Health Creation:
How can Primary Care Networks succeed in reducing health inequalities?

Report from a series of multi-stakeholder events held between February and September 2020

Thank you to our valued sponsors and partners, without whom this workshop series and report would not have been possible.

About The Health Creation Alliance

The Health Creation Alliance (THCA, previously New NHS Alliance) is the only national cross-sector movement addressing health inequalities through Health Creation.

Our mission is to increase the number of years people live in good health in every community. Our primary focus is on underserved and disadvantaged communities, which is particularly relevant given the disproportionate impact of COVID-19 on them.

We deliver our mission by: connecting the voice of lived experience to people setting the policies and designing systems and services; drawing on our members and extensive connections to bring together movements and collaborations that energise and empower professionals and local residents to take action; helping places to establish 'Health Creation communities of learning', bringing together professionals from diverse backgrounds, community members and people with lived experience to learn from each other. We also seek to increase the profile and status of Health Creation with policy makers, systems leaders and practitioners as an essential part of addressing health inequalities.

Become part of the movement by joining The Health Creation Alliance for free here.

About RCGP Health Inequalities Standing Group

The Royal College of General Practitioners (RCGP) Health Inequalities Standing Group (HISG) is a special interest group working within the RCGP.

Its overall purpose is to ensure that achieving health equity for all remains a key policy and practice focus, with specific reference to the role of General Practice as a speciality.

We achieve this by advising RCGP Council on issues relating to health equity in the broadest sense (not just disease specific) and to assist in the formation of RCGP policy on these issues.

We ensure that issues relating to health equity are on the agenda of all RCGP working parties and provide cross cutting support as necessary.

We also develop and disseminate evidence-based information on aspects of inequity in health which fall within the capacity of primary care to influence and to seek to bring such information to the attention of health professionals, media and government.

About the workshops and this report

In July 2019, The Health Creation Alliance (operating as New NHS Alliance) and RCGP HISG held a one-day event in London that posed the question "How can Primary Care Networks (PCNs) succeed in reducing health inequalities?"

That event kicked-off a debate about how PCNs might connect and work in partnership with local communities and a range of local partners, how they might be constituted to support those connections, how PCNs and local partners might draw on community assets and resources and shift power to enable communities to have more control over their lives, and how this work might be funded. It concluded that:

> Lasting reductions in health inequalities will only be possible through working in genuine partnership with communities…by seeing them as part of the system and a significant part of the route to lasting solutions.

Read the event report here.

This early event informed three further events that took place in 2020. Two of the events took place in February in Manchester and Birmingham. Due to COVID-19, the third was postponed and held in September 2020 as an online digital workshop.

Together, the events attracted over 200 delegates from a wide-range of organisations and sectors, including primary care. They built on the premise reached at the end of the previous event: people and communities are part of the health system and not separate from it, and that lasting improvements in health inequalities will only be possible through partnership with communities. They explored these issues from a range of perspectives to gain surround-sound insight into two questions:

- How can general practice and primary care work differently with communities and local partners to reduce health inequalities?
- What can PCNs do to enable and create the conditions for practices to work differently with local partners to reduce health inequalities?

This report captures the key outputs from the three events.

What we heard: the key messages

1 There is now significant evidence that the 3Cs of Health Creation – **Control**, **Contact** and **Confidence** – help to improve people's health and wellbeing. Integrated systems across health and care need to take wholesale action to embed Health Creation within their offer to their local populations.

2 PCNs that include communities and local partners within their governance arrangements will find it easier to build relationships, and align their collective efforts, to address health inequalities through community strengthening and action on the wider determinants of health.

3 Relationship-building with communities and local partners does not 'just happen', it requires resourcing. Dedicated staff-time is needed to work out how best to coordinate efforts with local partners to make the biggest collective impact on health inequalities.

4 PCNs are at the centre of a tension between systems requirements and enabling health creating activity in their localities. This should not prevent PCNs from working effectively with partners and communities. However, taking the right approach to the Network Contract DES, and the Tackling Neighbourhood Inequalities service within it, could help to reduce these tensions and enable better partnerships and alignment of actions to improve population health (*see key messages in full pages six to 10*).

5 Kindness is an important agent in transforming the way local partners work together. But the kindness of a community can be abused if it is not invested in.

