

The Big GP Consultation



Summary Report for Session 4: GPs in The Big Picture, Part I (Health inequalities)

Session Date: Wednesday 20th April 2022
No. of Participants: 43

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This report represents the views of the participants in the consultation and not the authors themselves

The Big GP Consultation

Introduction

The Big GP Consultation is a platform for GP Trainees and Early Career GPs to collectively discuss their vision for the future of general practice, and how they can shape the future system that they will be working in. This programme consists of six sessions, each on a key theme relating to the future of general practice.

This programme is endorsed by Faculty of Medical Leadership and Management ([FMLM](#)). For more detail about the wider programme, please visit our website [here](#).

Session 3 Findings

This report details the findings of **Session 4: GPs in The Big Picture, Part I (Health inequalities)**. Both the report, and the infographic, collate insights gathered from a pre-session survey (n=27), a post-session survey (n=13), and the facilitated breakout room discussions, which 43 participants took part in. The respondents were split evenly between GP Trainees and fully qualified GPs.

The topics covered in the breakout rooms were as follows:

Breakout Room 1: What can General Practice do to tackle the social determinants of health?

Breakout Room 2: How can we make tackling health inequalities central to a PCN's mission and operations?

Breakout Room 3: How can we equip ourselves with the knowledge, skills and capabilities to tackle health inequalities in primary care?

Breakout Room 4: How do we create a diverse and inclusive workforce within primary care?

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Key Themes

The key themes of the session are summarised in the infographic below. A high-quality copy of the infographic is available to download from our website [here](#).

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How can GPs be a part of The Bigger Picture? *The views of GP trainees & early career GPs*

Tackling health inequalities in primary care

Primary care has a crucial role in tackling health inequalities. Every GP has their own individual sphere of influence to make a positive change.



Tackling health inequalities must be central to a PCN and ICS's mission and operations, and the workforce need to be equipped with the skills and knowledge to achieve meaningful change.

This can be achieved through:

- earlier and broader staff training, particularly in the Core20PLUS5 approach
- active involvement of patients to share their lived experiences
- promotion of health inequalities as core quality improvement projects
- visible and accountable leadership across the PCN and ICS
- developing a shared learning culture promoting best practice
- valuing the part that Additional Roles play in tackling health inequalities



Current challenges



The absence of shared information on clinical records regarding social determinants of health hinders decision making and meaningful personalisation of care.

The absence of an equity lens in the deployment of the Additional Roles in primary care may be exacerbating health inequalities.

Creating a diverse workforce

The workforce needs to represent the communities we serve in order to build trust and understanding. Proactive recruitment through apprenticeship and collaboration with schools may help widen participation. In-house training of members of the community may also be beneficial.



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The Big GP Consultation

Breakout Room 1: What can General Practice do to tackle the social determinants of health?

GPs are in a good position to tackle the social determinants of health (SDH), but there are barriers inhibiting this, such as the limited availability of information about a patient's social circumstances, and limitations of a GPs' capacity and power.

Participants identified two key distinct ways in which they, as GPs, may impact upon social determinants of health (SDHs): firstly, the SDHs that *individual patients* experience, and secondly, the wider SDH landscape experienced more at a *community*, or even *national*, level. Participants felt that individual GPs may struggle with addressing SDHs at a community and/or national level. Issues such as the overall quality of local housing or employment opportunities were felt to be beyond the remit of GPs, and it was noted that GPs generally do not have the capacity, nor the power, to address these.

However, participants felt that GPs do (and many felt *should*) play a role in tackling SDHs at an individual level. This was driven by the recognition that SDHs not only play their part in influencing health outcomes, but also that a patient's wider context is important for a clinician to understand in order to meaningfully personalise their care.

Participants shared that many already feel some responsibility to support patients to improve SDHs, through writing in support of housing or benefit applications, for example. Others felt that, although SDHs may be beyond the scope of what a GP can *directly* impact, they should be signposting patients to services that support these issues. First-hand examples included participants regularly signposting those with mental health challenges and unemployment to the Richmond Fellowship. Signposts from a trusted source (such as a GP), alongside information on how SDHs impact upon health, could help to empower patients to address the challenges they face.

One key barrier to tackling SDHs in practice that was discussed was a lack of access to information about an individual's SDHs on their clinical record.

