

Addressing Health Inequalities

A guide for general practitioners

Produced by the RCGP Health Inequalities Standing Group

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Royal College of
General Practitioners

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[T]he existing gross inequality in the health status of the
people ... is politically, socially and
economically unacceptable.
(*Declaration of Alma-Ata*, 1978)

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Foreword

Everyone has the right to quality health care regardless of personal circumstances or where he or she lives, but the reality is that there are some patients who are not getting the services or the standard of care they deserve.

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GPs have an important role in reducing health inequalities. With unrivalled access to the heart of communities, we can influence the health inequalities agenda as practitioners, commissioners and community leaders.

By giving examples of good practice, national guidance and links to useful resources, this booklet shows that we have the skills and resources at our disposal to help reduce health inequalities and improve standards of care for our patients.

To have a National Health Service that is fit for purpose in the twenty-first century we must work to ensure that local services meet the needs of patients – and that all patients receive equally high standards of care.

Professor Steve Field
Chairman of Council, Royal College of General Practitioners
August 2008

Acknowledgements

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Introduction

Health inequality is a society-wide problem. Inequality issues exist in every area, no matter how affluent, and our aim should be to ensure better health for everyone regardless of socio-economic status. However, the most disadvantaged are the least assertive and are experiencing the worst health outcomes. Despite the fact that as a nation we are healthier than we ever have been, thousands of people die prematurely in the UK from infancy onwards. The national focus is to narrow the gap in health outcomes between disadvantaged groups in all areas, with a particular focus and national targets for the gap between the 'Spearhead' areas (those with the worst health and deprivation) and the rest of England. These Spearhead localities have been included on the basis of low levels of life expectancy, high cancer and cardiovascular disease (CVD) mortality rates, and high levels of deprivation. In the period 2002–2004 it is estimated that there were 13,700 more deaths in people aged between 30 and 59 in Spearhead areas compared with the average for England. But, even if not based in a Spearhead area, every GP will be aware of health inequalities within his or her local population.

Effective action is essential to prevent this cycle continuing for generations, but many GPs might feel this is beyond their remit or the problem is too big to solve.

The aim of this guidance is to demonstrate the ways in which GPs can positively influence the health inequalities among their local population as practitioners, commissioners and community leaders. It contains examples of good practice, relevant national guidance and links to useful tools and agencies. Primary care is innovative in its ways of working and has unique access to the heart of communities. These factors should encourage and inspire GPs that health inequalities are part of their core business and they have both the initiative and resources to devise local strategies to reduce them.

Identifying gaps in health outcomes

The first stage in addressing inequalities gaps is identifying the scale and nature of local problems.

Figures 1 and 2 (see pp. 2 and 3) are based on national modelling of what is driving the life expectancy gap in Spearhead areas and the interventions needed to narrow it by 2010. They need to be interpreted locally in the light of local demography but they demonstrate that many of the conditions causing health inequalities are already well known to primary care – with many of the interventions in primary care too.

To narrow the gap in life expectancy there are several groups that need to be considered:

- infant mortality is a problem in its own right as well as contributing to the gap in life expectancy, and has been included as a separate aspect of the overall national health inequalities target. While infant mortality rates at local level are small, it has been recognised that the gap in infant mortality between 'routine and manual' groups and the rest of the population is increasing
- preventing deaths in early middle age will also have a profound impact on the gap in life expectancy
- a third group that must also be considered is the over-75s – deaths in women over

the age of 75 are contributing strongly to the increasing gap between Spearhead areas and the rest of England.

As demonstrated in Figure 1, CVD, cancer and respiratory disease account for about two thirds of the gap between Spearhead areas and the national average. Reducing the number of smokers and effectively identifying and managing cases of high blood pressure and cholesterol are the three key factors that will make most difference most rapidly, both locally and nationally.

