PCN ROUNDTABLE
HEALTH INEQUALITIES

PCN clinical directors joined Pulse PCN editor *Victoria Vaughan* on Microsoft Teams to discuss how they are tacking health inequalities

Author: Victoria Vaughan. Front cover image: Getty Images

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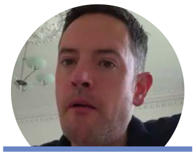

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Victoria What is your PCN doing to tackle neighbourhood health inequalities?

Kieran For us, it is challenging. We're not in one of the country's most deprived areas. Fareham was classed as the second-best place to live.

However, we still have certain groups that are deprived. We have quite a high homeless population, and the area's drug and alcohol unit is located where one of the practices is, so, obviously, they go hand in hand. We've looked at how to improve the physical and mental health of these patients, especially physical health, because obviously there is lots of evidence that their morbidity and mortality is substantially higher, by approximately 15 years.

With the aid of a home visiting team, led by one of our advanced nurse practitioners, who is our health inequalities lead, we set up a project that is a weekly service, knowing the DES [requirements]. We do a drop-in clinic there for two and a half hours, but now there's [also] a chronic disease component, [including] those with COPD and diabetes who aren't normally accessing the surgery.

We're now improving the quality of their physical care as well as their mental health, and linking in with the mental health services, but specifically physical health, because that's something they don't engage with.

The biggest issue is, there are no extra finances for any of this. The DES highlights all of this but [has not attached] something to it. The assumption is, we use what's already there – and what's already there is being stretched thinner and thinner across all of the different domains. The additional roles reimbursement scheme (ARRS) was there to assist primary care but now, [those staff are] having to do all the additional stuff that's being put on us, and [have less] ability to reduce primary care workload.

Shabnam We've got a lot of issues with long-term conditions. Our team decided to take a preventive approach. It's come about as a co-production with our local system partners, and we decided to focus on pre-diabetes.

We've already got a large cohort of patients with diabetes and that's obviously causing a burden on secondary care. If we can focus on this cohort of patients to prevent them developing the disease, it may reduce the burden later on in the system.

As Kieran has mentioned, there are workforce issues. Who is going to do this work? It definitely needs doing but the bulk of it ends up falling on ARRS staff, and that pulls them out of the other work they're meant to be doing.

David In the inequalities work for the DES, we are focusing on patients with severe mental illness. We are bringing in staff employed by the PCN to assist in getting to patients who are hard to reach or difficult to engage. We're aiming for as high a coverage as possible because there are some people who just cannot get to practices.

Hastings has been deprived for many decades and we're fortunate to have a lot of third-sector organisations that have the assets in their staff, whereas the practices have very few assets in the area. We are being allowed to influence the funding in order to build them up. The grand plan is to get the third sector involved in a lot of the outreach stuff and dealing with young families and children over the next couple of years. As people are saying, general practice cannot do it alone and ARRS is not enough.

Dan We're looking at bringing in low-friction points as access is often an issue. We're bringing in a smart type of triage model. We're currently creating online access points through our hubs. This will help support the inequalities work as there is availability across the day, and for those who haven't got the internet, there are traditional access points through supported telephone triage.

The theory is that this will support increased access and availability in a self-service model, and the traditional routes will be available for those who can't access technology easily.

We've also [created] health hubs. These are basically a clinical machine that the patient stands under that [measures] height, weight, BP and pulse, and feeds this information into their medical record. It's the first stage of proactive care. We're looking at a rollout into pharmacies and potentially a couple of supermarkets. The machine is more convenient than coming to the surgery.

Jenny Ramsgate has so many areas [for] population health [work]. It has been difficult to pinpoint one in particular. We were part of a pilot for population health and because we have a large elderly population we looked at housebound diabetics, and managing them using a multidisciplinary team approach with Diabetes UK, social prescribers, clinical pharmacists, specialist nurses and healthcare assistants.

We're now looking at our housebound patients and trying to prepare them for winter. With soaring fuel costs and food issues, we're trying to

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> **GPs have to update their knowledge regularly, but diabetes patients don’t get refreshers and updates**
>
> Jenny Bostock

get them to look at their housing for any draughty areas, to make sure they mitigate any problems, because we're worried that they are going to sit in the cold and not feed themselves.