Participants strongly felt that having SDHs coded in the record would be “massively helpful,” both to enable personalisation of care and to guide signposting. Ensuring that this information is readily accessible would save clinicians time asking about them, would support SDHs being given consideration during clinical decision making, and would also save the patient time and energy by removing the need to repeat their story in multiple settings.

In practice, participants felt there were three main methods through which SDH information may enter the record: it may be directly asked about and coded by a member of the practice team; patients may input it themselves through the NHS App; or it may be pulled in from

The Big GP Consultation

another source (e.g., housing information from the local authority). Participants felt that barriers to achieving this in practice included the workload associated with recording the information, how it would be shared and stored safely and with patient consent, and how to ensure the data was kept up to date. Despite these barriers, participants were very enthusiastic about the benefits that making this a reality would bring, and were keen to see it explored further.

Considering the general practice team more broadly, participants recognised and were positive about the role that social prescribers can play in tackling SDHs. However, it was felt that due to issues beyond their control, their full potential was not being reached. Referral to social prescribers is one area which could be improved. Participants spoke about how this referral was often “ad hoc,” rather than systematic. This risks GPs referring patients to social prescribers who present most frequently to the practice, ahead of those patients who do not regularly present and may benefit more from social interventions. As a solution, it was also noted that if a patient’s SDH information was available in the primary care record, this would allow for both systematic and proactive case finding by social prescribers, and would go some way towards unlocking the ability of social prescribers to tackle SDHs. In addition, it would facilitate both monitoring and improving the impact that social prescribers are having on SDHs.

The session also touched upon community engagement and the role this plays in tackling SDHs. It was noted that much of the community engagement focuses specifically on health and healthcare (such as targeted health promotion events) which do not aim to tackle SDHs. If desirable, participants noted that it would be possible for GP practices to develop relationships with local voluntary, community and social enterprises that aim specifically to tackle SDHs at a PCN-level.

The Big GP Consultation

Breakout Room 2: How can we make tackling health inequalities central to a PCN's mission and operations?

Participants called for wider staff training on health inequalities and the Core20PLUS5 approach. Participants felt that visibility was key to strong health inequalities leadership within a PCN.

[Core20PLUS5](#) is a national approach to support the reduction of health inequalities. An element of this approach sets targets within five clinical areas of focus. Although participants made some points that were critical of this approach, the targets were thought to provide a goal for practices, PCNs and ICS's to aim for, providing a focus that healthcare teams can work towards.

This breakout room discussed ways of improving health inequalities in their practices and PCNs. One recurring theme was the importance of wider staff training in health inequalities, particularly in the Core20PLUS5 approach. One example is to improve health inequalities training for "front of house" staff, such as care navigators. These staff may have numerous interactions with patients without being informed on the difficulties and barriers many people face when trying to engage with a practice. Participants felt that ensuring the whole practice team is trained in health inequalities will improve equitable access to healthcare.

Our participants discussed a number of key resources that are required in a PCN. One is to make use of data across the network and to share the data, as able, to inform and direct interventions. It was highlighted that in order to identify need, data must be recorded accurately which therefore emphasises the requirement to teach and train practitioners on the importance of coding, and how the data can subsequently be used.

GPs have some of the best databases in our healthcare system. The key is knowing how to unlock the data and its potential

It is crucial that data is not used to point fingers at individual practices and ensure that it is shared in a way that allows for lessons to be learnt and shared. A PCN leader shared an example from their practice. They noticed cervical screening uptake was low and identified that there was a potential language barrier contributing to this. Translating their patient information leaflets into more languages improved screening uptake dramatically.

It was noted that one benefit of a PCN is the ability to make changes on a larger scale, and that investment can be shared across practices and improve the health of a population more efficiently through achieving economies of scale. One way of increasing activity in reducing health inequalities, is by creating 'low hanging fruit' incentivised targets that are easily achieved thus improving engagement with the agenda and introducing new strategies quickly. It was noted that it is impossible to reduce all health inequalities at once but taking steps one

The Big GP Consultation

at a time to reduce them makes the task less daunting, more achievable, and recognises the health care and primary care only has one part to play.

Across a PCN there are a number of additional roles that would help improve the ability to tackle health inequalities and health inequity. These include those employed through the Additional Roles Reimbursement Scheme, such as social prescribers and health coaches, that are accessible within communities. There is an opportunity to make use of the valuable resources that the voluntary, community and social enterprise (VCSE) sector offers too. Health coaches and social prescribers are great resources that can be utilised across a network.