The rest of the gap can be narrowed by work on priorities such as early detection of cancer, infant mortality, good diabetes management and interventions in alcohol and/or drug-related disease. Whilst

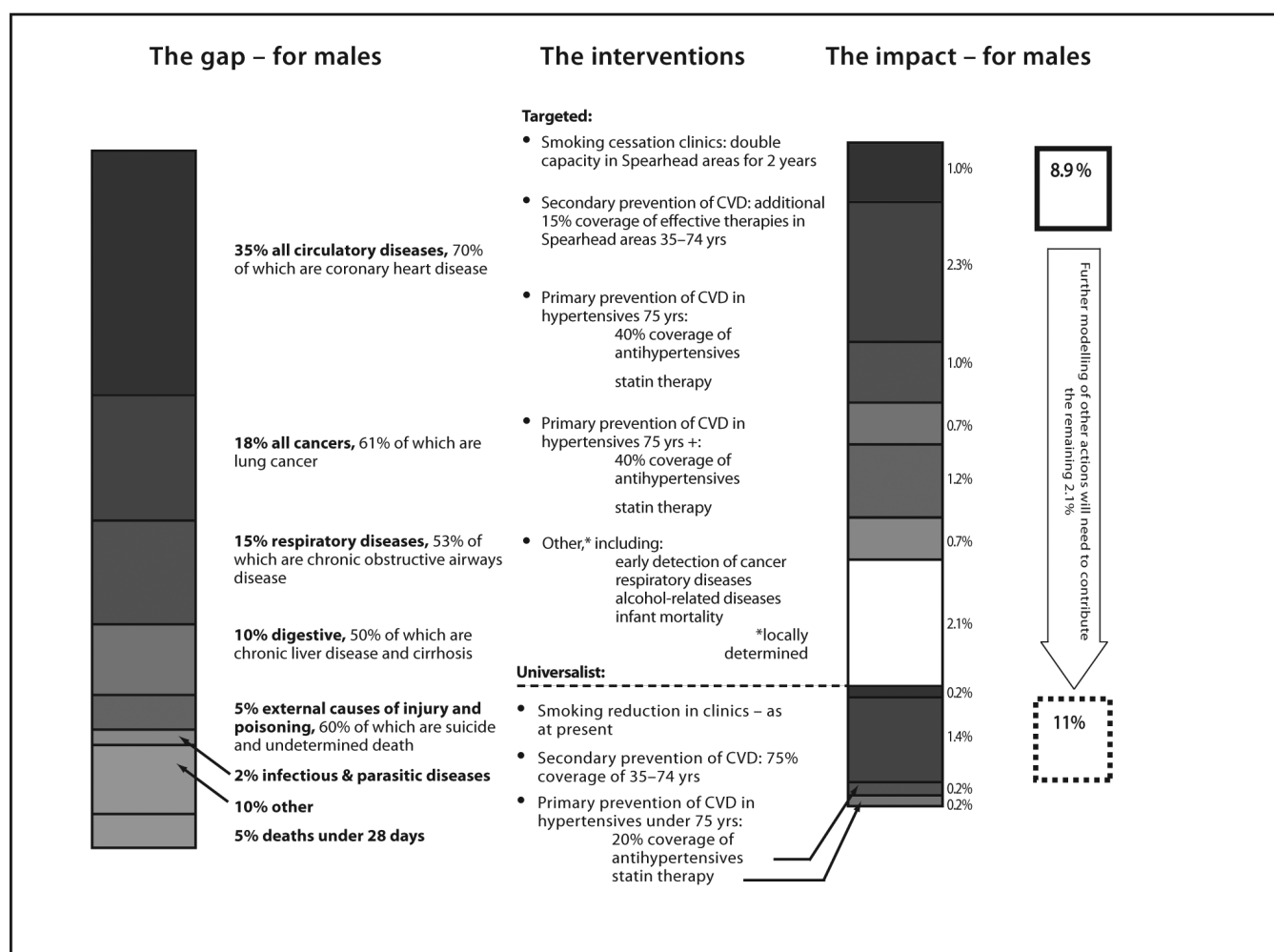


Figure 1: Modelled interventions to reduce the gap (males)

Source: Department of Health.¹

realising such objectives would appear quite straightforward, many of those with the poorest health are either not registered or do not attend their general practice on a regular basis. However, the need for the whole population to have access to quality general practice has been highlighted by a large USA-based review of all studies published between 1985 and 2005, which quantified the health benefits of GPs. The findings suggested that an increase of one GP per 10,000 population was associated with an average mortality reduction of 5.3 per cent, equivalent to 49 fewer deaths per 100,000 population per year.²

Therefore, to realise the challenge of reducing health inequalities requires addressing the issues of accessibility and

availability of general practice. In addition GPs will sometimes need to engage in activity and exert influence beyond the practice. This guide seeks to highlight how GPs can engage in such level of activity.