We also have a Travellers community who have recently come to the area. They've been here about a year, about 40 to 50 of them. Nobody would register them because they don't have a proper address but we've managed to get them an address for the piece of land they are on. Another problem is that they're illiterate mostly. Most of them don't go to school. The children just help on the campsite. So, we've been going out to the campsite and getting them registered, and we've actually managed to do health checks on them.

The other thing we're looking at is [access for people who are not so digitally able]. Although digital technology is going really well, we have a lot of elderly population who have landlines. They don't have a mobile so they can't send in photos. They can't access the online services. We're trying to make sure they can get access to services as well.

Laura The biggest issue for us was where to start because the data are very old and often highly inaccurate. We tried to get data from Public Health [England] and its data are often very out of date, so we've used various data collection tools – which also caused us many problems. So, we feel anxious entering into this work because [we're] guessing where the priorities are in our population, [we don't] necessarily [have] the best evidence.

We also worry if we have selected the right priority to concentrate on. Then we worry about creating postcode lotteries because there might be something brilliant going on in the next PCN. [Might] our patients benefit from that? [Might] their patients benefit from our project? In the end, we just have to pick something and go for it.

We picked diabetes and our housebound population, because we did a project with care co-ordinators where they rang the housebound diabetics. The conversations with these patients were hugely long. It was embarrassing, the level of care they'd had in the last two years. They might have been having the basics, but they had so many unmet needs because they couldn't communicate with us – because the way of communicating with health has changed.

Victoria **Did anyone have good data on which to base their decisions?**

Jenny We had quite good data. The clinical commissioning group (CCG) had someone who supported us, because for our population health project we needed to find data. The CCG analytics people were helpful as well because in general practice we don't have that information, so it's a really big problem to collate the information and make it into something meaningful.

David We've also done a population health programme and were the first in Sussex to do it. I think those that have done that first are more confident with their inequalities projects. The data support already had a good baseline for dealing with severe mental illness work. We also had [the data] cross-referenced with the acute trust as well. We probably could have got those data ourselves as practices, and I worry that trusting all those data to external parties might not help us in the future. We need our own ability to deal with the data, or a clear organisation that will do it for us.

Victoria **Would you like to see ring-fenced funding for health inequalities that is separate from the GP or PCN contract?**

David When you work in a deprived area and you are short of staff, sometimes your difficulty is spending the money because you have the

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> **I don't see a shortage of money, I just don't see security to invest and push it**
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> Dr David Fox

money but not the staff. The ARRS scheme has had some successes, but there isn't a long-term guarantee that this funding is there forever. We need something that will be structurally there for the next 10 years that helps us all invest in the workforce and take the money.

I am seeing money available, but very little or structure to invest it in.

Also, I think the system is developing a language with Core20Plus where we're siloing inequality for outcomes. Really we have to go back to core funding and make it [available] over a long period through the contract – a worthwhile investment to build up teams in deprived areas in primary care. Because we can't, we haven't got the green light to do that, we are pushing more to the third sector where it's their role.

So, I don't see a shortage of money, I just don't see security to really invest [that money] and push it.

Jenny There are funding pots, but [the problem is] getting the time to know how to access the [funding]. When I worked with a CCG I was told I could access some money to help with the Travellers. But I didn't have time to research these pots of money. If the system could tell us where they are, that would be great. They're almost hidden and a secret.

Victoria How do you know if your health inequalities projects are successful? How are you measuring outcomes?

Candice It's a very good question. How do we measure qualitative changes?

We had a late start to tackling all this because of various issues, one of them being a lack of manpower, which I hear is a problem all around.

In March we started the wellbeing series, which anyone could drop into, and we captured a lot of incidents and prevalence of diseases. For example, pre-diabetes - if you don't go looking for it, you don't know it's there, and it's amazing what you can pick up by just screening.

We measured with wellbeing scales and things, but I guess it's difficult [for a patient] to quantify how happy they are from one day to the next.

What has really become apparent is that we need systems to change. That's very difficult, even with the integrated care systems (ICS), because everyone is still having individual conversations and doing small projects, which are not joining up.

I think the ICS should be playing matchmaker between all these teams to make them work for the local population.

Jenny When we did our population health projects with the housebound diabetics, it really opened our eyes. We were looking at good patient care and preventing hospital admissions from people with good HbA1c control.

But actually, when the teams [visited the patients'] houses, they found drug hoarding – patients weren't taking their medication. There were people who were administering insulin in the same spot [each time], so there were problems with injection sites . [There was a need for] education, education, education. Patients didn't understand the importance of taking their medication, the importance of having their insulin and [controlling their] diet. Families [needed education] as well.