One question that was raised regarding resource management was how do practices and networks develop training on extra services, when they are already so stretched? Where does the headspace and manpower come from, and how can we balance those competing priorities?

Good health inequalities leadership within a PCN needs to be visible. Those with the leadership roles in health inequalities need to be adequately trained, skilled and equipped to take on the role. As GPs and healthcare practitioners we all have a responsibility to advocate for our most vulnerable patients. However, those in positions to improve health inequalities must ensure they are passionate and visibly promoting their agenda to all practitioners. These leaders (locally, regionally and nationally) need to be visible, advocate for our least heard populations, and inform other healthcare practitioners of practical measures they can take in order to reduce health inequities. Good leadership within a PCN also facilitates shared learning. This could be within the PCN from practice-to-practice, or more widely across the ICS and beyond. This collaboration will allow for lessons learned to be identified and shared (both good and bad), and promote the spread of good practice and innovation across networks and regions.

The Big GP Consultation

Breakout Room 3: How can we equip ourselves with the knowledge, skills and capabilities to tackle health inequalities in primary care?

There are a lack of training opportunities for GPs and trainees in health inequalities; this area requires more focus. Learning directly from communities, and from people with lived experience, was felt to be one strategy that would be impactful.

Initially the group had very little to say on what health inequalities training and education might look like, suggesting that this area is underdeveloped and under-explored, and requires significant work to promote at all levels.

The participants discussed training and opportunities at medical school which gave insight into health inequalities and stimulated interest in the area. Networks such as 'medical students international' provided an opportunity to experience the wide diversity of health locally and emphasised that one need not travel abroad to find deprivation. Training sessions on healthcare in health inclusion groups helped to break down barriers and educate GP trainees on health needs. These sessions were considered most effective when held by an MDT which also included patients to gain an insight into their lived experiences. It was thought that we could approach patients from health inclusion groups to see if they would be willing to share their stories and experiences with medical students, trainees and qualified health-professional, as learning from those with a lived experience is more powerful and longer lasting. Training Hubs can provide educational opportunities for qualified GPs. There are also videos/materials from third sector organisations which can supplement education, such as the Groundswell Group.

There are significant barriers to obtaining opportunities in health inequalities training. It was felt that there can be a poor culture in the NHS towards underserved communities. Opportunities to train and work with these communities can help break down individual biases and build individual and system understanding, and a willingness to engage with these communities. It is, however, currently difficult for trainees to find opportunities to experience healthcare for inclusion groups (such as homeless clinics, prison healthcare, drug dependency, etc).

Participants thought that there are opportunities to promote health inequalities QI and audit projects with medical students, trainees and qualified doctors, who need evidence of QI

When encouraging QI projects with a focus on health inequalities, it is important to avoid tick-box exercises and tokenism, and ensure the projects are meaningful and impactful. Projects could involve looking at patients who have repeat 'did not attend' (DNAs), or who access the majority of their care through walk-in centres/111/999/A&E, or by looking for the 'missing patients'; those not attending long-term condition reviews, smears or vaccinations, or who are not coded properly and therefore not easy to flag (such as military personnel, looked after

The Big GP Consultation

children or people with a learning disability). PCNs can also use population health tools and work alongside public health and local authority to help identify groups for improvement work, such as barriers to some accessing care, opening times, registration difficulties, lack of flexibility of appointments. There are also opportunities to work with third-sector organisations to explore how to embed healthcare and health promotion in places that traditionally underserved groups already are engaged with, such as community centres or places of worship.

Participants thought that discussion groups were good places to share experiences of health inequalities work. Some had attended conferences which helped create networks for further discussions, and allowed innovation and ideas to be brought back and discussed locally. The fact that virtual meetings/spaces are so much more used due to the pandemic has aided this. Platforms such as [FutureNHS](#) are good spaces to share information. Social media, such as Twitter, can also be useful to promote networking opportunities and pose questions to a wide audience. One participant talked positively about a peer-review system, where someone locally is sent to experience other ways of working in other locations. This person then brings back the learning to help inform and improve local practice. This two-way direction for information transmission helps prevent introspective working and promotes innovation and development.

The Big GP Consultation

Breakout Room 4: How do we create a diverse and inclusive workforce within primary care?

