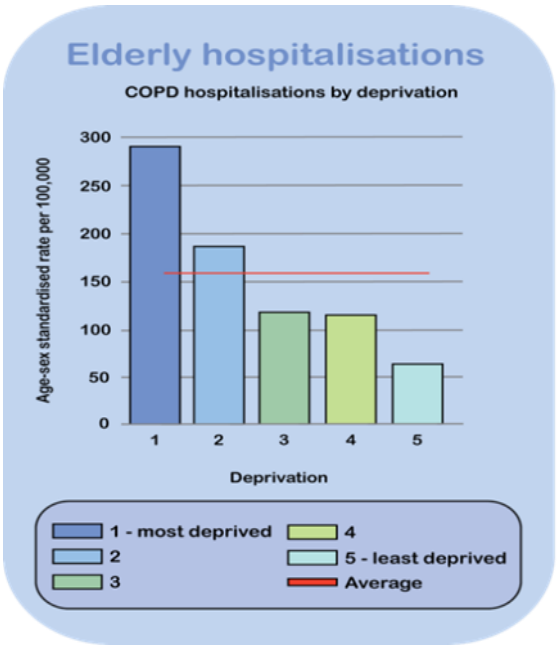
Bowel screening

23% less likely to take part in bowel screening

Older Adults

Demographically, the Scottish Borders has an older population than many other areas of Scotland. It is a great asset to our local communities that so many older people volunteer, run and support community groups and the wider social and economic benefits of this should be celebrated. However, we know that the health status of older adults in the Scottish Borders is also unequal with significant differences between socio-economic groups.

Within the Scottish Borders there is a very clear trend between deprivation and chronic obstructive pulmonary disease (COPD) hospitalisations, with those in the most deprived areas of Borders having 79% higher rates of hospital stays for this condition than the overall average for the area. **People who live in these deprived areas are over three times more likely to have a COPD hospital admission** than people living with the disease in the least deprived areas of Borders.



These differences are avoidable, and if the levels of COPD hospitalisation seen in the least deprived parts of Borders could be replicated across the whole population, the rates of hospitalisation from this disease would be 59% lower. This would have huge positive consequences for the ability of those living in Borders to age well and would reduce the cost of lengthy admissions to the health service.

Within the Scottish Borders, there is also a link between emergency hospitalisation in those who are over 65 years old and deprivation, **with the most deprived areas having 11% higher rates of emergency hospitalisation within this age group compared to the average for Borders.** Those who are over 65 years old and live in the most deprived areas locally are a fifth more likely to have a hospital admission than their peers who live in the least deprived parts of the county. If the playing field could be levelled, and the rates in the areas of least deprivation experienced across the Borders, there would be 10% fewer rates of emergency admission in our older adults.

Older people living in the most deprived areas of the Scottish Borders are:

>65 yrs emergency admissions

21.5% more likely to have an emergency hospital admission if they are over 65 years old

Fall admissions

55% more likely to be admitted with a fall

Preventable emergency admissions

51.5% more likely to have a preventable emergency hospitalisation for a chronic condition

Older adults who are admitted to hospital, particularly in an emergency, are more likely to experience functional decline, cognitive decline and delirium. Preventing the need for stays in hospital has benefits for the individual and the health and care system. Hospital care, especially emergency hospital care, is one of the most expensive components of NHS delivery. Within Scotland, 70% of emergency hospital admissions are for individuals over 65 years of age [7], and those over 85 years old account for a quarter of all bed days within the NHS [8]. Efforts to prevent hospitalisations, represent an opportunity for financial savings in the health service as well as improved outcomes for patients.

TACKLING HEALTH INEQUALITIES IN ACTION

The Director of Public Health Annual Report for NHS Borders in 2023 focused on the important role of prevention and showcased some important examples of how we can seek to do this more effectively, building upon existing good practice [9]. There are several areas where we know that we can have meaningful impact in tackling health inequalities by seeking to avoid and prevent the causes of ill health at source.

Social prescribing: Many people turn to the health and care service when their social needs are not being met. As many as 20% of GP consultations are thought to be almost entirely social in their nature. This represents approximately 200,000 consultations in general practice per year in the Borders. Social prescribing seeks to address non-medical needs associated with health by providing links for people to access community-based activities that promote their wellbeing. The offer around social prescribing, however, has to be comprehensive and address the specific needs of the population in the Scottish Borders. It is important that referral routes into social prescribing are clear and that we better align existing organisations and groups attempting to address these needs at present. There is much learning that can be done from examples across Scotland to get this right for our local communities and we should rightly be ambitious for what we can achieve locally.

