The role of Primary Care in Tackling Health Inequalities

Applying a Social Innovation lens

Final report of a multi stakeholder and ideas generation process

Introduction

In 2017, Community Development and Health Network (CDHN) were commissioned by the Building Change Trust (BCT) under the Social Innovation NI Knowledge Exchange Programme to use a social innovation approach to explore the role of primary care in tackling health inequalities in Northern Ireland. This report presents the outworkings of this project.

We do not view this report as the end product of this work, as we remain very much at the early stages of the design thinking process. Rather we intend it to be used as a stimulus for further discussion and action on this topic. CDHN, in our role as advocates for an end to health inequalities, will use this as a working document to help influence and shape future support for Primary Care Health Professionals in understanding and fulfilling their role in this field.

The report begins with a brief literature review of the current health inequalities situation in Northern Ireland and the role of primary care in tackling health inequalities. The second section outlines social innovation approach used, namely design thinking. The third section presents the findings from the insight gathering with primary care practitioners and the design thinking workshop. The final section presents recommendations for moving forward with this work.

About CDHN

With almost 2,000 members supporting tens of thousands of people, Community Development and Health Network (CDHN) is Northern Ireland's leading organisation working to empower communities, improve health and wellbeing and reduce health inequalities.

CDHN raises awareness of the root causes of poor health and health inequalities. We reshape the dominant narrative about the causes of and solutions to health inequalities and how to improve health. Through our work, communities and decision makers are supported to recognise and utilise assets, to work together to develop solutions, take action to improve lives, health and wellbeing and create a fairer, more equal society.

About Building Change Trust and Social Innovation NI

The Building Change Trust was established in 2008 as an initiative of the Northern Ireland Big Lottery Fund. With an investment of £10million, the Trust was set up as a ten-year initiative geared towards the development of the voluntary, community and social enterprise (VCSE) sector. This investment will be spent in full by 31 December 2018.

The Trust has supported innovative work since its inception, and in 2013 Social Innovation became one of its 5 core themes. In 2016 the Trust and its partners established **Social Innovation NI** as a cross-sectoral collaboration which aims to make it easier for those with innovative solutions to social challenges to access the support they need to deliver their ideas with impact and at scale. As well as two Knowledge Exchange Programmes, to date Social Innovation NI has delivered three cycles of the Techies in Residence programme, two cycles of the Social Innovation Skills programme, two series of Social Innovation Decoded workshops and two international social innovation festivals. With the closure of the Trust in December 2018, Social Innovation NI will continue under the leadership of the Community Foundation for Northern Ireland. More information can be found at www.socialinnovationni.org

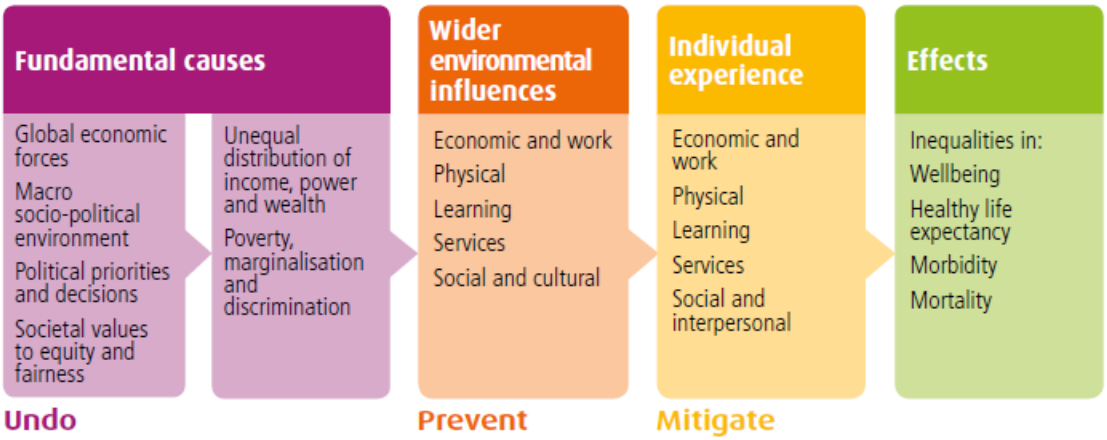
Section 1: Brief Literature review

Health Inequalities

Health inequalities are the avoidable differences in health experienced within and between societies, "varying according to the levels of social advantage, with worse health occurring among the disadvantaged" (Braverman, 2010 p32)

Where we are born, live, work and age affects our health, these factors are known as the wider determinants of health inequalities, they include employment, income, education, housing, and community. The determinants can be health protecting and promoting or damaging to health but these by themselves do not cause health inequalities, they contribute to good or bad health. It is the unequal distribution between the factors which are health protecting and promoting and those which damage health which lead to health inequalities. This exists because of an imbalance of power, resources and money.

NHS Scotland devised the following diagram to illustrate the relationship between power and resources, living and working conditions and health outcomes.



NHS Scotland (2015) Inequality Briefing 1 July 2015

Impact of health inequalities

The impact of health inequalities are; early mortality and higher rates of morbidity and co-morbidity for the more disadvantaged within society. In crude terms this means that people from more disadvantaged backgrounds not only live shorter lives but live more years with chronic illness and/or disability. Research and action into health inequalities have mostly focused differences in health relating to socio-economic status. However, there is intersectionality with other factors such as ethnicity, disability and caring responsibilities.

