The Fuller Stocktake: Let's not miss the opportunity to fashion a place-based, health creating future for primary care

A blog by Merron Simpson

Around seven years ago, soon after I became involved with the NHS Alliance (which has since been renamed The Health Creation Alliance), I recall the then CEO, Rich Stern, describing the emergence of GP Federations, Clusters, Cooperatives and Super-practices as being "an attempt to knit a series of corner shops into a system".

As a housing professional with a bent for influencing, policy and strategy, my thoughts went immediately to the strategic potential of what was known generically as 'General Practice at Scale'. I was delighted to be able to guide housing colleagues towards the heads of these new Federations, individuals who could help them to make a better connection between housing and general practice with the aim of addressing health inequalities. What I did not realise then, that I do now, is that primary care does not have a 'language of relationships', nor an embedded conceptual framework, to explain how such relationships help to improve population health and address health inequalities.

In an effort to make these sort of connections the norm, The Health Creation Alliance has held cross-sector events, undertaken and published research, created resources for Primary Care Networks (PCNs) and held meetings with NHSEI to explore and explain what we think needs to happen for primary care to play its part in creating health; working alongside communities and local partners to address the needs of their populations (you can find the links below). Throughout our work, we have acknowledged the experience of place-based systems´ partners who have put huge effort into building relationships with primary care, often with little to show for it. That is until the pandemic and vaccination roll-out abruptly disrupted the status quo, offering all of us new insights into how communities and local partners might develop long-term relational, networked ways of working to increase their success in reducing health inequalities.

Progress towards building primary care into a system, and a multi-disciplinary system around primary care, remains patchy.

Over the last couple of weeks, I have been both inspired – hearing about the great progress being made by Dr Chris Tiley a PCN Clinical Director in Truro developing some great work in equal partnership with his local communities – and equally dismayed – when I read Dr Farzana Hussain's piece in GP Online describing the 'missed opportunity with PCNs' and explaining her decision to step down as a Clinical Director of a London PCN. She cites the familiar problems of ´top-down management´, ´endless meetings´ and ´restrictive recruitment rules´ as part of the problem; this is echoed by a NW London GP who was interviewed as part of one of our research initiatives, who said of his COVID-19 experience:

"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".

The Health Creation Alliance is now assisting NHSEIs Fuller Stocktake team to work out how primary care might develop – particularly looking at how the new Integrated Care Systems (ICSs) might support that development. We have three main recommendations that might be summarised as: **Relationships, Relationships, Relationships.**

1. Relationships between individual community members

Integrated Care Systems need to recognise that community-led development – including strengthening the connections between people – is critical to addressing health inequalities. One of the causes of entrenched health inequalities is 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. Conversely, the processes involved in Health Creation involve the regaining of control through the rebuilding of the social ties that connect communities.

There is a need for a community development presence, where possible led by members of the community, in every neighbourhood. Where this is already happening and there are trusted relationships between community members, ICSs can encourage PCNs and primary care practitioners to get behind and support this activity. Where it is not happening, ICSs need to support PCNs to make a case locally for community development specialists to be employed. There is a strong clinical case for PCNs to employ community development specialists directly especially in places with low levels of social capital and infrastructure, for example through a more permissive and flexible Additional Roles Reimbursement Scheme (ARRS).

Community-led development is a key 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 and population health.

"Community Development work is not valued, it´s 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

2. Relationships between primary care/PCNs and communities

While GPs have always taken pride in their relationships with individual patients, they have been less confident relating to their patients 'en masse' within their natural communities. Yet, there are huge dividends to be paid through building the relationship with, and investing in, communities.

Community centres, where communities feel comfortable, are one place to go to connect with communities. Social prescribers could hold meetings there; nurses could hold surgeries there; practice managers could provide information there. But the greatest gains will be through conversations with communities, by listening to them and their concerns and working with them as equal partners, to generate solutions. Why not share your anonymised data with them and ask them what lies behind the data? Community narratives are incredibly powerful to understand the quantitative datasets, yet they are almost missing from health practice.

Integrated Care Systems could make 'working with people and communities' the first priority for their PCNs. Doing this will change the way they see the world – by digging deeper into what really matters to those communities and what is holding them back from achieving their health potential. Integrated Care Systems could also make budgets available for PCNs to devolve small grants directly to communities, to support health creating activities. Is this not the next stage for social prescribing… to invest in the community-led activities patients are being referred into?

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

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

Integrated Care Systems need to commit to supporting the emergence of PCNs that represent the breadth of communities and place-partners within their governance arrangements. When PCNs become neighbourhood-level version of Integrated Care Partnerships (ICPs) they will have a much greater understanding of, and connection to, the wider system. This could be transformative, offering the potential for primary care to work with many partners towards a shared 'population health' ambition, and for many more 'place-based' solutions and pathways to emerge for their patients.

There are, of course, a few steps to achieving this, but a PCN maturity matrix that prioritises 'working with people, communities and local partners' would help to fix this as a goal to work towards. A first step towards this might be to employ a Strategic Partnership Development Lead (aka Community DJ) who starts the process of connecting PCNs to local statutory partners, agencies, businesses and community groups. Again, could the ARRS not be more flexible to allow PCNs to employ these individuals?

"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". Local authority communities programme lead

Bringing 'relationships' into the primary care model

The existing model for primary care cannot provide a sufficiently holistic response to the health issues patients present with that are caused by social and economic inequality, rendering it unsustainable given the widening of health inequalities over the last 10 years. As an optimist, I am looking to the Fuller Review for Primary Care to be the turning point.

If it is to be pivotal, it must find a way to bolster primary care's capacity to build meaningful relationships. The following statements from two contributors to our last report on primary care speak for themselves:

*"Working with people from other sectors is enjoyable. You need to be in the conversations for all the other possibilities to emerge … but **capacity** is a problem".* PCN Clinical Director

*"The activities involved in relationship building are **not costed** into the model".* Health Visitor

Of course, GPs and the primary care workforce don't have to bear the whole burden for health inequalities and community health by themselves. There is an army of people and organisations outside the surgery door already taking sophisticated action. The capacity for primary care to develop good local relationships with communities and local partners at a strategic level needs to be built into, and costed into, the primary care model; then new pathways and ways of working can be forged. Until this happens, primary care will never be able to properly 'fit' within the new world of place-based working; it will never be able to fully shift to a health creating model and it will continue to struggle to play a meaningful part in reducing health inequalities.