6 Trusting relationships are absolutely key when supporting the most marginalised and most vulnerable people. Successful programmes, such as Focused Care and Housing First, always prioritise relationships and trust-building.

7 Communities with little social infrastructure and few social connections are starting from a low base. They need a skilled community development presence to support building of the connections between people and assets that lead to thriving communities. There is a clinical case for employing skilled Community Development workers in these places.

8 PCNs and general practices need to feel comfortable sharing power with patients and local partners. Involving them in governance and decision-making is the goal and there are some practical steps they can take towards this goal (*see page 12*).

9 PCNs located in places where there is a broader vision and shared ambition between public services for 'health in a place' can find it easier to align their efforts with those of other partners and communities.

10 PCNs could become part of an 'enabling state' where people are given the opportunity to be active partners in the process of building their lives.

11 There is a strong case for diverting 1-2% of the acute care budget into community Health Creation to support increasingly community-led action to address health inequalities. This has been agreed in principle by at least one PCN in Airedale, Wharfdale and Craven.

12 The Network Contract DES, and the service requirements within it, need to be more flexible and permissive, particularly in relation to the restrictions placed on Additional Roles Reimbursement Scheme (ARRS) roles and on how money is spent. PCNs need strategic-level, community-facing roles to bridge to and support community activity that creates health and addresses many aspects of health inequality.

13 PCNs and general practice can change their practices to respond to and support people through their *actual* recovery journey (including non-clinical elements of recovery). See page 11 for common ingredients of people's recovery journeys and ideas for changes to frontline practice that could make a big difference to their wellbeing and their ability to self-manage.

Thank you to our sponsors

The events were supported by NHS England and NHS Improvement and a range of partner organisations including: The Health Foundation, Carnegie (UK) Trust, Power to Change, The Taskforce for Multiple Conditions, Accord Housing, Walsall Housing Group, National Pharmacy Association, Birmingham VCS, Royal College of Nursing, Queen's Nursing Institute, Institute for Health Visiting, Association of Directors of Public Health and the Local Government Association. We are extremely grateful to their support and continuing interest in our work.

Health inequalities and COVID-19

Health inequalities – often used interchangeably with health inequities – are differences in health between different groups of people. Both are commonly used to denote unfairness; a state of affairs that is avoidable and unfair and that could be changed with the right mix of actions.

Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. *World Health Organisation*

Many individual factors have an impact on our health – income, employment status, educational attainment, housing conditions, historic childhood abuse, access to and quality of healthcare and many more.[1] These 'wider determinants of health' influence our health outcomes and longevity more than either genetics or access to healthcare.[2] They can be mutually reinforcing resulting in a greater burden of ill health in certain communities.[3] Evidence shows significant direct costs associated with health inequalities, and indirect costs as poor health also presents a drag on local economies.

Before COVID-19 there was a persistent 20-year gap in the number of years people live in good health between the most and least affluent areas*.[4] The pandemic has both revealed the extent of the 'health gap' and increased it.[5] Disruption to children's education, unemployment, food poverty, domestic abuse leading to psychological distress and mental ill-health are all more apparent and visible. The high number of COVID-19 deaths among people from certain BAME backgrounds has prompted a stream of data analysis and is starting to uncover the burden of risk factors experienced by BAME communities leading to worse outcomes.[6]

The 'gap' is expected to widen further following the pandemic lockdown periods and this has brought health inequalities to the fore in the NHS' response to the pandemic.[7] It has also brought a recognition that the NHS cannot do this alone; no matter how much money is channelled through it. The escalating problems need a wholly different approach.

All local partners have a role to play in this and the best outcomes will be achieved when PCNs join other local partners in getting behind community-led efforts to address the issues in the long-term.

Addressing health inequalities through Health Creation

Enabling people to increase their levels of **Control** and **Confidence**, through meaningful and constructive **Contact** with others, helps to build protective factors and keeps people as healthy and productive as possible. Control, Contact and Confidence are the 3Cs of Health Creation: they characterise communities that have been most resilient during COVID-19. Alluding to them, Prof Marmot says:

"To tackle inequality, society needs to enable all children, young people and adults to maximise their capabilities and have control over their lives".[8]

Building people's confidence and listening and responding to the voice of lived experience offers the best way to change our systems, policies and practices across both healthcare and the wider determinants of health to address health inequalities for good.