Our role as anchor institutions: Anchor institutions are large, public-sector organisations that are so-called because they are 'anchored' in their surrounding community. They have a big stake in their geographical area and have substantial assets that can support local community wealth building through procurement and spending power, workforce and training, and buildings and land. NHS Borders – alongside SBC and other large partners - has the potential to generate health beyond healthcare by shifting the way we employ staff, procure goods, use assets and resources and work with others. Together, we need to baseline the work we do as anchor institutions and build upon the opportunities we have to tackle wider health inequalities in a coherent and joined-up way.

Waiting well: increasing numbers of people are waiting for hospital appointments and procedures, including surgeries, and this can impact upon people's quality of life and ability to maintain working and other responsibilities. We recognise the importance of supporting people to 'wait well' to maximise the benefits from the procedure they are waiting for, ease some of their symptoms, prevent further symptoms from developing, and to promote recovery. We need to ensure that people are able to access the wider support they need whilst waiting to prevent de-conditioning and worsening of symptoms.

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Waste and ineffective healthcare: It is important that a modern NHS takes steps to ensure that the services provided actually deliver on the outcomes expected and make a real difference to the lives of patients that we serve. Focusing on the value of procedures being offered to patients is important in tackling health inequalities, ensuring we can direct care to the people who most need it and use scarce resources more wisely to address inequalities gaps. Waiting lists tend to disadvantage the most deprived, and is a hidden problem. We know that not all healthcare is appropriate in all cases, and so we need a meaningful discussion on realistic outcomes between patients and their clinician. The use of scarce GP time for primarily social reasons should also be addressed. Reducing waste in the health service has wider sustainability benefits & at a time of financial challenge is an ethical responsibility also.

Community development and place-making: building strong links with communities, third sector and advocacy groups is vital. These groups understand local need and experience so they can use community assets to make the most of health-benefitting opportunities. We must build on the existing good practice from initiatives in the Scottish Borders where this has been done well and we have seen community-wide changes being sustained and leading to improved outcomes. We must also be sure to link community development approaches with the place-making agenda being led by SBC. Well-designed environments that create the conditions for people to live healthier lives require insights from communities at every level of planning, design and development.

Good practice example: Whole Systems Approach in Eyemouth

A Whole Systems Approach is defined as applying systems thinking and processes that enable "an on-going flexible approach by a broad range of stakeholders, to identify and understand current and emerging public health issues where, by working together, we can deliver sustainable change and better lives for the people in Scotland".

The Scottish Borders was one of eight early adopter areas in Scotland, with Eyemouth adopting a community led Whole Systems Approach to supporting and promoting healthy weight, eating well and being physically active with a focus on children and health inequalities.
This work is informed by the ambition for children to have the best start in life and to improve children's health and wellbeing by having opportunities to eat well and be active. Every child should have the same opportunities to thrive, no matter where they live.

Since the first of three virtual workshops in March 2021 a group of local stakeholders have developed local priority themes and taken forward eight areas for action to address some of the causes of overweight and obesity that are being sustained beyond the initial timescales of the work.

ENGAGEMENT

Engagement for the strategy has taken place within several forums. Two workshops have been held to discuss the data content of the strategy, and to gather views from attendees about the impact that health inequalities has in their day-to-day lives and work, as well as how these might be best tackled. The workshops were attended by NHS and SBC staff, third sector organisations, and Community Planning Partnership representatives.

We asked attendees at our workshops for their views on health inequalities, including how they impacted their work, what needed to be done to address them and how we could improve partnership working on this agenda.

