Primary Care Networks and place-based working: addressing health inequalities in a COVID-19 world

A partners perspective

Supported by The Health Foundation

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In partnership with the
Royal College of General Practitioners
Health Inequalities Standing Group

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About The Health Creation Alliance

The Health Creation Alliance is the only national cross-sector group addressing health inequalities through Health Creation.

Our mission is to increase the number of years people live in good health in every community.

We achieve this 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 addressing health inequalities.

You can join the The Health Creation Alliance for free and become part of the movement here.

About RCGP Health Inequalities Standing Group

The Royal College of GPs 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 assisting 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.

The views expressed in this report do not reflect those of The Health Foundation.

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Executive Summary

COVID-19 has accelerated network formation and exposed health inequalities

COVID-19 has accelerated the formation of and action being taken by local networks in the community, giving communities and local partners an urgency, a higher priority and a confidence to act to support members of the community in many ways. The vaccination programme has accelerated the coming together of practices within Primary Care Networks (PCNs) to create a whole new service.

COVID-19 has also exposed the extent of health inequalities.

What happens now is critical. Primary care, increasingly led by (PCNs), has a huge opportunity to work in more networked ways with communities and local partners to address health inequalities.

Relationships at the heart of a different approach

For this opportunity to be grasped, the importance of good local relationships needs to be built into the way primary care works. Clinicians need to recognise efforts of communities and local partners and develop a relationship with the community that is taken as seriously as the patient-doctor relationship. Community building, to strengthen the connections between people, is core because one of the causes of entrenched health inequalities are a weakening of social ties between people. Being isolated reduces people's ability to take control of their lives and environments and that can lead to ill-health. The processes involved in Health Creation involve the regaining of control through the rebuilding of the social ties that connect communities.

PCNs would benefit from paid roles to build relationships locally and this needs to be supported by the Network DES Contract. Primary care does not yet have a 'language of relationships' nor an embedded conceptual framework to explain how relationships help to improve population health and address health inequalities.

We present three ways that PCNs might work as equal partners with communities and local partners to build on the opportunity of COVID-19. They are:

- engage with patients through community centres
- share anonymised data with communities to build trust
- invest in your community because this builds confidence and helps to sustain energy and action

Places with low levels of social capital – where there was not already a critical mass of relationships between local people – tend to be more disadvantaged. Community development – which enables the building and broadening of relationships between people through which people gain confidence and control over their lives – is the key to increasing population health and addressing health inequalities in these areas.

Tensions for PCNs aiming to shift to place-based working

Addressing health inequalities requires GPs and primary care partners to play their part alongside a wide range of local partners to deliver a coordinated place-based response. This new, more collaborative, way of working could help to reduce the burden on general practice and primary care as others are enabled to address health inequalities and create health within communities.

However, the shift towards place-based working through the PCN model is creating some tensions. Difficulties cited include the lack of incentives, capacity and encouragement for PCNs to build relationships with place-based partners and the treatment of health inequalities as a separate service in the NHS plan. The Network DES Contract can also be perceived as an additional burden that deflects primary care from engaging and collaborating with partners. (See page 18 for an explanation of the Network DES Contract).

Primary care remains at the heart of a tension between a shift to place-based working, where decisions are shared with communities and aligned with local partners, and a health system that, to some, still feels quite centralised.

Sustaining the effort

While relationships are critical, they are not, in themselves, sufficient to achieve sustainable long-term impact on health inequalities. Also required are:

- a shared ambition and vision for health in a place
- investment to develop the agency of communities
- new place-based model and pathways

It is also important to achieve the right balance between the community and professionals with each playing their roles optimally and seamlessly to achieve the vision.

Five stages that one place is going through to achieve this are set out on page 22. They are:

- agree shared geographies
- leaders get to know each other
- develop a shared evidence profile
- agree shared priorities and outcomes
- develop shared governance arrangements.

Pressing ahead with this sort of transformational change across a whole system can lead to and exacerbate tensions between local partners. Some of these are set out on page 23.

How can PCNs mature into place-based working?

To make rapid and sustained progress on health inequalities, PCNs need to become part of a broader approach within a place. They need to see communities and local partners as part of the population health system, not just recipients of it. Being in control leads to better health and wellbeing and working with communities as equal partners can support the power shift and offer more control. Some simple but powerful changes to the Maturity Matrix would help, so that 'Working in partnership with people and communities' becomes the start point, not the end game. If PCNs put this first, then the people, communities and local partners they connect with can help them to develop their approach to the other four components.

A wholesale shift to creating health alongside the current trend to population health management would also help PCNs to make real and sustained progress in addressing (and reducing) health inequalities.

About this project

A recent RCGP publication ***General Practice in the Post Covid World: Challenges and opportunities or general practice*** points to three features of the COVID-19 response that have the potential to transform general practice radically and permanently so that it is equipped to meet the health challenges of the 21st century:

- New ways of working enabled by digital technology
- Reducing workload by eliminating unnecessary contractual and regulatory compliance activities
- Developing the public/community health function of general practice

This report focuses principally on the third of these – on how general practice and primary care might develop its public/community health function – with a specific focus on how it might work successfully with the assets which exist within communities to address health inequalities. Drawing on insights from a series of interviews it provides a helpful 'partners' perspective' on this question, seeking to inform how this development might take place from the standpoint of those organisations and communities that make up those assets, described in this report as 'communities and local partners' as well as from the standpoint of general practice and primary care working in areas with high levels of deprivation. It also provides some recommendations for ways in which PCNs might develop this work further.

It should be noted that this project and report offers insights from a range of perspectives. The interviewees are too small in number to reflect a representative view.

PCNs are at very different stages and are working differently from each other. There is no 'typical' PCN, rather there is a patchwork of approaches. The project does, however, reflect the reality of what is happening in some places and provides insight into the realistic ambitions of some local partners in some places. In that sense, it offers glimpses of potential futures for place-based working to address health inequalities.

Background to and aims of the project

This project closely followed a series of multi-stakeholder events that were hosted by New NHS Alliance (now called The Health Creation Alliance) and the Royal College of General Practitioners Health Inequalities Standing Group and supported by NHS England and NHS Improvement and The Health Foundation as well as several other organisations and partners.

Two of the three events took place in Manchester and Birmingham in February 2020, before the COVID-19 pandemic first wave; the third event was hosted online in September 2020, featuring speakers mainly from Bristol and the south west. They followed an earlier event that took place in London in July 2019. Reports from the events can be found here: Health Creation: How can Primary Care Networks succeed in reducing health inequalities? .

As a series, the events sought to answer the question 'How can Primary Care networks succeed in reducing health inequalities?', the intention being to help primary care networks to develop their approach to address health inequalities in the light of the service specification to 'deliver locally agreed action on heath inequalities' that was announced in early 2019. Through them we also sought to inform NHS England and NHS Improvement's work on the Tackling Neighbourhood Inequalities service specification as well as the DES Contract.

COVID-19 has changed many things and has put the issue of health inequalities into prominence, increasing the determination, in some areas, to address its causes and consequences. It quickly became apparent that the relevance of the findings and perspectives on the core question from before March 2020 might have changed in the wake of the onset of the pandemic. This project has enabled us to go further and deeper, to understand better what has happened in the months since the COVID-19 outbreak and what the opportunities might be for primary care to be successful in addressing health inequalities in partnership with communities and local partners. It has also been informed indirectly by other COVID-related work of The Health Creation Alliance.

The key aims of the project were to:

- capture, interpret and explain the key shifts that have taken place in how primary care relates to and works with communities and local partners through COVID-19
- bring to life the changes that have taken place, plans to take further steps to sustain and embed this activity and the ambitions of communities and local partners for how PCNs might work with them going forward

The project aims to interpret these shifts and ambitions from a partners' perspective. This means learning about the how relationships between local partners – including general practice, primary care, communities and non-NHS partners – have changed and might change when looking through the lens of the broad range of partners who work locally to tackle inequalities and support population health outcomes, as well as from general practice professionals themselves.