This work opened a huge chasm of inequalities. We only had 122 patients in our cohort, but a lot of them were from very deprived areas and had no idea how to manage their diabetes.

If you think about clinicians, we have to update on our diabetes or whatever it is every year, but these patients were diagnosed years ago and there are no updates for them.

Really what has come out of this is [the realisation that] we need to educate our patients in all aspects [of their condition] – particularly the housebound and their carers. They'd forgotten that they can't have sugar in their tea and can't eat doughnuts and all sorts of things like that. So it was really an eye-opener, but it was difficult to know what to measure because so many things came out of it.

Victoria How much do you feel this is an exercise in education and communication rather than a clinical task?

Dan The communication element is massive. [We have to] let people understand how and where they can access services. I think [patients] assume that their only source of [help] is the oracle – the GP.

[We should let them know about] ARRS roles – that they might be much better seeing a first contact physio or social prescriber because they will get much quicker answers, and probably better, and they'll get to the solutions. Education is critical to that.

[Because of] that, we've got, I hesitate to say, a communications team. We're not Google, but we've got a comms marketing-type team to get this information out there, to advertise and to promote the roles, to make people aware [of what's available].

Shabnam I totally agree with Dan. The crux of this is education and awareness. Without a good communication team, without [sending] that message out to the whole population, we won't get very far on any of our agendas. I think we do need some kind of resource allocation to that side of things.

Victoria Are care co-ordinators doing that for you at the moment?

Shabnam Yes, they are. It's the care co-ordinators that are doing this, alongside a health and wellbeing coach and the community champions that are already embedded. When we were doing the project, we felt they were best placed.

Also, [consider] who patients listen to. They listen to their own before they listen to the GP.

David Yes. We know [this] from the vaccination programme. We were in an area of low uptake [and we found] that you can put a vaccination pop-up in the most deprived part of your [area] and people won't necessarily walk across the street to go to it.

We know that access isn't necessarily the issue. You can tweet, put messages on Facebook, you can drop leaflets, and people will not go to get a healthcare intervention or check.

I think we don't truly understand this as a system. There's still a lot of work that needs to be done with on-the-ground community [outreach, otherwise] we'll just bring in another wave of something that could be a large waste of resource.

We need something on the ground. As I get told very frequently by

> **The public health messaging needs to change, but also, we need people to understand how cheap primary care is**
>
> Dr Kieran Gilmartin

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non medics, it's the patient voice and the population voice [that matter. Those are] not a system-driven thing.

Jenny One of the issues with communication is that GP surgeries have been flooded with an array of staff. The patients don't understand what, say, an ACP is, or a paramedic practitioner, a physician's assistant, a nursing associate, a clinical pharmacist. We've got all these roles, and patients still want to see a GP. I think we need a national campaign, an advert on TV or something to say 'This is [the person] you need to [see], these are the conditions people can treat', because patients still don't understand. I'm a nurse practitioner and I get people coming in saying, 'Oh God, I wanted to see the doctor, [but] I got you'.

We need to guard against that. It requires a lot of hard work and I don't think anybody has cracked the answer yet but we remain hopeful.

Victoria Will enhanced access help with health inequalities?

David No. You can provide more access but you're not necessarily seeing the right people, the people who need access to that service.

For me to have to focus on a target is going to be a disaster. I need time to do less for [patients] that are high demand and start seeking out [patients] we've got no information on. That has got to be a major shift soon or we'll get lost in outcomes that don't matter.

Victoria Kieran, I'm assuming in an area with lower deprivation, you have more engaged, possibly demanding patients?

Kieran Yes. The problem is we've now got a culture that everything is instant. Social media, fast food, online ordering – everyone wants things now. We all know healthcare doesn't work that way and shouldn't. [We need the public health central messaging] to change, from the Department of Health and Social Care, and NHS England. [We need to tell people] 'to use healthcare when it is most appropriate' rather than 'if you've had a cough for three weeks, you've got cancer until proven otherwise, so go see your GP'.

The message is still 'go see your GP'. If they start changing the messaging and tell people where to go in the first place, [it will just be filled because] we all know that healthcare is overburdened. As we also know, £150 per patient per year is what we roughly get, but that's nothing when you think your Sky bill can be £140 a month.

People don't understand how cheap primary care is in this country. Until we get that properly out there, it doesn't matter about health inequalities because 'those who shout loudest get' – and that's the problem.