Resources (including Additional Roles) should be allocated on an equitable basis to ensure those patients who are in most need of care are able to receive it. Active recruitment through community engagement may help to create a more inclusive and diverse workforce.

The funding structure for Additional Roles means that these roles are currently distributed equally, rather than equitably. The absence of an equity lens in the deployment of these roles has the potential to exacerbate health inequalities. It was felt that Additional Roles (and other resources) are sometimes placed where people shout the loudest, rather than where there is the greatest need. It was suggested that clearer policy from national teams around equitable resource distribution is needed. Additionally, the salary models for Additional Roles and practice-based roles means that the PCN-based Additional Roles are more attractive financially, which can also worsen health inequalities as colleagues may leave smaller, more deprived practices for a PCN-based post.

Affluent, larger practices tend to become the lead practice who “host” the additional roles within a PCN, and they therefore tend to reap the benefits from having the additional roles in-house, with the smaller and often less affluent practices losing out. It was also mentioned that affluent practices tend to have larger estates which means they are able to recruit more staff and host more trainees, who are then more likely to stay on and work there.

It was felt that a distribution model where Additional Roles were targeted towards a specific population to make targeted interventions in areas of greatest need would be beneficial.

Fundamentally, systems need to be supportive to mitigate the challenges around health inequalities, not exacerbate them.

There was a rich discussion around the need for the workforce to truly represent the communities we serve in order to build trust within our deprived or ethnically diverse communities and gain a better understanding of the needs of those communities. Case studies where practices had actively recruited from local communities and created in-house training to induct these new members of staff into roles within the practice (such as health coaches or receptionists) worked well in terms of allowing the communities to feel represented (and understood in terms of language barriers), and therefore more likely to seek healthcare.

Active recruitment through apprenticeship and collaboration with schools and sixth forms was suggested as a good way of reaching out into the community.

The Big GP Consultation

Participants also outlined the importance of developing a practice culture that aims to understand the needs of the local population, with a focus on trauma-informed care. All new starters, and all members of the team, need to understand the concept of trauma-informed care so that they can care for patients while understanding the nuances and challenges that they may be facing.

There was a general agreement that disparities within the workforce itself was problematic and that employers have a social responsibility to ensure there is equity within the workforce itself.

There was a discussion around the gender pay gap (with [female GPs paid on average 15.3% less than men](#)). It was felt that the profession needed to lead by example by demonstrating equity in our own processes and systems. It was also felt that looking after the workforce was important in terms of improving wellbeing, and providing them with the headspace to explore important issues such as tackling health inequalities.

Participants also discussed how clinical systems could automatically share with the clinician the index of multiple deprivation (IMD) for each patient, perhaps providing a prompt to take a more thorough social history for patients living in deprived areas. However, a counter point was made that with the escalating cost of living, increasing numbers of people will be slipping into poverty due to reduction in net household income. This may not be as easily identified by this sort of prompt system, and these people could easily slip through the net.

The Big GP Consultation

High Impact Actions

The box below suggests areas of exploration which colleagues identified as being important in this session.

- Data on SDH - GPs need to know their patient population and have access to coded information on an individual patient's SDH in order to be able to support them.
- Training - GPs and the wider primary care workforce need to receive training on healthcare inequalities so they can actively help to support their patients and their communities.
- Leadership - Healthcare inequalities leadership needs to be visible at all levels.
- Collaboration - Practices should share examples of good practice, both within their PCN, and beyond.
- Workforce - Additional roles need to be distributed equitably to ensure that the patients who need care the most can access it
- Recruitment - Active recruitment and community collaboration might be helpful to tackle inequalities within the workforce.

The Big GP Consultation

Next Steps

The Big GP Consultation Team now aims to work with key stakeholders who have a responsibility for each of the areas on the previous page, to explore how these actions may be implemented.

The session outlined in this report is the fourth of a series of six sessions, with forthcoming sessions listed below. The Big GP Consultation Team will collate the insights shared in these future sessions and will continue to share them in the form of infographics and reports.

Session 5: GPs in The Big Picture Part II (Primary/secondary care interface, greener practice, holistic medicine)
...with guest **Professor Martin Marshall**
Report due May 2022

More information on future sessions can be found on our website [here](#).

Outputs from previous sessions can be found [here](#).

If you are a GP Trainee or early career GP and would like to participate in the remainder of the programme, please do let us know [via our website](#).