Health inequalities in Northern Ireland

The Department of Health (DoH) has responsibility for monitoring health inequalities in Northern Ireland. They monitor the gap between 20% most and least deprived, the gap between the most and least deprived and Ireland average, the differences between rural and urban areas and differences between Health and Social Care Trusts. In their analysis of the data DoH highlights the important of nuance and context in tackling health inequalities. For example there are indicators which show improvements for both the most and least deprived, but that the gap is widening due to these improvements happening at different rates.

DoH latest report on Health Inequalities was published in February 2018[1]. The report provides the following data on health inequalities

- Health outcomes are generally worse in the most deprived areas when compared with the least deprived areas. Large differences (health inequality gaps) continue to exist for a number of different health measures
- Life expectancy at birth has continued to improve in the north of Ireland and stood at 78.3 years for males and 82.3 years for females in 2012-14, with the inequality gap narrowing for males over the last five years, while remaining constant for females in 2012-14, the inequality gap in life expectancy at birth stood at 7.0 years for males and 4.4 years for females
- Healthy life Expectancy is perhaps a more accurate reflection of population health. At present the gap between the most and least deprived stands at 13.7 years for males and 13.0 years for females.
- Alcohol and drug related indicators continue to show some of the largest health inequalities monitored in NI, with drug related and alcohol specific mortality in the most deprived areas around five times the rates seen in the least deprived.
- In 2016, the under 20 teenage birth rate in the most deprived areas was almost six times the rate in the least deprived and the proportion of mothers reporting smoking in pregnancy in the most deprived areas was almost five times that in the least deprived
- Primary 1 obesity levels fell in the most deprived areas while increasing in both the least deprived areas and NI overall which led to a narrowing of the deprivation inequality gap between 2011/12 and 2015/16
- Rates of premature mortality generally decreased over the last five years in NI and both its most and least deprived areas. Inequality gaps narrowed or remained broadly similar, with the exception of death rates among under 75s due to respiratory disease
- The inequality gap in self-harm admissions narrowed by a quarter between 2008/09-12/13 and 2012/13-16/17 with improvements observed for NI and its most and least deprived areas (Department of Health and Information Analysis Directorate 2018)

Why Primary Care?

Deprivation doesn't just affect the people living in those conditions. It has profound effects on those providing services. Not only do individuals in deprived areas face poorer health outcomes than those in affluent areas, they're also more likely to suffer from multiple illnesses at a much earlier age, with the rate of mental illness three for four times as likely in the most deprived areas. These challenges

[1] https://www.health-ni.gov.uk/sites/default/files/publications/health/hscims-report-2018.pdf

are further aggravated by problems related to social deprivation such as higher levels of unemployment, fewer financial and other resources, and higher rates of addiction. Primary care professionals have limited consultation time with their patients, those working in deprived areas face a major challenge in adequately addressing all the problems their patients present with.

Key information about Primary Care Health Professionals in Northern Ireland:

General Practitioners (GP's)[2]

GP Practices are independent, small businesses, often operating from their own premises. They have a responsibility for employing their own staff including doctors, nurses, receptionists and healthcare assistants. The service works alongside other healthcare professionals such as district nurses, health visitors and social workers which are employed by Health and Social Care Trust. There are currently 336 GP Practices in NI, with 1722 practicing GPs (excluding doctors in training).

In response to the many pressure facing GP's at present, GP Federations have been established in Northern Ireland with two main aims –

- To support and protect GP Practices.
- To help deliver the transformation agenda in Health and Social Care.

The creation of the federation model has been led and funded by GPs themselves. There are currently 17 fully incorporated GP Federations covering all areas of Northern Ireland, all of which are owned entirely by GPs.

GP Federations aim to provide better care, delivered in a more responsive way and closer to home, for patients registered on the lists of practices within the Federation. The focus is on working across the local health and social care community, in collaboration with a wide number of agencies, to design and implement innovative healthcare strategies and ways of delivering high quality care.

Community Pharmacy[3][4]

Community pharmacists usually work in the high street and are involved in the sale and supply of medicines. There are around 535 community pharmacies in Northern Ireland and they are also employed as independent contractors with responsibility for employing their own staff.

They are responsible for dispensing medicines, instructing patients on their proper use, clarifying with GPs and other prescribers that dosages are correct, and checking that new treatments are compatible with other medicines the patient may be taking. Community pharmacists also sell over-the-counter medical products and instruct patients on the use of medicines and medical appliances. Some provide a minor ailments service which supports self-care through improved access to advice and a range of medicines used to treat common conditions without the need for a GP consultation. Some pharmacists will also offer specialist health checks, such as blood pressure monitoring and diabetes screening, run stop smoking clinics and weight reduction programmes.

[2] http://www.hscboard.hscni.net/our-work/integrated-care/gps/
[3] https://www.health-ni.gov.uk/topics/dhssps-statistics-and-research/pharmacists-statistics
[4] https://www.communitypharmacyni.co.uk/what-is-community-pharmacy/

Social Workers:[5]

Social workers work primarily, although not exclusively, with some of the most vulnerable and marginalised people in society. They work with people who may have difficulty living within the commonly accepted norms of society or who lack the means to do so and who may also have personal, social, physical or mental problems and are in need of support, care, protection or control. Social workers work in partnership with other public services, such as health, education, housing, police, probation and with the voluntary and independent sectors to promote and safeguard, and where appropriate to protect, the social wellbeing and safety of individuals, families and communities.