As well as being useful for general practice, primary care and primary care networks, this report will be particularly insightful for those involved in the shift to Population Health Management which, we conclude, should go hand in hand with Population Health Creation.

This project builds on the themes that emerged through the event series. A consistent and core message was 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.

A Partners' Perspective

The importance of understanding PCN development – and in fact any development in the health and care system – from the full range of local perspectives cannot be overstated. The NHS providing treatments to those who are unwell accounts for only 10-20% of a population's health.[1] Health creating and social interventions and advocacy carried out both by some in the NHS and many outside it can have a much bigger influence on people's health overall. If we are going to develop a health and care system that supports the other 80-90% – the wider determinants of health and the social processes involved in creating health, which mainly happen in people's homes, neighbourhoods, workplaces and wider networks – then the NHS cannot lead the charge alone.

The good news is that they do not have to. In every place, beyond the boundaries of the NHS, there are already many groups and organisations working to address the causes of health inequalities and to create health in communities. Primary care needs to not just involve them, but to invite them to lead the process of constructing a new type of heath and care system – one that attends to many more components of what makes people well.

This project and report have been led and undertaken by an individual whose professional experience, knowledge and connections lie significantly outside the NHS, while also having insight into NHS operations, functioning and developments. This has enabled the voices from outside the NHS to speak louder than is usually the case providing fresh perspectives on health inequalities, the breadth of potential solutions and how to access them, potential roles for PCNs and others steps PCNs might take to make it happen.

1.https://www.health.org.uk/blogs/health-care-only-accounts-for-10%-of-a-population's-health. Last accessed 17 November 2020

A note about language

One of the difficulties of writing any report that is intended to span both NHS and non-NHS audiences is the use of language. Different words are used within and outside the NHS to mean essentially the same thing and because of this is it can be hard for people operating in each sphere to grasp the relevance of what someone operating in the other sphere is saying to them. Sometimes these words refer to entire programmes and, unfortunately, opportunities for joint working can be missed.

The converse is also true. Sometimes a single word can mean entirely different things to people who work within and outside the NHS and this can also lead to misunderstandings and confusion.

Every effort has been made in this report to make the language clear both to people working within and outside the NHS. There is, though, always the potential for misunderstanding and it is important to be mindful of the different ways different sectors use language in interactions with others in the shift to 'place-based working'. As you read this report, please be aware of where the author is coming from; their background and experience. Doing this in all 'place-based' interactions will help with the process of connecting and relationship building.

The language of 'place' and 'neighbourhood'

The NHS has recently adopted the words Place and Neighbourhood to mean two specific geographical levels. Place is used to describe a geographical area that is, in most but not all instances, coterminous with local authority (upper tier) boundaries. Neighbourhood now refers broadly to the Primary Care Network level, typically populations of between 30,000 and 50,000. In this document, where these words hold these specific meanings, they have a capital first letter and are underlined.

For those working outside the NHS, the words 'place' and 'neighbourhood' have a much more flexible meaning as might be expected in everyday language. Other words that are also used to describe places where people live include 'area' and locality'. In this document, all these words are sometimes used interchangeably. Where they hold general meanings, not denoting a specific geography or systems level, they do not have a capital letter and are not underlined.

Where the document talks about 'place-based working' or 'place-based models' this refers to cross-sector approaches to understanding and addressing problems with communities at any geographical level.

Key findings and recommendations

- COVID-19 has accelerated the coming together of local networks and the confidence of communities to support people's wellbeing.
- COVID-19 has also revealed the extent of existing health inequalities and has led to higher levels of mental ill-health.
- Primary care needs to become more connected to local networks of communities, the voluntary and community sector (VCSE) and other local partners such as housing, police and local authorities. PCNs can support this process of connection.
- The NHS needs to make a wholesale shift to tackle both health inequalities and mental ill-health from a social determinant perspective, not principally a clinical perspective. Working with communities and local partners makes it more possible to address the root of people's problems.
- Relationship-building with communities and local partners needs to be valued as an essential role within the NHS. PCNs need paid 'connector' roles that focus on building these relationships at a range of levels, including at a strategic level. We recommend every PCN has a Strategic Partnership Development Lead that is an additional role within the Network DES Additional Roles Reimbursement Scheme. Without these roles it is difficult to see how the NHS will find the capacity to shift to place-based working.

Key findings and recommendations continued…

- PCNs need to seize on the moment during and following COVID-19 to develop relationships of equals with enhanced community networks that believe they are reaching more vulnerable people than before the pandemic. This can take many forms, such as engaging with your patients 'en masse' through community centres and sharing anonymised data with communities and inviting them to help you interpret it.

- Investment in communities needs to become central to PCN activity to address health inequalities. Ways this can happen include getting behind community-led projects, being a conduit for communities to reach and be heard by commissioners, recruiting community members as link workers through a voluntary and community sector organisations, making a case for community development specialists to be employed in your neighbourhood.

- A community development presence is needed every in place and especially in neighbourhoods that have low levels of social capital and infrastructure. This must lead to communities taking control and taking on leadership roles to strengthen their own communities if it is to have lasting impact on health in the place. It is intensive and time-consuming work that requires a skilled individual that is community-facing. Patient-facing personalised care roles such as link workers, care coordinators and health coaches can support this activity.

- PCNs are NHS England and NHS Improvement's chosen vehicle to drive engagement between primary care and communities. Those that are trying to engage with communities and local partners are experiencing some tensions caused by a number of factors including the restricted nature of the Network DES Contract. These are expanded in Section 5 (page 17).

- Focusing on what a good PCN looks like – from the perspective of communities, local partners and pioneering PCNs – will help to support the shift to place-based working. It can also help to establish a better national framework to support PCNs to make the shift successfully. Section 6 (pages 18 and 19) provides some pointers as to what a good PCN might look like from the partners' perspective.

- PCNs need to see themselves as part of a wider health and wellbeing system that reaches way beyond the NHS. The system needs a good vision for health in a place and partners need to find ways of working seamlessly to achieve it, building each other's capacity to contribute along the way.

- To improve population health and wellbeing, tackle health inequalities and deliver sustainable change, creating health must sit alongside prevention of ill health and treating illnesses. It needs to become part of what the NHS does in equal partnership with communities and other local partners. Being embedded in communities, PCNs need to lead this shift for the NHS.

- The framework for establishing and developing PCNs could be further developed to better support the shift to place-based working. Helpful developments include: extending the Additional Roles Reimbursement Scheme (ARRS) to include strategic-level connecting roles; incorporating the range of ways PCNs can develop relationships with local partners within the Tackling Neighbourhood Inequalities service specification and guidance; encouraging PCNs to developed a version of the Maturity Matrix that places 'Working in partnership with people and communities' as the starting point, and inviting them to help them address the other components of the matrix.

- By adopting population Health Creation alongside Population Health Management, PCNs and integrated care systems will maximise the potential of communities and all local partners to contribute towards the goal of improving health in a way that is inclusive and helps to reduce health inequalities.

Project methodology

The project was informed by a series of Zoom-enabled interviews that took place between August and November 2020 to draw on the experience of a range of individuals from across the health and care system. A Sounding Board comprising representatives from RCGP, RCN, QNI, IHV, NPA, ADPH, LGA, Carnegie UK Trust, Power to Change and C2 National Network helped to identify interviewees.