Professionals can help to create the conditions for people and populations to be well by adopting and embedding the 5 features of health creating practices within everyday practices and through health systems. These five – Listening and Responding, Truth-telling, Strengths-focus, Self-organising and Power-shifting – are the things that communities consistently say makes the biggest difference to them: these are the 'active ingredients' of Health Creation.

* The gap in life expectancy (LE) at birth between the least and most deprived areas was 9.4 years for males and 7.4 years for females in 2015 to 2017; for healthy life expectancy (HLE) it was 19.1 years and 18.8 years respectively

Primary Care Networks, health inequalities and Health Creation

General practices are embedded within local communities and, while GP practices working in areas of higher socioeconomic deprivation continue to be significantly more stretched than those in more affluent places,[9] all practices have assets on their doorstep – people and organisations, including patients themselves – who are often already supporting a population health approach.

A historical barrier to general practice accessing the 'renewable energy of communities' [10] has been a lack of strategic capacity to meaningfully engage with local partners and communities beyond individual patients or Patient Participation Groups. Many GPs are not only missing out, they are unaware of how much possibility they are missing out on. As one PCN Clinical Director put it: "*You need to be in the forum … in the conversations for all the other possibilities to emerge …*" In theory, PCNs could provide the additional capacity to connect general practices and primary care to a wide assortment of activity and possibility beyond the surgery door.

Having a service specification requiring PCNs to 'deliver locally agreed action on health inequalities' could help to focus minds; it could also reinforce the wrong perception that health inequalities can be addressed through a single service line whereas the issue actually demands wholesale frontline delivery and systems change.

What also helps is when routes are made available for people who have experience of poverty and discrimination to train and go into professions they wouldn't normally consider. Primary care could consider training and employing more people who are embedded within local communities to new roles such as social prescribers, care coordinators, focused care workers, health coaches, nurses and community development workers. Bringing more of the lived experience of community life centrally into primary care helps to bridge the gap with the community and change the culture.

A Quick Start Guide for PCNs

Developed from the discussions at our London 2019 event. Download a copy of the event report here.

1. Don't wait until the Tackling Neighbourhood Inequalities DES kicks-in, start now.
2. Involve your local communities and local partners in shaping your PCN.
3. Make sure your PCN governance arrangements include people from diverse communities.
4. Start now and share the process of developing your actions for tackling health inequalities with local partners.
5. Support general practices to work with communities as equal partners in pursuit of improved population health.

Key messages in full

There is now enough evidence to act

"Whether people have control of decisions and resources makes a big difference to their health".
Prof Jane South

There is now sufficient evidence that the 3Cs – **Control**, **Contact** and **Confidence** – help to improve people's health and wellbeing.

> "Connecting leads to increased confidence and enables people to gain control; it also saves lives and money". *Dr Brian Fisher, Chair; The Health Creation Alliance*

There is also an 'inverse evidence law' meaning that much less money is spent on evaluating the value of community connections as a means of addressing health inequalities than is spent on researching other areas. However, there is now no dispute; Communities matter to health and 'Health Creation' needs to become central to the health system.

Learning how to 'dance' well together

Connecting is at the heart of addressing health inequalities. Primary care and other local partners need to learn how to collaborate well or 'dance together'.

> "Open the dance floor … PCNs are currently too much about the dots and the dashes …we need to bring in the dance teachers, the walkers, the mums and toddlers". *Dr John Patterson, Chief Clinical Officer and Deputy Accountable Officer, Oldham CCG*

In fact, there are three sets of relationships that need attending to:

- those between community members
- those between primary care/PCNs and communities
- those between primary care and other local partners

The Old Farm surgery in Paignton has been developing partnerships with a wide-range of local and community-led organisations, including through social prescribing, since 2017. The Crafty Fox Café is one of these and it is a place where personal connections can lead to hope, joy, purpose and boost self-esteem.

> "Personally, the relationship with the community is one of the things that energises me, excites me and fills me with hope. Without Nina [the community development worker] and the Crafty Fox Café I would definitely be a much less effective GP". *Dr Mark Thompson, GP*

Kindness is an important agent in transformation

'Kindness' can easily be squeezed out of public services due to both process and cultural pressures. But COVID-19 has shown us all just how important kindness is to getting the right things done.