There are 8,228 (7,326 WTE) staff employed in Social Services grades. A small majority (51%, or 3,766 WTE) are social workers.

District Nurses[6]

The district nursing service is an essential part of the health and social care system, and often makes the difference between people being able to stay at home rather than being admitted to hospital or nursing home care. The district nursing team assesses care needs and delivers a wide range of nursing interventions to people in their own homes or close to their home. They play a key role in supporting independence, managing long term conditions, providing palliative and end of life care and preventing and treating acute illnesses.

A district nurse is a registered nurse with a graduate level education possessing a district nursing specialist practitioner qualification recordable with the Nursing and Midwifery Council (NMC). The specialist practitioner qualification focuses on a range of topics including: case management; clinical assessment skills; care co-ordination; autonomous decision making, enhanced clinical skills; population health; leadership and team management.

The District nurse works very closely with GPs. They can provide access to specialist nursing equipment and specialist teams such as the continence team, tissue viability, Oncology and Palliative care team, Diabetic team, 24 hour nursing team and Heart failure nurses (DoH District nursing framework 2018)

There are 1,018 District nurses in Northern Ireland.

[5] **https://www.health-ni.gov.uk/sites/default/files/publications/health/hscwc-march-18.pdf**

[6] https://www.health-ni.gov.uk/sites/default/files/publications/health/district-nursing-framework2018.pdf

Northern Ireland policy

In October 2016 a 10 year approach to transforming health and social care was launched, 'Health and Wellbeing 2026: Delivering Together[7]'. This plan was the response to the report produced by an Expert Panel led by Professor Bengoa tasked with considering the best configuration of Health and Social Care Services in Northern Ireland. When he was making his, Prof. Bengoa stated:

"The Department of Health needs to continue to work in partnership with other departments and sectors to tackle the underlying social, economic and environmental determinants of health across the population. Local health and care partnerships, if properly organised, can also do much through local initiatives and shared budgets to address these fundamental determinants of health and wellbeing." (Bengoa 2016)[8].

The then Minister for Health, Michelle O'Neill elaborated on this concept in her vision document for Delivering Together 2026 by identifying these two key actions in relation to tackling health inequalities:

- Build capacity in communities and in prevention to reduce inequalities and ensure the next generation is healthy and well;
- Provide more support in primary care to enable more preventive and proactive care, and earlier detection and treatment of physical and mental health problems.

The document goes on to state that:

"*Our future model of primary care is to be based on multidisciplinary teams embedded around general practice. The teams will work together to keep people well by supporting self-management and independence, providing proactive management of high risk patients. They will identify and respond earlier to problems that emerge whether related to health or social circumstances or the conditions in which people live, providing high quality support treatment and care throughout life. These teams will include GPs, Pharmacists, District Nurses, Health Visitors, Allied Health Professionals and Social Workers, and new roles as they develop, such as Advanced Nurse Practitioners and Physician Associates."* (Department of Health 2016)

In addition to this, Integrated Care Partnerships (ICPs) are playing a key role in how health and social care services in Northern Ireland are being transformed. They are helping to change the way care is delivered. ICPs are a new way of working for the health service in Northern Ireland to transform how care is delivered. The development of ICPs was one of the proposals put forward by the Review of Health and Social Care in Northern Ireland in December 2011 and a proposal to establish 17 ICPs was consulted on during the TYC Vision to Action Consultation between October 2012 and Jan 2013. In March 2013, the Health Minister endorsed the establishment of 17 ICPs across Northern Ireland

ICPs are collaborative networks of care providers, bringing together healthcare professionals (including doctors, nurses, pharmacists, social workers, and hospital specialists); the voluntary and

[7] https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf

[8] Bengoa (2016) Systems, not structures: changing health and social care Expert Panel Report https://www.health-ni.gov.uk/sites/default/files/publications/health/expert-panel-full-report.pdf

community sectors; local council representatives; and service users and carers. There are a total of 17 ICPs and their core aim is to design and coordinate local health and social care services.[9]

Recent developments in Health and Social Care in Northern Ireland.

In May 2018, the Department of Health released details of a series of initiatives being funded under the £100m Health and Social Care transformation fund. The planned package of investments for 2018/19 includes £15m for enhancing primary care – care which is largely provided from GP practices. This will include some £5m for the roll-out of Multi-Disciplinary Teams (MDTs) at GP practices. These involve the establishment of practice-based physiotherapists, mental health specialists and social workers - working alongside doctors and nurses to better meet the needs of the local population. The roll-out of MDTs this year will cover two GP Federation areas initially – Derry / Londonderry (covering 200,000 people) and Down (covering 75,000). The next phase of the planned NI wide roll-out will begin with West Belfast.

Our analysis of the situation

There is a clear political commitment in Northern Ireland to the concept of primary care taking on a much greater role in tackling inequalities and there are promising examples of primary care beginning to adopt an enhanced prevention role with continued support for the ICP model and the piloting of the new MDT approach. There are, however, limited opportunities for the primary care "family" to undertake research, training, support or knowledge exchange, either individually or collectively, to understand or effectively address the complex issues they are faced with on a daily basis.