A total of 22 interviews were undertaken and the interviewees were as follows:

Type of organisation	Location
GPs n=5 (some clinical leads for PCNs)	Nottinghamshire (x2), London, Paignton, Sheffield
Other clinical Leads n=1	Bradford
ICS ICC Development Lead n=1	Lancashire
Local Authorities n=3 • Commissioner n=1 • 'Thriving Communities' programme n=1 • Former LA CEO now patient lead n=1	Sheffield Oldham Hull
Community infrastructure organisation n=2	Sheffield and Bristol
Community Group/Hub n=3	Wigan, Plymouth, Devon
Community Development worker n=2	West Yorkshire, Paignton
Health Visitor n=1	London
Community Healthcare NHS Trust (Children's Nursing and Therapies) n=2	London
Housing association n=2	West Midlands, Greater Manchester
Community pharmacist n=1	

A topic guide was developed following the event series and informed by other discussions held by event partners through the first wave pandemic. This was used to guide the semi-structured interviews. The information collected through the interviews was collated into themes and then the themes structured to provide a readable and meaningful narrative. Quotes were selected to illustrate significant themes that were being expressed more broadly.

All the interviewees were invited to a follow up meeting to review and discuss and further hone the initial findings emerging from the interviews. Seven of the interviewees, one third, attended that meeting.

Detailed Findings From The Research

1. COVID-19: The great accelerator

The shock at the onset of the COVID-19 pandemic caused huge disruption within communities and informal services, across the statutory sector and to parts of our economy. While some of the effects have been very damaging – such as the increasing levels of unemployment in the hospitality sector and survival challenges for many charities – the unprecedented and rapid changes that took place have also served to speed up some positive trends for in population health and wellbeing that were already in play.

In particular, this project confirmed other sources of information, that COVID-19 has accelerated the formation of and action being taken by local networks in the community, giving them an urgency, a higher priority and a confidence to act that they didn't have before. Latterly, the vaccination programme has accelerated the process of PCNs working together to create a new service and has achieved rapid successes.

COVID-19 has also, sadly, exposed the extent of existing health inequalities. The Health Foundation's COVID-19 Impact Inquiry is looking into how people's experience of the pandemic was influenced by their health and existing inequalities and the likely impact of actions taken in response to the pandemic on people's health and health inequalities – now and in the future.[2]

COVID – an accelerator of networks and confidence

"Where pre-COVID relationships were already strong, COVID has taken it to another level". A housing provider

The first wave of COVID-19 prompted an 'emergency response' in many places as networks of organisations and individuals sprang into action to provide shopping deliveries, medicines deliveries, hot meals and other essential services to people who were shielding or isolating.

Community response teams, made up of community members, led the effort in some places. In others, a VCSE infrastructure organisation or a local housing provider took the lead in organising volunteers and partnerships of smaller organisations. And in others, the local authority brought the partners together to organise the support effort.

In some areas COVID-19 catalysed the formation of new support networks. In others the pandemic strengthened and developed existing community networks that had been coming together for some time:

"COVID hasn't changed the pattern much, it has just accelerated the collaboration in some places". LA Commissioner

Although the networks came together with varying degrees of harmony:

"There were multiple layers of volunteers: the networks were going on but they were not connected or coordinated". A London-based GP

Primary care involvement in local networks – a mixed and evolving picture

Local partners pointed to a mixed picture of general practice, primary care and PCN involvement in these networks while the GPs, pharmacists and PCN clinical directors interviewed expressed a desire to be more connected with local partners. Interviewees provided additional insight into some of the shifts that are currently taking place and the barriers to being active partners in the local networks.

One housing provider that works across 30 local authority areas reported seeing a big variation in general practice, primary care and PCN involvement in the local networks. Where there was most involvement, this was typically led by a practice nurse or other member of the primary care team rather than by a GP.

"There are some fantastic examples of collaboration. Some PCN teams very quickly supported the emergency planning approach. Teams of nurses right through to community homecare teams being given support on resilience and how to manage. In the worst places, primary care was nowhere to be seen and people felt abandoned and scared". A housing provider

Some said that primary care and PCNs were not ready to respond sufficiently quickly, perhaps due to other priorities.

"Very quickly everyone who worked in that neighbourhood came together … it was a big opportunity for the GPs to engage, but they missed a trick". A (different) housing provider

Others experienced positive developments in their partnerships with primary care as barriers dissolved and partners started to address the situation together. They expressed cautious optimism that this could be a 'key moment of change' for place-based working in primary care.

"COVID cemented the relationship with one PCN in particular. We already had the social prescribing contract with them and we said 'Send your vulnerable people our way, we'll sort out what they need'. The PCN was really pleased to have the service available to them". A VCSE infrastructure organisation

"*COVID has brought into sharp focus what PCNs should be doing already".* Nurse Managing Director of primary care hub

2. COVID-19 impact inquiry | The Health Foundation and Build Back Fairer: The COVID-19 Marmot Review | The Health Foundation

"Primary care people were prepared to talk (and flex the rules) because the system wasn't going to work any more. Some of the turning points happened when I was really honest about things – the shared problem meant there was a lower potential for problem-shunting. Relationships were built often through conversations between the meetings. COVID-19 has unlocked these conversations, made it possible for communities to drive things forward". A Community Development Trust

The perspective of one GP who is very connected to his local community provided a useful insight into the tensions between the different demands of the system and the community that limit the ability for primary care to be involved in local solutions.

"I felt completely removed from the [community-based] networks I was in and sucked into a system. It created a tension between the networks and existing hierarchies". A GP from NW London

A PCN working as equal partners with a community organisation

Zest is a community-based (and led) organisation in Sheffield that hosts a community café and a gym as well as being the base for a multi-agency team through which people can get support with employment, parenting and much more. The organisation delivers three 'People Keeping Well' contracts with the Council and through this people are enabled, including through being offered small grants, to develop wellbeing activities they want to do, such as a badminton group. They also provide 'infrastructure support' for other community groups in the area and do outreach into the communities to enable them to serve more groups who might not otherwise engage.

Zest has a particularly good and well-established partnership with one of the PCNs in its locality. The PCN contracts Zest to employ Social Prescribing Link Workers and they also employ a mental health worker, health trainer and wellbeing coaches providing one-to-one support. The programme is working directly with around 36 patients each week. The quality of the partnership is what makes it a success. The dialogue between Zest and the PCN is frequent and constructive, and the partners are sharing their experiences and know-how on how best to address problems – writing proposals for funding together, delivering together and evaluating success together. The level of trust is high and partners are working with the community to address their health issues together.

COVID – exposing the extent of existing health inequalities

Sir Michael Marmot's most recent contribution, ***Build Back Fairer: The COVID-19 Marmot Review*** commissioned by The Health Foundation as part of its COVID-19 Impact Inquiry highlights that the inequalities in social and economic conditions before the pandemic is contributing to the high and unequal death toll from COVID-19. It also stresses that multi-sector action from all levels of government is needed to build back fairer from the pandemic.

Our interviewees described their experience of the impact of COVID-19 on health inequalities in a range of ways.

Both community members and GPs also talked about an 'explosion' of mental health problems, linked to COVID-19 and health inequalities, and are grappling with how best to respond.

A local authority commissioner talked about the fact that health inequalities are long-standing. They stem from:

"Multiple generations of people who don't get the good education, don't get the good jobs, live in poor housing. They have poverty of choice … they don't always have the choice to go to other markets and buy cheap veg".

"It's knocked people's confidence, there are a lot of people with hidden illnesses". Leader of a community centre

"People can't access mental health services". Community members in one place

"How do we tackle mental health from a social determinant's perspective rather than a clinical perspective? It's difficult to put resources where the worst problems are because they are everywhere". A GP

Going forward interviewees pointed to many different aspects to this including digital inclusion, chronic loneliness, anxiety about leaving the house, unemployment and low skilled work, people hiding from debt, parents keeping kids off school, poor housing, poor food and a greater disinclination to be vaccinated against COVID-19 in some communities that are already at greater risk from the disease.

"There will be poorer health everywhere … but this will manifest in different ways in different places". LA commissioner

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2. Building relationships in places

GPs, nurses and other clinicians have long understood the centrality of the patient-doctor relationship. The importance of developing a trusting relationship with patients is core to medical practice and shared decision-making is now becoming the norm. Clinicians' relationships with communities are not afforded the same significance.

