Practical steps Primary Care Networks might take to get their ambitions to address health inequalities off on the right track

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.

For more information on how PCNs can tackle health inequalities visit:
www.thehealthcreationalliance.org/reports