[9] http://www.hscboard.hscni.net/icps/

Section 2: Social Innovation: The Design Thinking Process

Design team

CDHN used their extensive knowledge of the statutory and community and voluntary sector to identify suitable organisations and people to join the design team. Members were required to meet one of the following two criteria:

- The organisation has an active membership base and/or
- has working relationships with relevant primary care professionals

The design team was established with the following membership:

Organisation	Name
Community Development and Health Network (CDHN)	Joanne Morgan
Community Development and Health Network (CDHN)	Meabh Poacher
Healthy Living Centre Alliance (HLCA)	Tony Doherty
Integrated Care Partnership (ICP)	Stephen Slaine
Department of Health (DoH)	Aine Morrison
Clare Project	Many Cowden
East Belfast Community Development Agency (EBCDA)	Linda Armitage
The Innovation Lab	Rebecca Walsh (until summer 2018)
Work West	Patricia Flanagan (from summer 2018)
Work West	Michelle Dolan (from summer 2018)

The Innovation Lab initially supported CDHN with the design thinking process. They were approached due to their extensive experience in the use of human centred design and other methodologies. However, the person responsible for this work, Rebecca Walsh, moved to a new post in Summer 2018 and the Innovation Lab were unable to continue their support. Work West were identified as a suitable replacement due to their extensive knowledge and experience of design thinking/creative problem-solving approaches to stimulate innovation.

Design developments

The design team met on three occasions between September 2017 and February 2018. The focus was on clarifying exactly what the purpose and scope of the project should be.

Make up of Insight gathering workshops

During the course of the design team meetings it became apparent that our original idea of holding insight gathering workshops with mixed groups of health professionals was not going to be possible. The logistics of getting GPs and pharmacists, in particular, released for their duties was seen by members of the design team (and other contacts outside of the team) as very challenging. The availability of a budget to cover locum costs, whilst helpful, did not appear to be the answer to this problem, as part of the issue was the unavailability of locum cover for Gp's and Pharmacists, in addition to workload pressures.

Involving primary care users

The design team discussed the feasibility and appropriateness of engaging with people who have lived experience of using primary care services. It was subsequently decided not to engage with them, this was to ensure the focus remained on the experience of Primary Care Health Professionals. It was noted, however, that should the opportunity arise to continue this work, it is essential to engage with people with lived experience.

Secondary data search

It also became clear during the course of these meetings that we had not gathered enough background information regarding each individual health discipline (as advised by the Innovation Lab). CDHN took on the role of writing a more detailed scoping paper which was completed by April 2018. It contained an overview of the main statistical information pertaining to each discipline (numbers employed etc.) and a summary of the main policy and strategic documents relevant to each discipline. This provided helpful contextual information during the insight gathering stage.

Insight gathering workshops with Primary Care Health Professionals

The attendees

CDHN made contact with a number of key contacts and representative bodies to arrange workshops with the Primary Health Care Practitioners. Arranging the workshops proved to be very difficult. Following several months of discussion with key representative bodies including Integrated Care Partnership (ICP) Business management, Royal College of General Practitioners NI (RCGPNI), Ulster Chemist Association (UCA) and Department of Health Social work and District Nursing representatives, we eventually arrange five workshops as follows:

Insight gathering workshops		
Venue	**Primary care practitioners**	**Number of attendees**
Resurgam, Lisburn	GPs	5
Work West	Social Workers	11
Zoom meeting*	Community Pharmacy	4
Zoom meeting*	Community Pharmacy	5
Banbridge Health and Social Centre	District Nurses	6
	TOTAL	**31**

Format

In advance of the workshops CDHN engaged with Work West[10] to agree the design, scope and type of questioning style to be adopted.

[10] Work West is a Belfast based Social Enterprise with specific expertise in Design Thinking Methodologies
*Zoom is a video conferencing service.

The following core questions were asked at all workshops:

1. What is your understanding of health inequalities in Northern Ireland?
2. Tell me what it's like to be you? To be a xxx in the current environment?
3. Persona / scenario – each workshop had a core scenario with slightly different information provided depending on the discipline
4. How do you give consideration to all the other things going on in this person' s life and how they might impact on her health? (Linked to the persona /scenario)
5. How might you as a xx fully understand the health inequality as experienced by your clients?
6. How might you address and reduce the health inequalities in the community you serve?

Each question had a set of prompts focused on "how does that feel?" "How might we?" and "what needs to happen?" type questions. The role of CDHN was that of independent facilitator, which was explained to participants in advance. This was extremely important as participants needed to the opportunity to share their views and experiences with complete honesty (See appendix 1).

Each workshop was recorded and participants were informed of this in advance and their permission sought. Participants were reassured that once each workshop was transcribed, all reference to them personally would be removed, no comments would be attributed to them personally and the recording would be destroyed. The only exception to this was the workshop with District Nurses who did not wish the conversation to be recorded as they felt it may curtail the honesty with which people could speak. Detailed written notes were made as an alternative.

Each workshop took between one and a half to two hours.