The opportunity for clinicians who do take their relationship with communities as seriously as the patient-doctor relationship is significant, given that communities are made up of their patients.

The efforts and potential of communities and other local partners need to be recognised and valued when addressing health inequalities. This is partly because both the causes of and the solutions to many health problems – for which people seek help from primary care – are social and economic in nature. Community building, to strengthen the connections between people, is core because one of the causes of entrenched health inequalities are a weakening of social ties between people and higher levels of isolation. Being isolated reduces people's ability to take control of their lives and environments and that can lead to ill-health. The processes involved in Health Creation involve the regaining of control through the rebuilding of the social ties that connect communities.

"There are very good clinicians still trying to diagnose in a medical context rather than a social one". LA Commissioner

"It's relationships that make things work, not systems!" Director of a Community Development Trust

"We need to create healthy places and communities rather than institutions to keep people healthy … you create healthy places by creating resilience". Patient and former LA CEO

The language of relationships

Primary care does not have an established, shared approach to expressing how place-based relationships can help to improve population health and address health inequalities. Neither does the framework for general practice and primary care include it. At least one interviewee drew attention to the fact that there is no 'language of relationships' in primary care (or the NHS) so, while relationships are crucial, the need for them remains hidden and undervalued.

"*A lot of the language of relationships has a values-base – 'kindness, trust, health creating'. It's not language heard much in primary care which has a lot of specific operational language and acronyms that freezes people out. It doesn't feel like we've got shared language".*

"If I heard GPs talking about 'moments for trust-building' that would be a bridge-building moment … it would show that they really understand". A Community Development Trust that holds a Social Prescribing contract for a PCN

Four types of relationships to consider at the community level

While there are many dynamics to community-level relationships, there are, broadly, four sets of relationships to consider:

1. Relationships between community members

Being connected to other people is critical to improving people's health, strengthening communities and building resilience. We know that loneliness is bad for our health and COVID-19 has shown us how important it is to stay connected to those we love. Helping people to connect to other community members needs to become an explicit goal across the health and social care system including primary care and to be resourced. It is also important for communities to build the connections themselves – apart from the health and care system. Helping people to connect and take action together must be supported by a community-embedded community development presence.

2. Relationships between primary care/PCNs and communities

This is an important dynamic because the concept of shared decision-making is equally applicable at the community level as it is in patient-facing work. Primary care needs to have an ongoing dialogue with communities so they can understand how they experience their health problems, be responsive to their needs (as a community) and requests and so that they can share information and power with communities.

How you develop the relationship with your communities is important and there are four things to consider:

- It takes time to build trusting relationships
- The relationships need to be credible with the community
- Once the relationship has been built it needs to be maintained by consistent listening and responding leading to actions that work for communities and regular feedback.
- Equal relationships last far longer so genuine power shifting/sharing with communities is required.

Four types of relationships to consider at the community level cont…

3. Relationships between other local partners and communities

There are a wide range of organisations locally that have many connections with communities. These include community groups, community-led businesses, housing organisations, police and fire services, schools and local authorities (public health, social care, community teams). Some are actively addressing health inequalities and creating the conditions for communities to be resilient and to flourish while others may be less engaged in doing so. Increasingly, local partners are working together to provide a comprehensive 'partnership response' to issues faced by communities; these have strengthened through the pandemic.

Local partners' pre-existing relationships with communities vary in strength and trust levels. It is important for primary care to understand how they work and whether and how it might be possible to add strength to them as they get to know their communities. This issue has come to the fore in the way the COVID-19 vaccination plan has been rolled out, with trusted community members helping others to overcome their fears.

4. Relationships between primary care/PCNs and other local partners

Primary care's relationships with other local partners is also important. Most local organisations would actively welcome closer working with primary care and would welcome primary care representatives to join pre-existing partnerships and enrich actions being taken locally. Doing this could also enable primary to develop good relationships with communities more quickly if they are able to build positively on trust already built up with the community.

Where partnerships are not functioning well, there is a case for primary care to lead their development and PCNs provide a good mechanism to do this.

Connectors across the system

Several interviewees pointed towards the need for people who are a bridge between community and the health and care system. They spoke about specific paid roles to complement the many informal connectors and those who embrace connection as part of their day-job.

Here are some of the phrases that different interviewees used to describe come of the roles that are needed:

"There needs to be a sense of independence from the system; they need to look like people in the community so they're accepted".

"Peer-to-peer roles are key – these often operate around a particular agenda".

"You need some specific bridges, people who sit somewhere between the institutions and community".

"You need some people to connect the system to itself … because you're now looking at a completely different (networked) system. Ultimately, you need to be able to guide people to be able to find people … where they'd be lost otherwise".

The paid roles described here go beyond the patient-facing roles that are already part of PCNs – link workers, care coordinators, health coaches. They operate at a more strategic level to build relationships that will change the system into a much more networked system.

Throughout the event series, the notion of communities and local partners 'dancing together' was discussed and developed by delegates. The term 'Community DJ' started to become the way to describe people who are employed to build strategic-level relationships between the health system and local organisations. A more official title might be 'Strategic Partnership Development Lead'.

In a few places, people are already employed to be that bridge; they are working at a strategic level to extend and consolidate networks across the health system and to harness the power of partnerships to deliver a wide range of services in different ways that work for their communities. It takes time and skill to build and maintain constructive and productive partnerships which lead, over time, to different ways of working across the system. It was agreed that the Strategic Partnership Development Lead role is integral to the success of the health and care system and provision must be made for them to be universally employed by PCNs. This will then free up clinical and patient-facing roles to concentrate on the individual's journey to better health and wellbeing.

"You need to be in the forum to be in the conversations for all the other possibilities to emerge. It's good to talk! You find out things and that helps you to develop further …". A Clinical Director of a PCN starting out on the journey of relationship building

A strategic relationship builder for health

Lancaster Integrated Care Community (ICC) is one of eight ICCs in Morecombe Bay. ICCs work together to improve the overall health and wellbeing of the community by joining up health, care and public services with voluntary, faith and community groups to provide collaborative care out of hospital where possible and supporting people to have information about, and where possible, how to self-manage their health conditions.

Lancaster ICC employs a Development Lead whose principal role is to build strategic-level relationships with local partners – including community groups, public services, third sector organisations and housing.

The Development Lead combines information from a wide range of sources to learn about problems affecting local communities that may be impacting on people's health; including risk stratified population data, information about individuals being referred to care coordinators and through conversations with cohorts and groups within the community, asking them what they understand the issues to be.

They then meet up with partners in the area to work out how they might solve the issue, together. Over 90 different partners are now invited on regular basis to talk about what issues they're facing and what the solutions might be. This approach has led to the emergence of a range of new types of 'services' that better meet people's needs and that support Health Creation in the process including:

- A co-led clinic, run by a substance treatment service and people in recovery, running weekly sessions from a GP surgery, providing advice and guidance around the use of alcohol and also treatment options for dependent drinkers.
- Pop up health checks available at livestock auctions, on auction days, which have uncovered a lot of health issues among farmers
- A COVID-19 response of around 200 local volunteers organised by a local church in response to COVID-19; the ICC is offering them support from a health perspective
- New referral pathways for homeless people, with housing organisations

"When we talk to people at events, we find all sorts … we ask partners in the group for help, bounce ideas off them, work out the best solutions together". Lancaster ICC Development Lead

This role is now connected into the local PCNs and the ICC Development Lead is also the link between the PCN and the community. The PCN Clinical Lead for Lancaster attends ICC meetings and the ICC Clinical Lead attends PCN meetings. The Development Lead, currently funded through the CCG is, in effect, providing a strategic partnership lead role for both the ICC and the PCN.

"I'm guessing other PCNs around the country won't have the benefit of ICCs and they won't have a 'me' dedicated to community partnership working and development". Lancaster ICC Development Lead

3. Supporting community-led initiatives following COVID-19

Community centres and hubs report that they are reaching a lot more vulnerable people due to the COVID-19 pandemic. These are people who have been historically underserved, while often being described as 'hard to reach'. The question here is how general practice, primary care and PCNs respond to and work with increasingly networked communities.