GPs' levels of influence

The Health Inequalities Standing Group (HISG) of the Royal College of General Practitioners (RCGP) and the Health Inequalities Unit at the Department of Health identified six key areas in which GPs can exert their individual and collective influence to help reduce health inequalities:

- GPs and individuals
- GPs and the primary care team

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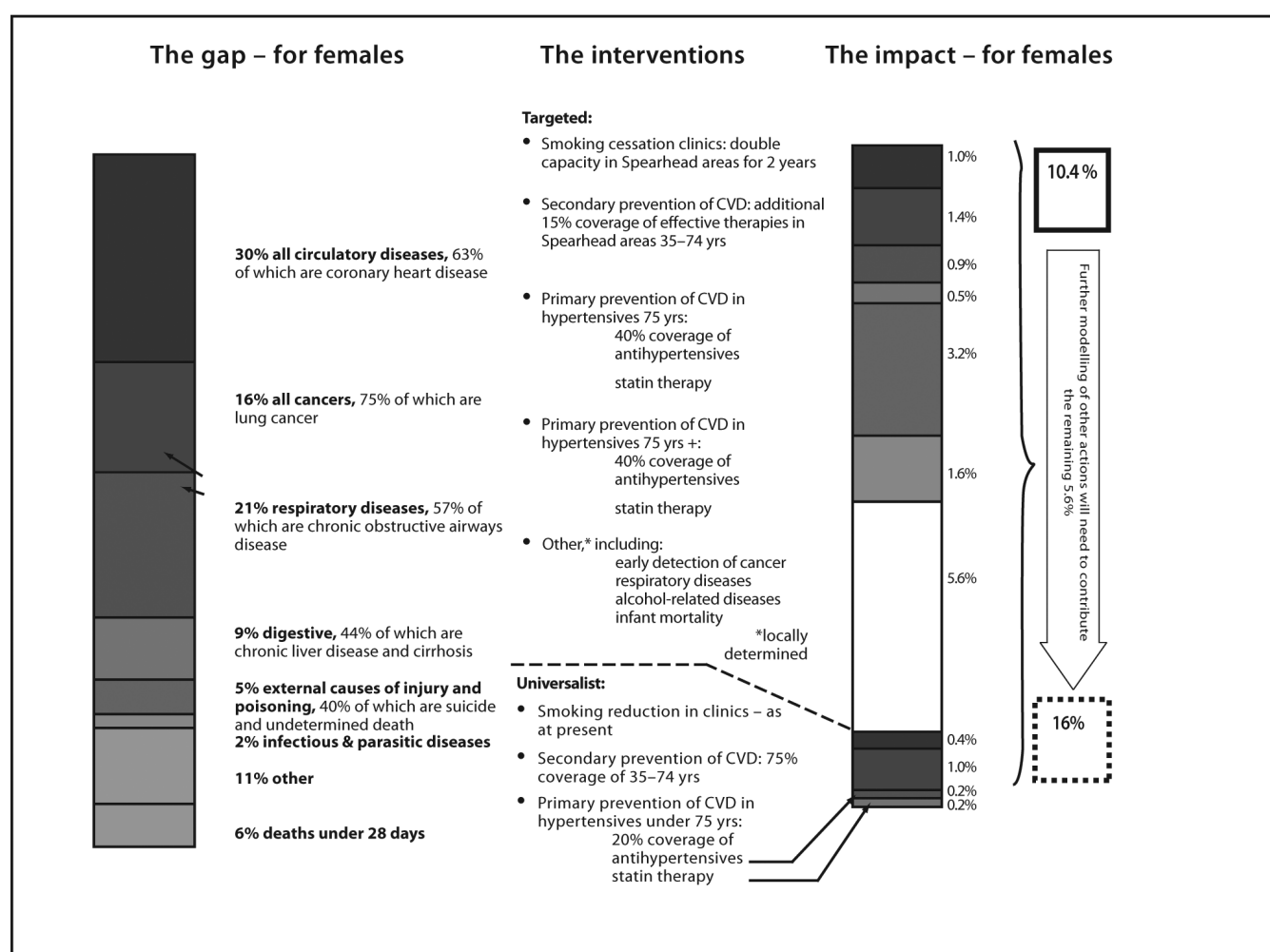