Design Thinking Workshop

The next stage in the process was a full day Design Thinking workshop. All those who had participated in the workshops were offered the opportunity to take part. Again locum cover was provided. Eight Primary Health Care professionals participated. Another four expressed their intention to participate but were unable to secure locum or other cover. The breakdown was: two GP's, three Community Pharmacists and three Social Workers. No District Nurses were able to participate. Their workshop occurred shortly before the Design thinking workshop and as a result they did not have adequate notice in order to free up staff to attend.

Work west facilitated the session (Patricia Flanagan and Michelle Dolan), leaving CDHN staff free to participate and provide insights.

The workshop took the following format:

Topic	**Led by**
Overview of Design thinking Methodology - whole group	Patricia Flanagan Work West
Summary of Insights from Workshops – whole group	Joanne Morgan CDHN
Further Insight Gathering – whole group	Patricia Flanagan
Framing the challenge – whole group	Patricia Flanagan
Ideas generation – two small groups	Patricia Flanagan

It was agreed in advance between Work West and CDHN that the full design thinking process could not be implemented in one day. The workshop would instead focus on agreeing insights and ideas generation.

Section 3: Findings from insight gathering and design thinking workshop

Core Themes from insight gathering workshops

A number of core themes emerged across the five workshops, these have been summarised below:

Understanding of health inequalities:

There was a spectrum of understanding regarding health inequalities and their causes, with most participants demonstrating a broad understanding of the core concepts. For example there were frequent references to the impact of social, economic, environmental factors on health and wellbeing. At times there was a tendency to focus quite quickly on lifestyle and behaviour change issues. In some instances issues such as smoking, obesity and a lack of physical exercise were referred to as "health inequalities" along with references to people needing to "take personal responsibility for their own health". With further discussion most participants acknowledged that a general feeling of a "lack of control" and motivation make it difficult for people to take personal responsibility. There were no references made at any of the workshops to an evidence base for action to tackle health inequalities

Feelings:

The most commonly expressed feelings from all participants were of frustration, being unrecognised and undervalued, feeling dis-incentivised, demoralised and overwhelmed. Each individual discipline felt that that other disciplines within the Primary Care "family" did not recognise, understand or value their role. Each professional was also very clear that they feel very committed and passionate about their roles and still "love the job"

Crisis management

This issue was experienced and raised by every participant and was seen as having far reaching consequences for individuals, their respective discipline, the Health and Social Care system and most importantly the people they are all trying to treat and support. It was commonly referred to as "firefighting" at all workshops. A lack of resource and time to deal with complex issues appropriately was the most commonly cited reason for the current work practice of crisis management. The consequences of this are clearly referenced in the remaining core topics articulated by participants.

Being a central point of contact / gateway to the NHS

This was recognised as an essential role for all involved, but manifests in different ways for each discipline. For example, GP's and Community Pharmacists require no referral process, whereas Social Work and District Nursing both require referral (including self-referral).

Relationships

The building and maintaining of relationships with people/patients was acknowledged and cited by all as key and critical to their role as Primary Care Health Professionals. It was reiterated that increasingly the provision of time for proper conversation and relationship building with the person / patient is very limited due to the crisis management issue.

Tacit[11] / soft knowledge

There were frequent references made to the vast amount of information and knowledge about individuals and their lives, held by each discipline that is mostly unrecorded, not used or shared with anyone else. Some referred to it as "soft information". CDHN introduced the term "tacit knowledge" as a descriptor. It refers to the "extra" information gathered about people, most of which relates to their childhood, background, extended family, etc. that may not be of direct relevance to the issue they present with, but provides important contextual information to the health provider. Interestingly, some Social Workers referred to the lack of opportunity to record or share that information as "depersonalisation ".

Recruitment

This was an issue for all participants but to varying degrees. Getting permanent posts replaced is an issue for all but can take up to a year within a social work context, which seems to have become an accepted timescale. This has an effect on workload and continuity, as posts either remain vacant or have to be backfilled by existing team members, or they are filled by agency staff on a temporary basis.

Signposting

Signposting emerged as key role for all the disciplines; however they all articulated their struggle to incorporate it as a core and consistent element of their respective jobs due to time constraints.

[11] Tacit knowledge is sometimes referred to as know-how (Brown & Duguid 1998) and refers to intuitive, hard to define knowledge that is largely experience based. Because of this, tacit knowledge is often context dependent and personal in nature. It is hard to communicate and deeply rooted in action, commitment, and involvement (Nonaka 1994). Source: www.knowledge-management-tools.net

Specific issues identified at insight gathering workshops

Each workshop also highlighted specific issues or themes for each of the Primary Care Health Professionals Disciplines. These are summarised below:

GP's:

The group of GPs frequently referred to "a culture of expectation" that has emerged in society. This refers to the scenario where people present to the GP with a problem (often not medical) that they have an expectation the GP will or should be able to "fix". This was seen as placing an undue burden and stress on the "system" as the issues affecting people is outside of the remit of GP's and may be outside of the remit of the Health and Social Care system (some examples given were loss of a job, impact of poor housing, poor employment options).

Following on from this the GP's highlighted their struggle to put a collaborative / multi agency approach into action, specifically in relation to issues that are not medical at their core.