Dr Elizabeth Kelly explored three type of kindness: '*Random acts of kindness*' can be an emollient in our daily experience; '*relational kindness*' offered over time can be a great energiser; and *'radical kindness*' is often experienced as an irritant, but it can provide the disruptive force necessary to change dynamics between people, processes and systems.

However, kindness must not be taken for granted. As people stepped up to volunteer in large numbers during the pandemic, it's important to remember that:

> "The kindness of a community can be abused by the statutory sector if it's not invested in". *Deirdre McCloskey, Mid and East Antrim Agewell Partnership*

Invest in relationship building

Integration starts with relationship-building and that takes time and effort:

"Integration doesn't just happen – everyone is too busy doing the day job!" *Dr Andrew Parsons, Modality Partnership*

Building relationships with communities and local partners, and making things happen through them, needs to be recognised as a valuable activity, and one that needs investment to make it happen. Only when this happens will primary care, local partners and communities be able to coordinate their efforts in the best way to address health inequalities.

"Voluntary sector groups know how to get access to funding that could complement health funding – just one of the reasons to invest in integration". *Bill Graham, Community Innovation and Development, Modality Partnership*

Bill Graham´s role is that of a 'Community DJ', building relationships with the different stakeholders in the health and wellbeing of a local community, enabling them to 'dance to the same tune' and work effectively together. This is a not a patient-facing role. Rather it is a strategic-level function that is enabling general practice and primary care to extend and expand their approach to addressing health inequalities by working with the grain and energy of communities and local partners.

The question was asked, should such a 'partnership development' role become a common feature for PCNs? Should it be included in the future as one of the roles that could be reimbursed through the Additional Roles Reimbursement Scheme (ARRS)?

Tensions between clinical and community-based health inequalities work

Doctors are trained in diagnosing and treating illness rather than looking outwards to the social determinants on health and/or taking an active role in creating health with their patients. They are also answerable to specifications that can take their attention away from what is happening outside the surgery door. This can lead to tensions when they try to respond to people's life-outcomes and when communities and other local partners seek their support for health and wellbeing programmes. Social prescribing link workers are a frequent focus of tension as primary care and community-based organisations often have different approaches.

In some places, COVID-19 has changed the local dynamics and caused some crucial conversations that have helped to unblock and resolve difficulties as primary care has discovered the value of networked community partners.

"GPs were referring many more people to the Trust through social prescribing and it became clear that without the ability to recover the full cost (of the link workers), the service would not be able to continue. Conversations in that moment unlocked the money. They also helped to shift other ongoing conversations with the CCG about the broader role of the Trust as a community anchor". *Charlie Ferdinando, Health and Wellbeing Team Leader for Southmead Development Trust*

Relationship building with vulnerable people: Focused Care and Housing First

Relationship-building is absolutely key with homeless, marginalised people in particular… there are very small windows of opportunity for building trust".
Paul Wright, Accord Group

Two programmes that support people with complex clinical needs, social challenges and often mental health or addiction issues through building relationships of trust were explored at the events.

Focused Care in Oldham has provided a route for GPs to address people's needs in the round by providing a programme of support for people who often engage poorly with services, and who show poor health outcomes in terms of life expectancy, morbidity and premature onset of multiple chronic conditions.

"I'd written him off. I'd put him into the ´expected to die within a year´ category…. Whatever they have done, they have turned him around. He's a different man. Focused Care has achieved something I couldn´t". *GP, Greater Manchester*

Housing First is an evidenced housing solution for people with multiple and complex needs who have a history of entrenched or repeat homelessness. It reduces rough sleeping, helps people to sustain tenancies and provides access to medical treatment services through GP registration, relationships with practice staff, flexible appointment times, fast-track referrals to specialist health services, social prescribing and navigation of health. It works on the premise that people have the right to a home and that flexible strengths-based support is provided for as long as needed for people to reach their goals and aspirations.

Places with little social infrastructure

Some places have low levels of 'social infrastructure'[11] – good quality and accessible usable buildings, services and organisations are thin on the ground, and community activity and social connections lack energy. However:

"Every place has some social infrastructure; we just need to make the effort to look for it". *Paul Morgan, Chair, C2 National Network*

Places like this can benefit from a skilled community development presence to start building the connections between people and assets that lead to thriving communities. There is a clinical case for employing Community Development workers in these places.