Figure 2: Modelled interventions to reduce the gap (females)

Source: Department of Health.¹

- Practice-Based Commissioning
- engagement with the PCT
- working in partnership with other organisations
- influencing the national agenda.

Indeed one of the fundamental premises of effective interventions to reduce health inequalities is that interventions need to take place at the level of the individual (for example consultations in general practice), the community (for example smoking cessation awareness programmes) and society (for example changes in seat belt laws to reduce fatalities from road traffic accidents).

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Ideas for further work in these areas are described in the guidance, as well as examples of good practice, relevant national guidance and links to useful tools and agencies.

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1 GPs and individuals

The wider context

Health inequalities are not just about health. They arise from a myriad of wider determinants of health, some of which can lie within the remit of the GP. In addition to socio-economic status, race, gender, disability, age, sexual orientation and religion might also have a significant role to play. Many health inequalities are inter-generational, i.e. the circumstances in which people are born and brought up will have consequences throughout their lives. Therefore general practitioners practising family medicine are ideally placed to influence the consequences of inter-generational factors.

Other practical ideas for strengthening links with individual patients include ensuring that all practice staff (including temporary staff and locums) are aware of local services (both voluntary and statutory) to which they can make referrals, and making sure that patient records are as up to date as possible to reflect their wider circumstances.

Patient feedback into the daily working of the practice will also help ensure that services reflect the needs of local people and can be developed in a responsive manner. Patient experience surveys are already widely used and are highlighted in Section 4 of the Quality and Outcomes Framework (QOF). Taking this one stage

further, an elected/nominated patient council, or modified versions of existing patient participation groups, could assist with the provision of input into areas such as information, policies and services.

A key challenge for general practitioners seeking to reduce health inequalities is how to provide both continuity of care for patients and also run an accessible service. This is particularly an issue for vulnerable groups such as homeless and traveller populations, prison and wider offender populations, those with learning disability, refugees and asylum seekers, many of whom face a double disadvantage of health inequality and difficulty of access to health services. The increasing policy emphasis upon GP-led health centres could have real potential to provide more equitable access to comprehensive GP services. Patients certainly value the following (in decreasing order of importance for the response group): thoroughness of the physical examination; a doctor who knew the patient well; a doctor whose manner was empathic; a reduction in waiting time (even by as little as one day); and flexibility of appointment times when visiting their general practice. Patients were also questioned about their willingness to pay for primary health care and their involvement in the decision-making process regarding their treatment. Patients were found to be most likely to want to pay

for a reduction in waiting time and also to see a doctor whom they knew well. However, compared with those patients on high incomes, those on low incomes understandably placed a greater emphasis upon cost yet wanted less of an involvement in decision making.¹

Improving aspirations

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Seeing the individual patient in the wider context of his or her social, financial and domestic environment can open up the potential for signposting the patient towards wider support. The COMPASS employability initiative in Glasgow has used primary care as an innovative intermediary in supporting people into employment. It highlights the importance of empowerment. Many communities have low expectations about their quality of life, with many people living in the most deprived areas expecting to live no longer than their parents did. Improving *aspirations* has to come from inside local communities and be led by local people. GPs can contribute to this agenda by considering their own interactions with patients in terms of time, relationships and how information is given and received. Developing and maintaining communication skills is key to interaction with patients, as recognised in *Good Medical Practice*.³ The content, context and delivery of information in the practice must also be reviewed to ensure it is timely and appropriate for local people.