This quote from one of the participants illustrates this issue:

"The overwhelming thing is the hopelessness, the sadness and the lack of motivation and we aren't the answer to that problem"

Community Pharmacy:

There were many issues highlighted that are specific to Community Pharmacy, the most pressing of which s their contractual arrangement which remains unresolved with the Department of Health. As a result, Community Pharmacists are operating under interim funding arrangements and whilst the release of the transformation funds in recent months have led to the announcement of a new Pharmacy First scheme[12] alongside other initiatives, many Community pharmacists feel the underlying contract and funding issues have yet to be resolved satisfactorily.

The role of Community Pharmacy in rural areas was also highlighted with some expressing their view that in these areas, especially where there is no immediate or easy access to a GP surgery, Community pharmacy carries out a "triage role". This mean Pharmacists are assessing people presenting with a range of complex medical issues and arranging for their treatment, often in a secondary care setting. This has obvious implications for the profession in terms of workload and remit.

It was highlighted that Community Pharmacy are also dealing with a range of non-medical issues, often providing counselling and other therapeutic services as "add on" or" extra" services for their community. They are frequently in the position of having to offer support and advice to people with serious mental health issues, yet developing skills in this area this does not appear to be part of their core professional development.

This quote from one of the participants illustrates the point:

"**There are huge mental health problems….we try to refer people on because if you don't catch them in that moment you have lost them and we are not equipped to cope".**

[12] https://www.chemistanddruggist.co.uk/news/2m-minor-ailments-scheme-northern-irish-pharmacy-contract

Social Workers:

There were a high number of issues identified specifically relating to social workers, many of which focused on the implications of a very bureaucratic and "administrative heavy" system. All who participated highlighted the significant issues that the current Human resources processes pose, specifically in relation to the recruitment of staff (as identified in the previous section).

The social Workers who participated highlighted the absence of administrative support and the increase in mandatory paperwork completion. They made a connection between this and a perceived reduction the amount of time they spend in face to face contact with clients.

All those who participated said they felt that whilst the strategic and policy direction for social work "says all the right things", there is a disconnect between that and the practice on the ground which is focused on crisis management. There was a feeling of disillusionment that no clear channel to challenge this seems to exist.

This quote from one of the participants illustrates the point:

"I think social work should be concentrating on the bigger things – injustices, we have maybe individualised the problem too much whereas we should be looking at the bigger issues"

District Nursing:

The participants in this workshop highlighted the need to acknowledge the different levels that community nursing services operate at - e.g. District Nursing and Acute Care at Home teams which are funded differently and provide different services. As a result patient experience and expectation can be affected; this can cause tensions for District Nurses who have to deal with them.

This group also referenced administrative burden of paperwork which in their view has meant their clinical role is suffering. They voiced similar issues to Social Worker's in terms of a lack of career progression opportunities and the effect this has on morale at times.

They articulated the value they can see of engaging with community groups and organisations for additional signposting and support but cannot pursue this due to time constraints

In common with the GP's they talked about talked about the "culture of expectation" they have observed and recognised that this is a complex issue and there are lots of reason why it has emerged e.g. The fact that we are a region emerging from "the Troubles and its effects "

This was the only group to specifically reference the impact of having no government. They stated that they feel they have progressed with the transformation agenda as set out by Bengoa[13] which has resulted in additional work / service provision but no additional money as yet.

This quote illustrates the point:

"On the ground staff are feeling overwhelmed. One person has to wear so many hats and be specialist in so many roles…..social work, occupational therapy, we overlap into so much"

[13] https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report

Design lab workshop summary

Additional insight gathering summary:

Following the summary provided by CDHN of the core themes and specific issues identified from the individual workshops, participants were given the opportunity to discuss and share additional insights. The following is a summary of the main additional insights gathered:

The group share their experiences of having to focus on small changes with individuals because there is no route to be part of making bigger systemic change. This provided a very helpful insight into some of the reason why some Primary Care health Professionals tend to focus more on individual behaviour change

"If all I can do is help a person in a small way to make a small change its better than nothing".

There was recognition, however that ideally, health professionals would have the opportunity to do both – support individuals **and** bring about societal change. This part of the discussion revealed however that there is an overwhelming sense of disempowerment. The participants in this process could see no way to challenge the blocks in the system to progress new ways of thinking and working – for individual disciplines or as a multi-disciplinary collective.

"We don't feel empowered to deliver change"

We also unpicked the issue of communities being without purpose and motivation and what might fuel that – benefits system, low expectations, no sense of focus or purpose, low levels of resilience and coping etc. were identified as possible and probable reasons.

Framing the challenge:

It was acknowledge that the process to date had highlighted a number of quite complex issues for Primary Care Health Professionals, and that the most useful thing to do would be select two main challenges for the ideas generation session. Based on the workshop insights feedback by CDHN and the additional insights generated by the previous discussion, the following two challenges were agreed:

1. How might we collaborate to develop new ways to share our collective knowledge?

2. How might we empower ourselves to drive the change that is needed?

The first challenge was devised in recognition of the "tacit / soft knowledge" issue. The second, in recognition of the lack of power and control felt and expressed by participants.

Ideas generation:

The final stage of the process was an ideas generation session with two small groups. Each group was assigned a challenge and had to come up with as many ideas as possible initially, eventually filtering through to a few practical ideas that could be possibly implemented.