The route to success is to engage with communities on a level playing field where community resources are valued, power is shared and partners play to their strengths. Asking 'how can we best support you' is the next question following 'what matters to you' and is the route to building resilience and strength of communities

"Definitely not being 'done to' … rather they asked 'how would we best to support you through this'. It is a really positive quick, dynamic process. It brings out good will and enables people to play their role". Housing provider and partnership coordinator.

Interviewees offered several ways that primary care networks might work as equal partners with communities to build on the opportunity of COVID-19. We present three of them, with examples:

- Engage with your patients through community centres
- Share anonymised data with communities to build trust
- Invest in and nurture your community

Engage with your patients through community centres and hubs

Community centres and hubs are places where people congregate.

Seeing them as spaces in which people (also 'patients') feel comfortable congregating could help to reframe community hubs as a place where primary care can engage informally and outside of the traditional patient consultation. They could be places where meaningful two-way dialogue takes place between health professionals and communities.

"We can easily get a crowd of 60+ people to a meeting if someone from the health centre came to explain to the people what the changes are and how it works – such as E-Consult". Community Centre Volunteer, Plymouth

Some centres also have treatment rooms designated for health appointments. Through a process of dialogue and small amounts of investment they could be equipped for use for a broader range of appointments.

It would be appropriate to deliver some 'low level' health and wellbeing services from community centres that would prevent escalation, such as mums' and toddlers' check-ups and weekly clinics for people who are concerned they may have a health problem but would rather not go to the local surgery. Pharmacies could bulk-deliver prescriptions to the community centre for collection, where requested.

"Around 2000 people/week use the centre. Many would see a doctor or nurse in a community setting but many dread going to the GP surgery or other places for treatment. There are a lot of stressed Mums who will talk to community centre staff but won't go to the doctor because they don't want to be prescribed anti-depressants. If you had a nurse once a week we could offer them reassurance and say … 'Come in tomorrow, I'll make you an appointment'". Community Centre Manager, Wigan

Share anonymised, publicly available data with communities to build trust

In Oldham, the local authority analysed publicly available data through their 'Thriving Communities Index' overlaying it with information coming through the 'COVID hotline'. The data showed BAME communities being harder hit by the pandemic including a significantly higher death rate from COVID-19.

When additional national restrictions were brought in, in August 2020, the day before the Muslim festival of Eid, Oldham's Asian/Bangladeshi community were particularly affected. This compromised trust-levels between the community and the statutory partners.

The local authority took time to regain trust by meeting with community leaders and sharing the data with them. The religious leaders responded very well once they saw the evidence behind the restrictions. They worked with the authorities and local GPs to communicate why the restrictions had been necessary to their congregations and also the broader range of support available – food parcels, medicines deliveries etc. The information was translated into different languages and was communicated through a range of channels including meetings at local mosques, radio broadcasts (such as Mosque am) and SMS. Some GPs were instrumental too, offering training videos, messaging within their practices and there were street teams offering door to door testing.

PCNs are becoming increasingly data driven as they embrace the shift to Population Health Management. There is a significant opportunity to build trust by sharing this data with communities. In many instances, community members will be able to tell you the reason behind the trends and will help to unlock solutions to the issues that the data is pointing to.

Invest in and nurture your community

Thriving communities require resourcing and nurturing. While there has been a significant focus recently on 'volunteering' in the NHS, those who work in the most disadvantaged neighbourhoods know that pro bono effort is not a significant part of the solution to health inequalities.

Communities can be very generous and much of what they do will be driven through their care for others and compassion for their neighbours. However, building this effort into viable and economically sustainable activity that supports communities both economically and socially and that successfully addresses endemic health inequalities will require ongoing investment.

"The kindness of a community can be abused by the statutory sector if it's not invested in". Deirdre McCloskey, MEAPP (from the Event Series).

There is a case for ring-fenced money to be made available to PCNs specifically for the purpose of supporting community-led activity. Communities have recourse to a wide range of other funding sources, although they typically have to bid for them and this can hold them back.

Ways in which PCNs can support this investment in communities include:

- getting behind community-led projects and supporting bids for funding
- supporting alignment of your practices' activities with community-led bids for funding to provide a more joined-up approach spanning clinical and non-clinical activity
- being a conduit for your community to reach and be heard by commissioners, helping them to understand why they should fund community-led work
- offering matched-funding to amplify their activity, where your community has secured resources from other sources
- recruit and pay community members as link workers and to undertake other connecting roles
- invest directly in community-building, either through supporting existing community development specialists that may be employed by other organisations or through funding community development specialists directly

4. What about communities with low levels of social capital?

In some localities, there are low levels of social capital. This means that the value of the relationships between people who work and live together and the knowledge and skills that they have and share are at a low ebb.

The interviewees were aware of such areas and offered a single solution – community development. This was seen as key to success in addressing health inequalities and there was dismay that the importance of community development is not sufficiently recognised.

"Community Development work is not valued, seen as 'nice to have' – it's one of the roles that has disappeared. The whole system will grind to a halt if community development people aren't invested in". A local authority commissioner

'Support for community groups' is described within the Universal Personalised Care model and this was noted by the interviewees. However, they also felt that this is not the same as community-facing community development which is needed in addition.

"They're very patient-focused, they don't work with the whole community. You can't just pick a community up when you need it and then discard it when you don't". PCC Development Lead

There is a need for a community development presence, where possible led by members of the community, in every neighbourhood. In places where there are low levels of social capital and infrastructure a community development specialist is needed to enable trusting connections to form between community members.

Local authorities, community groups and businesses, third sector organisations and housing associations sometimes employ individuals with the community development skill-set. Where this is already happening in a place and trusted relationships between community members and between communities and agencies are being built, PCNs can encourage primary care practitioners of all types to get behind and support this activity. This includes link workers, care coordinators, health coaches and other new PCN roles.

Where it is not happening, PCNs need to make a case locally for community development specialists to be employed. There may even be a case for PCNs to employ people with this skill-set and these roles should be considered as one of the ARRS specified roles. However, it must be recognised that this is a community-facing role, not a patient-facing role; over time it must lead to communities taking control and strengthening their own communities.

Community-led development is the route to building social capital that enables communities to have control over their lives and environment. It is this control that is health creating and leads to better community or population health.

5. Are PCNs the right vehicle to address health inequalities?

Addressing health inequalities requires GPs and primary care partners to play their part alongside a wide range of local partners to deliver a coordinated place-based response. This new, more collaborative, way of working could help to ease the burden on general practice and primary care as others take a lead on aspects of addressing health inequalities and creating health within communities.

PCNs are NHS England and NHS Improvement's chosen vehicle to drive engagement between primary care and communities. However, several general practitioners questioned whether they are, in fact, a good vehicle for doing this alluding to some tensions. This was also voiced as primary care being at the heart of a tension between a shift to place-based working and a health system that continues to feel quite centralised.

Specific concerns include:

- **The GP-led nature of PCNs and the way they are funded** was cited as a concern, when: *"It's [addressing health inequalities] not just about general practice, but PCNs are currently a GP club"* . A GP

- **The treatment of health inequalities as a separate service in NHS plans**, reflected in a discrete service specification for health inequalities, when what is really needed is a wholesale shift to place-based working with communities and local partners

- **A lack of incentives and encouragement to connect with local partners:** *"The activities involved in 'relationship building' are not sufficiently costed into the model".* A Health Visitor

- **A lack of capacity to engage meaningfully and productively with local partners** at a strategic level to develop new possibilities for services and pathways through which issues relating to the wider determinants of health can be addressed: "*Working with people from other sectors is enjoyable ... but capacity is a problem".* PCN Clinical Director

- **The different levels of community integration** and interest in relationships by practices with different populations that have come together to form a PCN. While this is surmountable some are nonetheless finding it an additional challenge.