Compass employability initiative, Glasgow

In autumn 2003 NHS Greater Glasgow commissioned the development of a project to explore whether primary care could be used as an intermediary to support people into employment. The

service 'Compass' was rolled out in 15 practices in Greater Pollock to allow primary and community health staff to refer patients for employment support.

Many of the clients that registered with the scheme were considerably distant from the labour market (on the employability index score), and a significant number indicated a 'health problem' was a key barrier to employment – the highest proportion being mental health problems.

Since 2004 130 clients were in paid jobs (85 per cent of these were sustained for over 6 months) and five were in voluntary work or further education. The majority of clients had significantly improved their employability index score, there was a substantial increase in the proportion of clients who described their health as 'good' compared with the start of the project and there was a reported increase in healthy lifestyle choices.

The success of Compass also had wider impacts on the health system by reducing the uptake of medication and use of primary care services (reduction in the number of patients visiting their GP regularly). It has also led to a reduction in the amounts of benefits claimed and an increase in economic output locally.²

Reducing health inequalities in Tower Hamlets

A team from Queen Mary University has developed a project covering all GP practices in the borough with the aim of reducing inequalities in healthcare delivery and improving the health of the population. The group will focus on

the three diseases that contribute most to poor health in the local population: diabetes, CVD and chronic obstructive pulmonary disease (COPD). Working with GPs and patient groups, self-management programmes will be developed alongside a campaign to improve the public's awareness of its right to access healthcare services. The aim of this arm of the project will be for patients to work in partnership with their GP to manage their own health more effectively.

In addition, each practice will receive an equity report on its performance by age, sex and ethnic group in each of the three disease areas. These reports, based on baseline data collected from the practices, will compare service provision across the borough and against national standards. The team will analyse the results with the practice and support them to improve their services. This support might be in the form of education, staff development or using IT systems to support case management.

Bromley-by-Bow children's centre

The Bromley-by-Bow children's centre is allowing integrated working in Tower Hamlets by offering a range of services in one place based around the needs of children and families.

The centre offers a range of activities broadly grouped around enterprise, education, environment, health and the arts. There is a GP surgery based in the centre with a list of over 5000 patients. Patients attending appointments are exposed to a diverse range of opportunities including an IT facility with free public access and scheduled lessons, educational courses ranging from basic skills to higher diplomas, and arts activities for all age groups. The centre's staff and health teams can easily attend each other's meetings and, where appropriate, make some home visits to families together.

More information is available at www.bbbc.org.uk.

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2 GPs and the primary care team

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Capacity and capability

All members of the primary care team have a role to play in reducing inequalities. To successfully target and deliver these reductions, the skills of the team must be combined with information on inequalities in the local population. This information can come from a number of sources – nationally (Health Inequalities Intervention Tool, Community Health Profiles, the Health Poverty Index), locally (PCT annual public health report), or from within the practice (case finding using practice registers). Tools such as Health Equity Audit are available that can be applied to these sources of information to create a more targeted profile of the local population. This initiative to improve the management of long-term conditions in Runcorn is an example of the many initiatives now undertaken across the country at practice level. The initiative impacted in a number of areas by combining analysis of local inequalities data with innovative ways of delivering care.

Management of long-term conditions in Runcorn

The Castlefields practice serves one of the most deprived populations in the local area. The PCT targeted chronic diseases such as CVD and diabetes by

developing disease registers and calling and recalling patients to nurse-led clinics. Here patients were offered evidence-based treatment and lifestyle advice with regular audit to monitor progress and boost staff morale. These audits have shown the number of myocardial infarctions in the target population fell by 50 per cent and deaths have fallen by nearly two thirds. More diabetics were identified after the introduction of the clinics and the proportion of diabetics with a HbA1c > 10 fell by half.

More complex conditions such as mental health and elderly care were also addressed. The practice contributed to the provision of more proactive psychiatric care based in the surgery, which led to a reduced number of admissions and shorter inpatient stays for those who were admitted. In elderly care a district nurse was recruited to work in conjunction with a social worker to provide rapid response to referrals, hospital in-reach and proactive management of high-risk patients. Again the main impact was reduced number of admissions and decreased length of stay.