The ideas:

1. How might we collaborate to develop new ways to share our collective knowledge?

The underpinning view was that in order for collective knowledge to be shared, relationships of trust must be developed between Primary Health Care Professionals, both in an individual and multi-disciplinary sense:

- Create a platform for Primary Care Health professionals to come together and share knowledge and provide peer support
  - In individual disciplines
  - In multi-disciplinary groups
  - With clear and articulated outcomes / benefits for both the health professionals and people / patients
- Secure "buy in" from senior management and leaders to ensure there is dedicated time set aside for this peer learning and sharing that is protected and forms part of KPI's and other targets
- Pilot this approach in a small number of areas
- Secure buy in from senior management and leaders to ensure there is dedicated time set aside for Primary Care Health Professionals to build and maintain relationships with groups and organisations and to create asset maps of local communities outside of the Health and Social Care sector
- A mechanism must be created for Multi-Disciplinary groups to express and share their views on individual and strategic issues relating to health inequalities and their role in tackling them.

2. How might we empower ourselves to drive the change that is needed?

The underpinning view was that it is essential for Primary Care Health Professionals to be able to learn from the experiences of those they support " get into the shoes of the people you support", and have somewhere for that information to go. This generated ideas broadly similar to challenge 1

- Identify and support potential leaders and others interested in the issue of health inequalities and systemic change
- Invest in the development of communication channels / platform for both health professionals and users of services to be able to better understand each other's perspectives and priorities
- Create opportunities to join forces within individual disciplines and across them, in order to share experiences, practice and learning
- Ensure these opportunities for sharing have purpose and make use of technology such as "Zoom" to facilitate participation
- Facilitate local Primary Care Health Professionals to understand and connect with their peers in Primary Care and other service provision areas.

Conclusion

The Knowledge Exchange Programme was designed to facilitate an exchange of experience and views relating to the role of Primary Care Health Professionals in tackling health inequalities in Northern Ireland using design thinking methodologies.

The Process

The process of facilitating individual workshops with each discipline allowed them to express honest views and experiences of their role in a Primary Care context. It also provided CDHN with useful insights regarding their understanding of the core topic (health inequalities), their understanding of the role of other Primary Care Health Professionals, and the pressure points affecting their particular discipline.

The Design Thinking workshop provided an opportunity for participants to meet their peers and colleagues. Many commented on the day that there are normally no opportunities provided to them to meet in that context, i.e. to share experiences and practice and to be solution focused. (The GP's and Community Pharmacists commented that the Integrated Care Partnership Structure provides some space for sharing of data, but not in the same context).

The workshop also facilitated an introduction to design thinking methodologies which all participants found to be extremely useful. The facilitator did highlight that this was only a "taster" of the methodology as we unable to implement the full design thinking cycle, due to time constraints. All participants indicated a willingness to be involved in further design thinking workshops, should the opportunity arise.

Core issues:

Clearly there are a number of core issues which have been identified as a result of this process, many of which do not facilitate Primary Care Health Professionals to understand or tackle health inequalities in a meaningful, consistent or strategic way.

There is no clear route for Primary Care Health Professionals to avail of support or training to enhance their understanding of health inequalities and the evidence base for tackling them. This includes training on specific issues such as promoting positive mental health and suicide prevention.

There are no mechanisms for Primary Health Care Professionals to meet in their individual disciplines or on a multi-disciplinary basis, limiting their opportunities for peer support and sharing of collective knowledge.

Equally, there are no clear and consistent mechanisms for their individual and collective knowledge about the consequences of inequality, as experienced by them and the people they support, to be used in influencing or changing policy and service design and delivery. This has led to a feeling of disempowerment and frustration amongst those who took part in this process.

Clearly there are also systemic issues which must be addressed at Department of Health level. These include the serious resource, bureaucracy and human resource issues identified by all participants, which hamper their abilities to complete the core tasks of their jobs. This has compounded the feeling of disempowerment.

In spite of all of the challenges this process identified, the passion, commitment and “love for the job” was evident from all who participated in this process. This was a group who were very honest and willing to share their experiences. They were equally open to challenge and to creative thinking. This process has demonstrated that the design thinking methodology provides a huge opportunity for Primary Health Care, and other parts of the Health and Social Care system, to further understand and develop creative solutions to very complex social issues.

Whilst this Knowledge Exchange Programme has now come to an end, CDHN are keen to ensure it is only the beginning of a new process of dialogue and critical thinking. We will share this working report with a number of key decisions makers and influencers and will seek to continue our collective design thinking journey.

Appendix 1:

Design Thinking guidelines to conducting insight gathering/ interviews

24/09/2018

G.P

Anna is a woman in her middle years. She is overweight and walking with a bit of a limp. She tells the GP that her leg is causing her pain.

Social Worker

Anna is the primary carer for her mother who is in the early stages of dementia. Her mother lives a few streets away. Anna is feeling pressured in maintaining that role.

District Worker/ Health Care Worker

Anna's daughter, 17, lives with her and has just had a baby. The house in now cramped. Her 14 year old son also lives there.

Pharmacist

Anna has been self-medicating with over the counter medication from her local pharmacy for the last three months.

Open questions for health care professionals

Introduction: Will use open questions to find out what it's like to be you. Really interested in understanding your experience etc.

1) What is your understanding of health inequalities in Northern Ireland?
2) Talk me through how the appointment process with Anna would work . What do you do before she comes into the room, and what do you do when the appointment is over.
3) How do you give consideration to all the other things going on in Anna's life and how they might impact on her health?
4) How Might You as a GP fully understand the health inequality as experienced by your patients?
5) How Might You addresses & reduce the health inequalities in the community you serve?