The question arose as to the impact the DES Contract, in its current form, is having on PCNs' abilities to address health inequalities in partnership with communities and local partners. The responses suggested that the DES Contract may be making it more difficult for PCNs to work cohesively on this.

The difficulties as experienced by the interviewees included:

- **The perception that the DES has increased the burden for GP practices:** *"The PCN DES forced us to do more as practices".* GP and Clinical Director

- **The additional requirements of the DES taking attention away from place-based collaborative working**: *"The board are so tied up in the DES tick box, it almost disincentivises bringing people on board from the local population".* GP and PCN Clinical Lead

- **The new funding through PCNs has effectively made them into commissioners and this has had an impact on local partnerships:** *"When PCNs got the money, they became less partnership focused and more contractual focused".* A local authority commissioner

- **Increasing the number of commissioners in places – from two to three – has made it more difficult to fund cohesively for the place:** *"In a place-based system, we need to consider how we spend the DES money as a borough … the DES Contract is fairly prescriptive, it's hard to deliver on outcomes – it's very tight".* A local authority commissioner

- **Confusion as to how to use the DES and what is possible:** "*PCNs are still confused about what they can/can't do with it. They're worried about getting it wrong. Management of the new staff is difficult".* A local authority communities programme lead

Summarising the tensions and difficulties in moving to a place-based approach, one interviewee explained:

"You currently have different contracts, targets, outcomes, measures of success and competition for resources … until you cure some of this, behaviours won't change". Patient lead and former LC CEO

The Network Contract DES – what is it?

The Network Contract DES is the vehicle through which individual primary medical services contractors participate in a PCN. It contains specifications that set out requirements or obligations that each practice of a PCN is responsible for ensuring is carried out on behalf of the PCN. The specifications become part of the practice's primary medical services contract. It is not obligatory for every practice to participate in a PCN but where it does, this will be through the Network Contract DES.

Current service requirements include: Extended hours access; Structured Medication Review and Medicines Optimisation; Enhanced Health in Care Homes; Early Cancer Diagnosis; Social Prescribing Service.

Four further requirements are due to be incorporated into the Network DES for 2021/22: Anticipatory Care, Personalised Care, Cardiovascular Disease Diagnosis and Prevention and Tackling Neighbourhood Inequalities.

It is intended that there will be a Network Contract DES each financial year until at least 31 March 2024 with the requirements of the Network Contract DES evolving over time. The contract and services will continue to be informed and shaped by engagement with PCNs and other interested stakeholders.

Additional Roles Reimbursement Scheme

A PCN is entitled to funding, as part of the Network Contract DES, to support the recruitment of new additional staff to deliver health services. The new additional staff recruited by a PCN are referred to in this Network Contract DES Specification as ´Additional Roles´ and this element of the Network Contract DES is referred to as the ´Additional Roles Reimbursement Scheme´. Currently these roles include: Clinical pharmacists, Pharmacist Technicians, Social Prescribing Link Workers, Health and Wellbeing Coaches, Care Coordinators, Physician Associates, First Contact Physiotherapists, Dieticians, Podiatrists, Occupational Therapists, Nursing Associate, Trainee Nursing Associate.

6. What does a PCN that is addressing health inequalities well look like?

While there have been some improvements to partnership working, this is patchy and the connection points between communities and primary care are nevertheless under strain in many places.

Having a view for 'what good looks like' in terms of addressing health inequalities could help PCNs to support their general practices and wider primary care partners to develop their connections with local partners to achieve broader goals. It could also help to inform NHS England and NHS Improvement to frame the contract and guidance in ways that support new connection points.

The interviewees answered this question from several discrete perspectives.

The view from two communities

Two community members offered a view from each of their communities. They said that, in an ideal world, primary care would be more visible and accessible… not just through medical appointments.

There would be more direct engagement and involvement with communities, for example to pass on information, check people are OK, find out what the community priorities are. Communities would be heard and general practices would respond.

"GPs have a duty of care to patients. They would be able to go much further in meeting this if there was stronger direct engagement through existing community groups".

A PCN that is actively addressing health inequalities is one that supports its practices to engage meaningfully with its community through existing community groups.

The view from GPs

PCNs are current organising in a range of ways and mechanisms for engaging with the wider community are developing. Some are more organic, others planned and there is no shared view of what 'good' looks like. One PCN is planning a structured 'parliament-style' system while another has an Integrated Care Partnership involving many local partners coming together to work on five priorities through Multi-Disciplinary Teams and with dedicated Nurse Clinical Directors helping the PCN to connect.

Others are wrestling with how to manage the interface between formal healthcare and more informal activities and programmes, when to bring people from the local population on board and how to 'hand over' to communities.

The view from one GP who works closely with community networks was that PCNs must be expansive and reflect the broad range of organisations and networks across their geographies. Rather than being led by GPs, the governance of PCNs needs to allow for diverse leadership and membership.

"PCNs are expressions of the ideology of the people who own them. Some PCNs are offering place-based coordination … providing broad voting membership to a broad range of partners".

Including community members on PCN Boards and bringing them into membership will enable PCNs to have a different set of conversations with local partners. They will have a broader knowledge and be better placed to take ownership of how they use the DES Contract and funding to align with other place partners who are also working to address health inequalities.

"PCNs and the DES Contract are separate things. The contract is just a vehicle … you can still get the money and the roles … It then becomes a question of alignment".

The view from a VSCE contractor

One VCSE organisation offered a view from their experience as a provider of the social prescribing service. The biggest thing for them was to be engaged as a true partner, working with the PCN towards a common goal, gaining an understanding how each other works and building a trusting relationship. The alternative, that they had also experienced, was being engaged in a transactional way, as a sub-contractor. They felt this was not only much less satisfying but that it also detracted from the quality of the service.

"One of the success factors is having an advocate in the PCN who understands the voluntary sector and what we're capable of providing. Someone who has worked in the VCSE before – if you don't have someone like this in your network, then there is no one championing you" .

A combined view from local authorities, the VCSE and a Health Visitor

A good PCN is one that:	And that is client/community facing so that:
• is open and transparent • has diverse governance and leadership (not just GPs) • is part of a system that has coherence – one that prioritises with partners to provide focus across the system • has a purpose within the system • understands its DES and uses it as far as possible to achieve place-based outcomes • is outward-looking, has respect for other agencies, understands and acknowledges their skills • establishes a good power balance with partners – so that everyone is equal in terms of the contribution they're making • evaluates, reflects, learns – and embeds	• the barriers to access are reduced because primary care goes to the community • communities are supported to address community and individual wellbeing themselves • the PCN supports a shift to community-led community development, working with community-based partners to deliver this • the PCN and partners work seamlessly together to provide a good client experience and journey (not just a 'service') • services pathways are built with local partners so that they meet peoples' diverse needs – their social, material and economic needs as well as their medical needs.

7. How can PCNs, communities and local partners play their part in a sustained effort to reduce health inequalities?

All the interviewees agreed that relationships between PCNs, communities and local partners are critical. However, there was also an acknowledgement that relationships are not, in themselves, sufficient to achieve sustainable impact on health inequalities in the long-term.

Interviewees identified three things that need to happen for local partners to maximise their impact and sustain action on health inequalities in the long-term. These are:

1. Develop a shared ambition and vision for health in place
2. Build and invest in developing the agency of communities, so that they can be active partners in creating their own health
3. Build the place-based model and pathways

A fourth element is to get the community and the place-based model working optimally and seamlessly to achieve the vision.

Each of these is explained and expanded below.

Develop a shared ambition and vision for health in place

Most interviewees were cognisant of the need for all local partners to be working towards a common, well-articulated vision and set of goals for health in a place. They also acknowledged that this is not happening yet in most places and where is it, there is often a gap between the written documents and action on the ground to implement it.