Delivering this type of care will require leadership from GPs and other senior members of the team. In some areas, it might

require collaboration with other practices or voluntary organisations and community groups. Other healthcare professionals such as health visitors, community nurses, care workers and pharmacists are already working on reducing inequalities through their work in areas such as smoking cessation, case finding and child health. Making links between practices and these services will create a more co-ordinated local response that avoids duplication.

The Sheffield CVD initiative demonstrates the impact joined-up services can have on reducing local inequalities.

Sheffield City-wide Initiative for Reducing Cardiovascular disease (CIRC)

CIRC delivered high-quality secondary prevention programmes to an estimated 14,000 individuals with CVD in areas of highest need, with 51 local GP practices receiving a tailored programme of support. A city-wide programme of user support and community engagement with black and minority ethnic communities was also linked into the practice-based activities. Additional funding has enabled the programme to be incorporated into the mainstream services of the local PCTs. In the three years between 2000 and 2003 Sheffield saw a 23 per cent decline in cardiovascular mortality in the under-75s in the most deprived fifth of its population compared with a 16 per cent decline in the Sheffield population as a whole.

The changing nature of the primary care team has real potential to impact positively upon health inequalities. In particular the development of the nurse practitioner role has widened access to primary care

for patients in a number of ways. When integrated within the primary care team the role can lead to an increased availability in appointments – both longer appointments and at different times of the day. Where the nurse practitioner is female, patients appreciate having the choice of consulting a female clinician, and high levels of satisfaction with the service are expressed by both patients and practice staff.¹ The role has been highlighted as a potential solution to the problems of recruitment and retention of GPs. However, there remain some barriers to optimising the potential of this role in reducing health inequalities. These include some nurse practitioners not having the legitimacy to be able to sign all their own prescriptions or refer patients to secondary care. This is despite taking medical histories, conducting physical examinations, requesting investigations, diagnosing minor illnesses and deciding upon treatment plans. There are instances where patients have completed a consultation with a nurse practitioner but have had to wait for a prescription to be signed by a doctor or return to the practice later to pick up a prescription.² Therefore the role of the nurse practitioner in reducing health inequalities is clearly one that has great potential but is still developing.

Similarly the extended role of the community pharmacist is a developing area that has the potential to reduce health inequalities. The evaluation of a scheme allowing pharmacists to prescribe and dispense medicines currently limited to general practitioners without losing the right to free prescriptions generated some encouraging findings. The total number of general practitioner consultations was not reduced by the scheme but the proportion that were for minor ailments decreased. The distance travelled by the patient did not appear to affect patient choice.³

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3 GPs and Practice-Based Commissioning

Identifying need

Practice-Based Commissioning (PBC) presents primary care with a number of opportunities to reduce inequalities by allowing the primary care team's unique knowledge of the area to influence the provision of care. GP practices are at the frontline of delivering patient care and can use their significant knowledge of the population to identify and target specific individuals or groups with particular needs. Such knowledge can be used to provide a stronger focus for commissioning, working jointly with appropriate community partners. Practices must consider themselves as serving the whole of the local population – not just those who come through the surgery door. Effective commissioning to reduce inequalities relies on having an accurate picture of local need and a good overview of local services in order to achieve the best possible outcomes. The new duty of Joint Strategic Needs Assessment (JSNA) is the means by which local authorities and PCTs will describe the future health, care and wellbeing needs of local populations, and the direction of service delivery to meet those needs. JSNAs will contain information on inequalities and inequities, and their content will help shape the objectives of Local Area Agreements (LAAs). GPs will play a vital role by supplying information and adding to the PCTs' contribution to

JSNAs. They will also be delivering the outcomes on a daily basis in the way they work with patients and how they refer. Practice-Based Commissioners should try to reflect relevant aspects of the JSNA and the LAA in their own commissioning plans.