The NHS can support this effort by listening to communities and helping them to build the social infrastructure that communities can use. For example, shared space – where people feel comfortable meeting both informal and formal services – is highly valued; a neutral environment can encourage people who have lost trust in formal services to re-engage.

Building community activity can be supported through a recognition of community groups and semi-structured platforms like time-banking that enable people both to receive and to give help; 'give' is one of the five ways to wellbeing.[12]

Sharing power with communities

Creating a more equal power dynamic with local partners and communities is an important part of developing constructive partnerships. But, this can be a challenge when care is over-medicalised, or when dedicated time is not carved out for these activities. It has been noted in places where the power dynamic has changed, that the important conversations often happen outside of formal PCN meetings which tend to be transactional in nature and focused on matters of contract and specification. The spaces between the meetings are where the real conversations happen, relationships are forged and more flexible working arrangements can emerge.

Primary care networks can consider the 'Practical steps PCNs might take' (*see page 12*) to drive broader engagement and start a different type of conversation with local partners that can lead to the emergence of constructive and energetic partnerships.

Shared ambition and vision for 'health in place'

"There's a big world out there and if we're going to reignite our communities we need to talk to the people that make them up … and that goes for primary care and everyone else". Dr. Tracey Vell, GP and chief executive for the Manchester LMC

Some PCNs are located in places where there is already a strong vision and shared ambition for health and wellbeing, often driven by local authorities and involving many partners including the NHS. Where this is happening, it is helping to align partners toward the task of addressing health inequalities.

Greater Manchester's starting point to transform its entire public sector workforce was to develop a shared ambition, vision and outcomes around 'health in place' and then invite others in. The PCNs are embedded within the neighbourhood project and 'place structure' so they need to become part of a shared endeavour, locally.

> "We didn't say that Primary Care Networks had to include education, housing, probation etc… it quickly became clear that they needed to". *Warren Heppolette, Executive Lead, Strategy & System Development, Greater Manchester Health & Social Care Partnership.*

This 'whole public service' approach requires all public services to make a different set of connections and a different power-dynamic with communities.

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Investing in communities to create health

While community Health Creation activity is not as expensive as healthcare that treats illnesses, neither is it free. The experience of community organisations and non-NHS partners is that successful pilots are too often not commissioned on a long-term basis, despite evidence showing their positive impact on health and financial savings; acute services always take priority.

The Airedale, Wharfdale and Craven Health and Care Board has agreed, in principle, to direct 1% of the £220m health and care budget into community strengthening within three years. This conscious decision to invest in communities' health creating activity needs to be adopted more widely and encouraged by NHS England and NHS Improvement.

Towards an enabling NHS

Jen Wallace, Head of Policy at Carnegie UK Trust, started by quoting feminist Audre Lorde:

"There's no such thing as a single issue struggle, because we do not live single issue lives".

The problem for our welfare state, including our health service, is that it was built on the assumption that people's needs could be met within narrow, defined categories. Because of this, it has failed the same people over and over again.

An enabling state – one that has shifted away from silo-based activity to something much more holistic – must give people the opportunity to be an active partner in the process of building their lives. COVID-19 could be a tipping point and through recent work exploring responses to the emergency phase of the COVID-19 pandemic, Carnegie UK Trust has identified seven steps to an enabling state

Step 1. Put wellbeing at the centre through more genuine and mutually beneficial partnership working

Step 2. Give people permission to take control through enabling person-centred, not service-centred, responses

Step 3. Help people to help each other through recognising people and communities are the 'first resort' for community wellbeing

Step 4: Support people to participate fully through more investment in local and hyperlocal responses

Step 5: Move upstream by ensuring that long-term planning is built into structures and processes

Step 6: Build in Radical Kindness through removing the barriers to relational service delivery

Step 7: Tell an authentic story of change by creating a shared vision and focus for the future

The DES Contact and Service Specification

Representatives from the NHS England and NHS Improvement Primary Care Group provided an update on progress with the Network Contract DES at two of the three events. Delegates discussed with them how the contract, and services within it, might support a better interplay between local system, community partners and broader societal determinants of health inequalities. The team were clear that the contract and services will continue to be informed and shaped by engagement with PCNs and other interested stakeholders.