"Unless we have the shared ambition and vision then we'll always be working around local relationship. That's not a bad thing but there's only so far you can go". A housing provider

"The Health and Wellbeing Strategy probably does this but most people don't think about it". Local authority commissioner

"We have the paper and words but these don't translate into action. We must properly buy into it, it must affect our decisions and actions". A GP

"The vision is being developed … We've done the workshops but how much staff understand … it's still a work in progress". A Health Visitor

It was also noted that the increased focus on Population Health Management, which focuses on the use of data to drive analysis of the causes of health issues, will not succeed in the long-term unless there is a collectively-owned vision for health in a place.

"The discussions about health inequalities is a very paper-based exercise, very data-driven" Community Development Worker, working in a PCN.

"Somehow we have got to move away from it being just about relationships or about data/evidence… if we don't start getting the vision together and then work backwards to make it happen on the ground then…" Patient lead and former local authority CEO

There were also concerns about how to make sure community voices are heard in the development of a local vision and strategic plan.

"The 'Community Rep' on the board doesn't feed back to us". Community Centre Leader

"When you sit in the meetings about strategies and plans, you very rarely find someone with much experience of health inequalities. It's very frustrating. How do we practically make that happen?" Community Development Worker, working in a PCN

Build and invest in building the agency of communities

The response to the COVID-19 pandemic has shown that people and communities have a huge amount to offer each other. They have energy, passion, empathy, skills, versatility and a willingness to look out for and take care of each other in both informal and organised ways.

Community-led working gives communities control and that helps keep people healthy, so by making their contribution they are also creating health for themselves and for their wider community.

There are concerns, however, that this important and health creating work being undertaken largely by the community will remain under-invested in and both communities and VCSE organisations that support them could become over-burdened. While this activity is taking place largely outside the formal healthcare system it is a vital pillar in the fight against health inequalities and needs to be supported by the NHS.

There's a concern that *"In a rush to sort COVID-19 we shore up A&E and everyone else gets shoved into the community as a way of cost-saving. We risk setting up new systems to get people from other forms of support into communities, and then community assets start falling over".* A local authority communities programme lead

To improve population health and wellbeing, tackle health inequalities and deliver sustainable change, creating health must sit alongside the prevention of ill health and treating illnesses.

It needs to become part of what the NHS does in equal partnership with communities and other local partners. Being embedded in communities, PCNs have the opportunity to lead this shift for the NHS. The pandemic has shown what needs to be done; PCNs now need to play their part in building the agency of their communities and this includes investing in them.

Well-run community organisations need paid staff and community strengthening activity that builds resilience needs to be funded if it is to be sustainable. Money needs to be directed to the right places.

"There's money swimming about in the health system but spending it in such a way that we get these communities developed … Communities need paid roles. There's a lot of discussion about 'how do we deal with health inequalities'? We're not going to get very far if we don't have any resources to do it". Community Development Worker in a PCN.

"It's about being able to make a commitment to staff, rather than just doing short term piloting … We've been doing this for 21 years, we know what works!". VCSE infrastructure organisation

Relatively small amounts spent on connecting people and organisations and on activities that support health creation locally can make a meaningful difference to health and wellbeing outcomes. These activities need to be costed into the PCN model.

Resourcing relationship-building and Health Creation in health systems

The Lancaster Integrated Care Community has committed to long-term funding for its Development Lead roles, that are also operating on behalf of the PCNs.

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.

Build the place-based model and pathways

Clinicians are used to working through care pathways. However, people's and populations' health is impacted by a wide range of non-clinical factors and these are key drivers of mental ill-health and health inequalities.

The question, then, is how can care pathways can be extended and expanded so that people can gain access to a wide range of non-clinical interventions – such as help with debt, access to suitable housing, companionship and a wide range of small things that will ultimately lead to improvements their health. These are starting to become known as 'place-based pathways'.

"*If a person presents as 'depressed' don't just prescribe [fluoxetine]. They need connections, Citizens advice etc".* A local authority communities programme lead

Social prescribing link workers are the new operational connectors who are helping to connect primary care to the broader system through working with individual patients. However, this role alone is insufficient to shift the system into a fully place-based model of care.

"The DES Contract has put the operational level in … the social prescribing link worker is that connector. But the strategic role … there's a gap between the clinical director and the strategic level".

"*Everyone in the system needs to understand what they can do to help primary care and what primary care can do to help them. Once that understanding's there, you'll know how to access the solutions for individual people".* A local authority communities programme lead

PCNs need to know about what else is happening in their neighbourhoods. They need to know who the other partners in the system are, what their responsibilities are and how they interact (or how they might interact). They also need to invite communities to help to shape the 'place-based' pathways and services that are being developed by PCNs and local partners, so that they work and address their real needs.

This knowledge is critical to building a Place-Based Multi-Disciplinary Team that can expand the scope of 'pathways' by addressing people's wider needs and difficulties that impact on their health.

"Place-based working is a Multi-Disciplinary Team on steroids".

There's an operational pathway but there's a strategic understanding pathway too… the strategic understanding has to come first. Being together (place-based) opens up the possibility for new pathways and they are being worked through with individuals". Local authority communities programme lead.

Traditional Multi-Disciplinary Team	Place-based Multi-Disciplinary Team
• Social worker	• Debt advice
• Psychiatrist	• Housing
• Nurse	• Employment
• Pharmacist	• Relationships
	• Community Development Specialists

Oldham is working through a staged approach to developing a 'shared systems leadership' across the Place and across Neighbourhoods. Doing this enables new pathways to be forged through which people can address and resolve their broader issues and needs alongside their clinical needs.

Stage 1 – Agree shared geographies: Oldham went through a process to negotiate and adopt shared geographies between primary care and other partners in the borough at the Neighbourhood level). This was a painful process, but all agreed it has paid off. Working to the same geographies has enabled consistency of local partners and leaders coming together – the GPs, nurses, schools, police, councils, community workers and many others. The fact that the conversations were focused on the same places has helped to accelerate a shared understanding of the needs of localities and of the development of shared solutions.

Stage 2 – Leaders getting to know each other: To work effectively together in the long-term requires people getting to know each other. In Oldham, this was enabled through a series of workshops where around 140 operational leaders across the whole system, including primary care, came together. Seven common characteristics of the new place-based working arrangements that everyone agreed on were identified. It also enabled smaller groups to convene to focus on and drive forward cross-sector solutions across smaller localities.

Stage 3 – Develop a shared evidence profile: Evidence was brought together from a wide range of sources. Importantly, this led to a range of discussions that enabled a rounded and grounded interpretation of the evidence. Having a full range of perspectives, including hearing from communities about what lies behind the evidence, is critical to understanding both the needs of the area and the potential solutions. It helps all partners to make sense what the issues are and it helps to drive a common approach to solving them. It enables Neighbourhood-level leadership groups to develop their own approaches for their localities.

Stage 4 – Agree shared priorities and outcomes: At some point, local leaders and partners need to agree on a realistic and manageable number of priorities for focus as well as outcomes that will help all partners to know 'what good looks like'. It is important that these priorities are arrived at through taking in all perspectives; it need not take a long time to reach consensus if all partners are focused on the same locality, are listening to each other and are both providing and helping to interpret the evidence together.

Stage 5 – Develop shared governance arrangements: Shared, inclusive governance across a system at any level is difficult to achieve. However, as local partners start to work together and to respect each other's input, it should be possible to introduce more sophisticated governance arrangements at Neighbourhood and Place levels. This might be done in steps; for example, broadening PCN membership and leadership to community and statutory partners might be a step on the route to sharing evidence which might be a step on the way to developing a shared data protocol between partners and this would be a step towards sharing budgets towards meeting shared local goals.

Get the community and place-based model working optimally to achieve the vision

The three elements set out above – collective vision and ambition, sustained community agency and community building and place-based model and pathways involving many local partners including communities – provide a means for PCNs, communities and local partners to work together optimally to deliver a sustained effort to address and reduce health inequalities.