Identifying what data the practice holds, and how it can be used and (if necessary) improved, is the first step. Thinking beyond the boundaries of the QOF will ensure that information gathered and utilised is comprehensive and appropriate. The local public health department is a key resource for other data sources and might be able to provide assistance with analysis and needs assessment. Any assessment of need should involve patients to sit on the stakeholder group, help identify health priorities and other key issues as well as using the results to help plan and develop future services.

The evidence base for health inequality interventions would suggest that, when implementing an intervention across a local area, adequate funding, good leadership, partnership with communities, and firm political support were all necessary for the success of the intervention. In addition the intervention should be appropriate and well designed, and the objectives should not change over the course of the programme.¹

The Keep Well initiative in Scotland identified communities 'at risk through deprivation' and enhanced primary care services in these areas to prevent the development of serious ill health. It illustrates the importance of establishing clear priorities and starting with small changes.

Keep Well, Scotland

The Keep Well programme, which runs from 2006 to 2009, aims to increase the rate of health improvement in deprived communities by identifying and targeting registered 45–64-year-olds with clinical and lifestyle risk factors for CVD. These patients are offered appropriate interventions and services, and are monitored and followed up.

Pilots were run throughout 2006 and 2007 in which primary care in deprived areas has been enhanced with extra resources for staff and services to identify, contact and assess these high-risk groups. Evaluation of the initiative began in 2007 and will conclude in 2010. Short-term outcomes (reported annually) will include reach, access, uptake and compliance. Longer term the programme aims to modify the prevalence of CVD risk factors and ultimately reduce premature CVD mortality in deprived areas. The programme runs in tandem with the new General Medical Services (nGMS) contract.

Targeted commissioning

The reduction of health inequalities needs to be a theme running throughout PBC. For commissioning to be innovative and truly impact upon health inequalities, it might require a change in culture, service delivery or the development of new alliances and partnerships in order to target the most

deprived communities most effectively. Looking at how equitably services are delivered and whether they meet local needs has to be a proactive process that draws in people who, traditionally, have not had good access. Working with local third-sector groups might be a way of assessing these hard-to-reach groups.

Adequate time needs to be set aside to implement any planned changes and to evaluate their impact. The results of this evaluation should be made transparent and shared as widely as possible.

The North Prospect Community School is an excellent example of service delivery changing to better serve the needs of local people.

North Prospect Community School, Plymouth

Joint working between the school, the local PCT and GPs to understand the needs of the local community culminated in the opening of a GP surgery on the school site in 2005.

A door-to-door consultation exercise identified that the health-related issues which most concerned families were smoking cessation and teenage pregnancy. There was also a problem with access to GP services, which was felt to be having a negative impact on the health of local families.

Having a GP surgery at the school allows quicker, earlier intervention when young people require support from health services. Both the school and families have benefited from faster, more effective referrals and there has been a significant improvement in pupils' behaviour and a reduction in vandalism.

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Do area-based interventions to reduce
health inequalities work? A systematic
review of evidence *Critical Public Health*
2007; **17(4)**: 317–35.

4 Influencing the national agenda

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Resource allocation

Numerous academic papers have highlighted the ‘inverse care law’ where the provision and development of services is inversely related to clinical need. GPs, both individually and as a body, are in a strong position to act as advocates, raise awareness and exert pressure to change this situation. GPs can work collaboratively to highlight the need to prioritise resources for deprived and rural practices and service development. Any policy should be in collaboration with other interested professional groups. This should be backed up by a positive media strategy in order to inform patients of the benefits to them. Professional bodies such as the RCGP can assist the process by developing standards for practice-based inequalities needs assessments.

One pressing area of national interest is the complex area between primary care access, quality, cost containment and patient feedback. One example of the dilemmas highlighted in a large London-based survey of primary care patients was that participants reported poorer availability of general practitioners in highly computerised practices and in practices running emergency appointments compared with practices that had a lower level of

computerisation and allowed patients to turn up and wait to be seen.¹ Undoubtedly, however, the provision of recall systems in highly computerised practices has allowed primary care to undertake a more proactive role in chronic disease management. Therefore it is possible that, whilst lower computerised practices without a high level of computerisation provide a higher level of GP availability for acute need, this is at the expense of proactive chronic disease management to address the key outcomes described earlier in this guide.