There was consensus around some important themes and areas for further work, as below:

1. Need to provide the most appropriate care at the right time for those who truly need it:

- Challenges identifying those living in deprivation
- Those who need care the most aren't always the ones who receive it
- Attitudes towards health and care can differ amongst population groups

2. It can be hard to get the correct information about local services:

- Many professionals and clients are not aware of the services available and what could help

3. Barriers to services make it more difficult for certain population groups to access to health information or care:

- Location of services and transport options are important given rurality of Borders
- Support is needed for patients who do not attend appointments

4. There is a need for collaboration and partnership working:

- Communication is essential between services and organisations
- Siloed funding leads to duplication

5. Changes in services and access leading to worse health outcomes:

- Lack of community services capacity
- Long waiting times
- More specialist service and support is often needed but not available

6. Wider determinants are affecting health

- Financial concerns and cost of living crisis
- Employment contracts and conditions
- Educational opportunities
- Transport
- Poor quality housing
- Climate change and work towards net zero
- Food environment

There is much more that we need to do to engage with communities, third sector organisations and people living and working across the Borders. There is an important role for community development work to be ongoing as we consider next steps. We are also in the process of completing an Equalities Impact Assessment to support our work and the voices of a wide range of people and groups should rightly be heard to inform that.

Through the Community Planning Partnership we will develop an approach that involves all sectors and areas of the Borders in these conversations.

PARTNERSHIP WORKING

The Scottish Borders Community Planning Partnership (CPP) is required to prepare and publish a Community Plan. The Community Plan focuses on improving outcomes and there are specific outcomes relating to reducing inequalities for the whole of the Scottish Borders under theme 3 on promoting good health and wellbeing. The CPP aims to take a Borders wide approach with community planning partners collectively working together with local communities and businesses.

The CPP is the obvious starting point for developing a delivery group to take forward an action plan for delivering health inequalities. The wide representation of that group would enable us to take a cross-sector approach in our response to the issues identified.

Going forward, we also want to make sure that we involve the voices and views of community organisations and individuals through further engagement and consultation events in localities.

RECOMMENDATIONS

There are three themes that we have identified for further work, which will enable us to evaluate progress, develop new approaches to tackling inequalities and maintain momentum in our prevention activities.

Improving access to data and monitoring of progress against health inequalities indicators

- Develop a health inequalities dataset to ensure that everyone has a clear understanding of the issues and outcomes relating to health inequalities across community, primary and acute care and Identify metrics that will provide real-time insight into the progress being made and the changes in population-level outcomes.
- Improve access to data on preventative spend across statutory partners so that we can make more aligned and co-ordinated decisions to invest in upstream interventions.
- Consider how we improve our understanding of the health and wellbeing of our rural population by developing an improved measure of SIMD that better reflects the Scottish Borders.
- Promote the routine use of Adverse Childhood Events (ACEs) in many services and settings to better understand some of the challenges faced across different areas of the Borders. Childhood is key as it impacts on a whole lifetime so working closely with education colleagues to explore how we can support and develop this work.

Developing a sustainable partnership approach to developing interventions

- Build on existing good practice of community-led approaches to tackling health inequalities, such as the Whole Systems Approach in Eyemouth.
- Promote a health in all policies approach through the joint Health and Social Care Partnership with colleagues in SBC.
- Develop the role of CPP member organisations as anchor institutions, recognising the impact that large employers and providers of services can have on the health and wellbeing of their staff and wider communities through procurement, employment and wider policies.
- Share good practice guidelines with partner organisations to ensure that health and wellbeing is promoted throughout all community work, including in relation to food and nutrition.

A strong focus on prevention activities across the NHS and our partners

- Developing a joined up system of social prescribing that brings together existing services such as the Wellbeing Service, Local Area Coordinators, What Matters Hubs, Housing RSLs, and localities to respond to the social challenges that many people experience.
- Share and develop best practice amongst primary care colleagues to tackle the growing demand for conditions such as type 2 diabetes and to better support people to manage these conditions.
- Review the use of procedures of limited clinical value so that resources can be spent most wisely and fairly.
- Take a health inequalities approach to driving up screening rates across the Borders to promote early intervention amongst groups who have typically been less likely to engage.
- Consider how we address long-standing issues of access deprivation across the Borders through digital solutions and in working with transport colleagues to better connect people to our services.
- Promote schools to be healthier places for young people to learn and grow, including supporting calls for vape-free schools and to encourage similar decisions to be taken by other partners.
- Measure and tackle health inequalities in employment provision, working with the public and private sectors.
- Identify the disadvantaged within housing provision and work with partners to tackle underlying issues.
- Work with the Criminal Justice System to reduce the harm from deprivation and break the cycle of the harms from drug & alcohol use/abuse.
- Consider how the disadvantaged could have the harms from isolation, including transport poverty, mitigated.

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