Key points raised by delegates include:

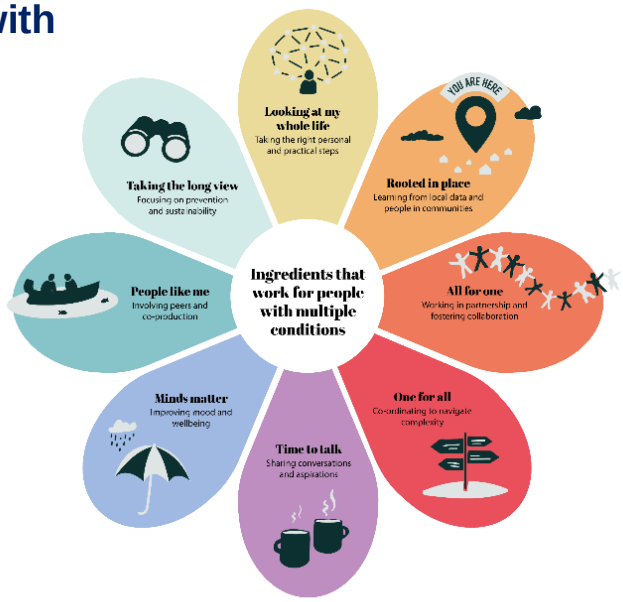
- The DES Contract needs to become more flexible in terms of the type and range of Additional Roles Reimbursement Scheme (ARRS) roles that can be appointed by PCNs
- There is a clinical case for appointing Community Development workers to build connections in a place, given the proven damage loneliness can do to people's health
- 'Community DJs' – people who make strategic-level connections with community groups and other local partners in order to help align PCN and partners' activities to create a bigger collective impact – is one way to invest in building relationships and connections
- PCNs could be offered a small ring-fenced budget to invest directly in community development or community-led connecting activity
- Going one step further, PCNs could be permitted to invest this money to build on existing community connecting/strengthening programmes locally, that are already successful, rather than PCNs starting new programmes and managing these roles themselves

Resources for PCNs

Recovery journeys; what works for people with multiple conditions and how can PCNs and commissioners respond?

Improving care for people with multiple long-term conditions requires a model of health that is more balanced between the medical and social models, addressing the wider determinants of health, not just reacting to illness or promoting behaviour change. This requires a profound shift in how we think about and coordinate services around health.

Despite the need for listening and flexibility to take account of different personal and local circumstances, the Taskforce on Multiple Conditions offers eight commonly identified ingredients that work for people with multiple conditions that all frontline professionals can incorporate and that PCNs could support the adoption of.



Building services to support people's recovery journeys

In order to answer the question: How might people's actual recovery journeys drive what PCNs, GPs and local partners do and invest in?, delegates heard from one individual who had lived experience of trauma and mental ill-health. Five 'features' of people's recovery journeys were identified and some suggestions for how PCNs might respond were identified.

Recovery Journey – key features	What PCNs could do to embed the features
Access to 'trusted people and environments' so people feel able to open up about things they feel ashamed early on in their journey. Ideally, this 'trusted person' would be of a similar age and have some experience of what the individual is going through.	PCNs could work with community partners to provide access to empathetic 'peers' in congenial settings who can build trust with people, help them to face their truths and get to the bottom of what is troubling them.
People not having to repeat their story over and over again to different professionals. Recounting damaging experiences, coupled with the frustration of people not understanding, causes further damage and anger at a deep level; it reinforces negative feelings.	PCNs could develop 'information-sharing protocols' with partner organisations, to enable sharing of information with the individuals' consent. This would mean they only have to tell their story once.
To be seen as a person with talents and strengths (not just focusing on their problems) is very important in terms of confidence-building. People often need help to spot their own strengths and to find a place they can exercise them.	This is a key reason PCNs need to connect with community partners – because they can provide access to a whole range of possibilities to develop and employ/enjoy their talents.
Follow up ´did not attends´ (DNAs) because when people don't attend their appointment, it is often because they are struggling to hold onto all the strands of multiple services and other things going on in their lives.	PCNs need to work with GPs to change the way they respond to 'DNAs', so that people are followed up, perhaps by a social prescriber, especially when it happens often.
"Knowing what the map is…" because 'multiple vulnerabilities' occur when people are facing several problems at the same time and they feel out of control. One of the ways to start to get control back, making people feel better, is to be able to see a route through.	PCNs could support the development of a 'Support Map' that GPs, social prescribers, health coaches, care coordinator and others across primary care build up with people to help them to navigate their own care path.