Joint work with PCNs in this place-based model will improve health and wellbeing.

It could also reduce the number or frequency of people turning up in general practice. Connecting primary care into place-based working also makes it possible, over time, to identify ways of reducing capital requirements.

For example, placing general practices into community hubs or 'one-stop shops' where people can access a range of different types of support and opportunities will reduce the number of separate buildings required to deliver care.

"There's an eco-system to it – it leads to major change in places" Local authority communities programme lead.

Examples of some tensions between PCNs and local partners in place-based working

There are inevitably some tensions as relationships between partners take time to mature. Even where there is a shared ambition to work together, cultural norms and current demands on different parts of the system can get in the way. The points below illustrate the source of some of these tensions and provide a steer for overcoming them.

PCNs have effectively become commissioners/purchasers: The scaling up of general practice – initially through the coming together of federations, then through promotion of Primary Care Home and now through active development of PCNs – is providing a much needed 'point of engagement' with general practice at a higher, more strategic level than is possible through individual practices. Providing them with dedicated funds for specific purposes has also made for a more complex picture locally. *"When PCNs received money for Social Prescribing link workers, it introduced a third commissioner into the place (in fact, 15 new commissioners)".* A local authority commissioner

Specialist vs networked Social Prescribing link workers: Some PCNs prefer to employ specialist link workers to work with specific sections of the population e.g. for young people, a link worker who goes into schools to address mental health issues. The VCSE sector tends to favour more generalist link workers: *"You need generalist link workers and then build specialisms on top".* A VCSE Infrastructure organisation.

Pre-existing place-partnerships and joint working arrangements: Encouraged by the Localism Act 2011, local partners outside the NHS have had a longer history of working together across different places, neighbourhoods, localities. In general, they would prefer PCNs and primary care to join existing partnership mechanisms rather than establishing new ones.

New drivers of place-based working: Population Health Management is encouraging primary care to be led by evidence about a place. Local partners also collect a range of data from a wide range of sources and this must be brought together with the health data to provide rounded Place and Neighbourhood profiles (as well as informing solutions at other geographical levels). Local partners are not always used to sharing data with other local partners or communities.

Top-down performance management: As Neighbourhood and Place arrangements develop, some outcomes need to be generated by local partners and communities working together in a place. The shift to place-based working is just one dynamic that is affecting PCNs and primary care, as the NHS is also experiencing increased centralisation. Going forward, a shift to place-based working with local partners and communities will be more possible if PCNs are released from some top-down measures as they adopt local measures instead.

8. What needs to happen for PCNs to mature into 'place-based working'?

Throughout this project and the event series that preceded it was a consistent, strong message; Lasting reductions in health inequalities will only be possible through working in genuine partnership with communities and other local partners.

In every place, beyond the boundaries of the NHS, there are already many groups and organisations working to address the causes of health inequalities, the wider determinants of health, and to create health in communities. In addition to local authorities (social care, public health, communities teams, environmental health) these include: community groups, voluntary and community infrastructure organisations, housing associations, police, fire service, education and others. PCNs need to connect and work with them to deliver a bigger collective impact and support general practices to do the same.

The forthcoming Tackling Neighbourhood Inequalities service specification and guidance provides an opportunity to set out the various ways that PCNs might connect primary care into the considerable existing activity and networks beyond the NHS. The Additional Roles Reimbursement Scheme could also be extended to include connecting roles.

PCNs might consider the following actions:

- Invite one or more community members to join your PCN board or leadership team so that you can hear about this work on a regular basis.
- Invite all those communities and organisations to contribute to your plans and efforts to tackle health inequalities, for example through a 'partnership board'.
- Invite local partners/community groups to your training sessions and development days to explore ways of improving local health outcomes with the PCN team.
- Join existing place-based networks led by others locally and work out how primary care can support their work to organise local partners towards constructing a new type of heath and care system that attends to the wider determinants and supports health creation.
- Employ a Strategic Relationship Development Lead to build strategic-level relationships with organisations and community networks outside the NHS and explore possible collaborations.
- Contract appropriate voluntary and community organisations to employ Social Prescribing Link Workers where they already have a trusted relationship with the community.
- Consider employing one or more skilled Community Development Specialists where they don't already exist. The roles must be community-facing, not patient-facing

How might they use the PCN Maturity Matrix to support this?

The NHS England and NHS Improvement's PCN Maturity Matrix outlines components that underpin the successful development of PCNs. It sets out how they can progress and grow the scope and scale of the role of networks in delivering greater integrated care and population health for their neighbourhoods. It is designed to support PCN leaders, working in collaboration with systems, places and other local leaders within neighbourhoods, to work together to understand the development journey both for individual networks, and how groups of networks can collaborate together across a place in the planning and delivery of care.

The five components of the PCN Maturity Matrix are:

- Leadership, planning and partnerships
- Use of data and population health management
- Integrating care
- Managing resources
- Working in partnership with people and communities

To make rapid and sustained progress on health inequalities, PCNs need to move quickly beyond seeing these as five separate components. They need to see communities and local partners as part of the population health system, not separate from it.

The PCN maturity matrix is not a checklist or performance management tool and a number of systems have developed their own version of the maturity matrices to meet local need. Since 'Working in partnership with people and communities' is so central, we propose that it must become the starting point for PCNs, not the end game. If a PCN makes working in partnership with people and communities first, then those they connect with can help them to develop their approach to the other four components, and much more.

The PCN Maturity Matrix – a revised perspective

Connect with and work in partnership with people and communities to:

- Develop Neighbourhood-based, cross sector leadership, planning and partnerships
- Bring together and interpret data on the wider determinants of health alongside clinical data
- Develop local approaches to Population Health Management and Health Creation (see below)
- Develop integrated approaches and new pathways to address people's medical, social and economic issues and support them to connect with others, to build confidence and gain control over their lives (the 3Cs of Health Creation)[3]
- Manage resources to achieve the best possible health and wellbeing outcomes for your population, as defined by communities with input from local partners
- Use the new roles in the Network DES Contract in a strategic way to support place-based working and address health inequalities with communities and local partners.

To correctly determine the causes of ill health and to deliver the most impactful solutions requires the active contribution of all local partners.

"The PCN doesn't need to be the formal owner of this, there are plenty of networks already existing. The Council is the natural coordinator. Primary care needs to reach into this rather than re-invent the wheel. They just need to be connected into this". Local authority communities programme lead

Population Health Management and Health Creation

Population Health Management focuses on data as a means of understanding the causes of ill-health and to guide action. This will work best when data generated by NHS organisations is combined with other data from a range of local organisations to develop a rounded profile of the issues faced by local populations that are having an impact on their health and wellbeing.

Alongside the data and informed by it, solutions need to be drawn up in dialogue with communities and other local partners, and actions coordinated with them.

The impact will be greater when PCNs and primary care do this routinely.

Creating the conditions for communities to find and deliver their own solutions to health problems, in partnership with the NHS and other local partners, is becoming known as Health Creation. PCNs, and integrated care systems more generally, need to adopt population Health Creation alongside Population Health Management; when they are doing that they will make real and sustained progress in addressing (and reducing) health inequalities.

3. Health Creation I. The Health Creation Alliance. https://thehealthcreationalliance.org/health-creation/ Last accessed 1 March 2021.

Health Creation and the features of health creating practices

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 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". (Health Equity in England: The Marmot Review 10 years on).

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.

Primary Care Networks need to adopt a population Health Creation approach throughout their systems alongside Population Health Management.

Discovery Learning Programme for Primary Care Networks

The Health Creation Alliance is offering a 'Discovery Learning Programme' for PCNs who are ready to explore how to go about implementing some of the elements in this project. For more information, email neil@thehealthcreationalliance.org

Become a member of The Health Creation Alliance

Join our national cross-sector movement for Health Creation, access our resources and get information about all our activities: **https://www.thehealthcreationalliance.org/members/**