Evidence-based policy

Policy and practice on reducing health inequalities should be based on the best available evidence. This guidance has been informed by the current evidence base in this area and also provides some examples of innovative ways of working that have delivered on this agenda. GPs must trust in their own experience and their relationship with patients as a starting point for change. At a local level sharing clear and relevant information between practices serving similar populations might be a practical way of disseminating good practice, which should be supported by PCTs, Local Medical Committees and, where feasible, academic institutions. At national level,

the royal colleges as a group must make health inequalities a priority and work collaboratively on their reduction.

Reference

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5 Partnership working

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The local knowledge that GPs have puts them in an ideal position to take part in local projects that affect the wider determinants of health and reduce inequalities. These might range from work with the local authority, such as JSNAs and Local Strategic Partnerships, to collaborations with the voluntary sector.

The organisations involved need to be made more aware of the benefits of involving GPs in their work, and be more proactive in approaching them and offering them roles at policy and strategic as well as operational levels.

Blackpool – a partnership approach

Men in Blackpool have the second worst life expectancy for males in England and Wales. The PCT and Borough Council agreed to take action. In 2006, they appointed a joint Director of Public Health between the local authority and PCT, and made reducing health inequalities a key joint target in their Health and Wellbeing Improvement Plan. This plan ensured that all policies were 'health proofed' before being signed off. The partners analysed the reasons for early death and addressed these through a number of negotiated agreements across many sectors including health, employment, environment, housing

and education. The agreements targeted geographical areas and sub-groups within the population with the greatest need.

Improvements included better access to alcohol treatment services, training on brief interventions for staff, falls prevention and road safety activities for older people, expanded nutrition and physical activity community teams and public sector employment initiatives for vulnerable young people.

A number of outcomes are being measured but successes to date include access to alcohol treatment within one week of referral and a reduction in the number of injury admissions in older people.

6 Engaging with the Primary Care Trust

Partnership working between GPs and the PCT should be a relationship that meets the expectations of both parties. PCTs have an essential role to develop in supporting Practice-Based Commissioning that reduces health inequalities. Their performance management and training structures are crucial for this, as is their assistance in producing timely and relevant health intelligence data that GPs can use to plan services. Many GPs already have roles within PCT structures on the Professional Executive Committee or as members of working groups. There is potential for the number of GPs in these areas to be expanded further. GPs might also have a role to play in the structure and contents of the PCT prospectus, particularly needs assessments and patients' ratings of services.

There is also a need for further strategies to address health inequalities in which GP input into PCT work will be invaluable. For example, the QOF has provided PCTs with an unprecedented supply of data that could be utilised to reduce health inequalities. Recent research in the field of diabetes demonstrated that, despite a higher prevalence in the highest quintile of deprivation, the rate of 'exception reporting' was also higher from practices situated in areas of high deprivation.¹

The sometimes contentious area of access and the patient's reported experience

of primary care is also an area that will require further collaborative working between GPs and PCTs. For example, a systematic review of innovations in service provision to improve access to primary care demonstrated that walk-in centres and NHS Direct have improved access for white, middle-class patients but it is possible that in so doing they have widened the gap in health inequalities.² The services were highly rated by patients. However, developing such programmes so that they are responsive to the needs of the whole population is an area for future development.

There can be no more chilling form of inequality than someone's social status at birth determining the timing of their death.

(Alan Johnson MP, speech to the New Health Network, 12 September 2007)

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Appendix

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Tools and resources

Health Inequalities Intervention Tool

www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx

Commissioning toolkit for long-term conditions

www.commissioningforthelongterm.org.uk

Needs assessment toolkit

www.everychildmatters.gov.uk/strategy/planningandcommissioning

The Health Poverty Index

www.hpi.org.uk

Community Health Profiles

www.communityhealthprofiles.info

Review of the health inequalities infant mortality PSA target

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065544

Health Equity Audit: a guide for the NHS

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084138

Good Medical Practice (General Medical Council)

www.gmc-uk.org/guidance/good_medical_practice/index.asp