Practical steps PCNs might take (download)

By Dr Chris Tiley, GP at the Lander Medical Practice in Truro

The NHS now recognising the primacy of health inequalities is a significant breakthrough. But doctors need to digest the clinical as well as social benefits of community interventions if they are going to support their important counterparts in Health Creation – the local authorities, housing, community groups, community builders. And to do this, GPs need some practical steps they can take to address health inequalities.

These steps have been developed by Dr Chris Tiley, GP, Lander Medical Practice in Truro through his experience and through wide-ranging discussions that took place at New NHS Alliance events on 15 September and 6 October 2020. They aim to help PCNs get their ambitions to address HI off on the right track. It is a simple template and one that can be adapted according to local need.

1) A change of heart is needed by PCNs that are often given target driven agendas that need supervision and enforcement. The nature of addressing HI through community interventions has to be approached very differently. For change to be lasting and effective, the 'locus of control' must be in the community rather than externally driven and it is important to realise the community already contains mature networks that can gather information and find solutions / resources.

Clinical approaches may risk ignoring this and when engagement has occurred it has sometimes not been on equal, respectful terms.

PCNs therefore need to let go of the reins and trust the community to do the legwork around addressing HI and engage with the community as equal partners. But be passionate at the same time – enthusiasm goes a long way!

With this in mind:

2) Make the commitment to addressing health inequalities explicit – clinical directors should state it is a priority and point to the following as initial steps:

2a) Include a member / members of the community on the PCN executive (typically six clinicians) to help inform decision-making.

2b) Have a designated health inequalities lead clinician whose role could include developing a local steering group with representation across different sectors (In Truro we have a GP, member of local council, housing, police, social prescribing and community members represented in a WhatsApp group). Ethnic / minority groups should be represented wherever possible. The lead clinician could also interface with 3)

2c) Appoint a 'Community DJ' – this is a role envisaged to link the PCN with the wider community to facilitate communication and understanding across boundaries.

3) A specific role for financial advice would be extremely helpful to help with benefits, debt and poverty – such a person may already be out there – ask the community! They could be based in the surgery waiting room or other community hub.

4) Look for outreach e.g. Cornwall Farmers' Hub – finding people where they are is an important part of reaching more marginalised groups and thereby reducing health inequalities. Placing resources in the heart of deprived communities follows the same principle.

5) An anchor institution with local resources (hospital / council) can help to stabilise nascent groups and maybe offer advice / finance if needed.

6) Ensure any PCN decisions are climate friendly and do not affect the community locus of control.

Remember to ask people not so much 'what is the matter with you?' but 'what matters to you?' to open a meaningful conversation and seek to build new relationships through the above process. In the end, addressing health inequalities should create better health and wellbeing with a social / health and financial benefit we will all feel.

Next steps

The Health Creation Alliance is currently engaged in two projects supported by The Health Foundation.

Primary Care Networks and place-based working to address health inequalities in a COVID-19: A Coalition Perspective

This project provides a 'coalition perspective', from a wide range of local partners who are working in partnership with general practice, on the question of how PCNs, communities and local partners can address health inequalities in a COVID-19 world. It aims to inform practice and policy by going further and deeper, within the new context presented by COVID-19, than was possible through this event series.

Community responses to COVID-19, learnings for NHS

This project provides insight and learning on how the NHS can better work with local people and communities based on community learnings from their response to COVID-19.

The first publications will be published in March 2021, and the second in April 2021.

Please contact us if you would like to receive a copy of either one of them, or both by e mailing Neil@TheHealthCreationAlliance.org

Discovery Learning Programme for Primary Care Networks

The Health Creation Alliance and RCGP HISG are offering a 'Discovery Learning Programme' for PCNs who are ready to explore how to go about implementing some of the elements in this project.

Find out more about the opportunity for learning here.

Become a member of The Health Creation Alliance

The Health Creation Alliance

Join our national cross-sector movement for Health Creation, access our resources and get information about all our activities here.

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