Why what's stopping you?

How do you feel about ……..

What needs to be done to …….

Tell me about what it's like ……..

Appendix 2:

Issues for Gp's

Main feelings – frustration, depressing, unappreciated, undervalued, committed, interested, understanding

Understanding of Inequality:

- Seeing the impact of poverty, unemployment addiction and unhealthy behaviours
- Student population – not counted in terms of service planning for services are not sufficient
- Houses of multiple occupancy and families with lots of issues including finances
- Outside of what you as a Gp feel you can do
- Patient expectations have changed / entitlement culture – it's your(GP) job to fix me
- Unrealistic expectations - and more so within middle to upper classes – Not necessarily among working class
- Sense of purpose and control is very important otherwise people will feel what's the point
- Without a funded GP service there would be greater social inequalities

Other key points

Role of income

- Recognition that money "buys you health"
- Role of private healthcare
- An "anathema"

Consultation process

- Gp's have important role to play in introducing idea of making change
- Important signposting role
- Limited in a 10-minute consultation – rarely get to the core issues
- Lots of judgment calls made in a very short space of time – is the issue they have come in with the core issue?
- Often impossible to find out in one consultation #
- It's important to deal with what is important to the patient
- Some awareness of the need to deal with issues in a context, e.g. weight and bereavement

Relationships and continuity

- Continuity is important – GPs have the opportunity to build relationships over years
- Gp's often underestimate how much people trust their judgement
- The therapeutic role GPS play is very important
- People feel they must go to the Dr to solve social issues

Tacit / soft knowledge

- GPs hold a lot of tacit (soft) knowledge about people's lives - "we know more about them than almost any other health professional"
- That knowledge is not recorded or shared in any way

- That tacit / soft knowledge is not recognised or appreciated by other parts of the system – the time to build relationships and trust
- ICPs are the only platform for the use of that knowledge to plan and deliver services
- ICPs are providing an avenue to raise issues such as frailty and SP and do something about it
- Always easier to focus on qualitative, measurable data

Solutions

- Ideally all services should be able to share data and knowledge about people – e.g. GP, police, ambulance etc
- Multi agency approaches and solutions might help
- Gp's have a role to play in preventing illness
- Social prescribing is one of the ways forward for society – GPs have a role to play
- Gp's want to contribute to solutions that are not medical – that are social, environmental etc
- Can see how different approaches work better – e.g. supporting families to come up solutions for themselves
- Can see that they have a role in identifying wider issues such as transport etc and how that can be barrier to accessing the right services
- Need more support with finding the right course of action once the core problem has been identified

Tensions

- Gp's feel very undervalued in the HSC system, frustrated and unappreciated by other professionals
- Tension between regional policies and what will work locally
- Big part of Gp's role is to manage uncertainty and risk

Issues for Pharmacists

Main feelings: frustrated, unrecognised, undervalued, depressed, pressured, committed, determined

Understanding of inequality

- Life expectancy, Poverty, Lifestyle
- Socio economic status of someone can make a big difference to their health outcomes
- Mental health
- Where you live
- Access to services and transport
- Also recognise the role of private healthcare
- The wealthier you are the more you can afford to be seen privately and skip waiting lists
- Funding issue for community pharmacy isn't helping inequalities, in fact it may be contributing to making it worse

Access to GP services

- Massive problem for rural areas
- Dungannon – no new GP registrations
- West – issues travelling to GP – if no access to car and can't afford taxis
- Issue of waiting for an appointment – up to three weeks
- Issue of 1 appointment 1 in Gp's – pharmacy picks up the rest

Added value provided by Pharmacy

- Act almost like triage
- People attend pharmacy instead of GP or A and E sometimes inappropriately
- Provide counselling services, although not contracted to do so
- Referrals and signposting – proactively contacting other support organisations who can contact the patient directly, rather than leaving it with the patient to do
- Referrals for mental health issues – although this is very difficult as pharmacy have problems directly referring in
- "feel like I'm a counsellor, a social worker, a pharmacist all in one "

Issues with added value

- not part of core contact
- not measured or evaluated
- not remunerated or resourced adequately
- pharmacists are having to give their time voluntarily to ensure the patient get the right care – e.g. pharmacists involved in setting up voluntary organisation to provide counselling to avoid waiting lists
- tension between the policy drive for using pharmacy first and the fact that it isn't resourced
- "dump left" – transformation – but no money for it

- Feel there is much more that pharmacy could be doing but to needs to be resourced at some level
- Also require training as pharmacists are provide support that they are not trained or equipped to deliver
- No recognition of the services provided
- Providing a good service is very difficult when it isn't resourced – insurance issue emerge re equipment etc.
- In relation to referrals and signposting – it is left up to the patient to feedback – no formal mechanism with other services
- "Underused as a community in the grand scheme of primary care"

Contract Issues (all linked to the section above)

- Contact issues for over 11 years – no proper contract in place
- Current contact does not account for additional services or resource them adequately
- As independent contractor HSC have no duty of care to staff

Time constraints and resourcing

- Can see potential for much broader role but no time or resource
- Staffing issues lead to patient safety issues
- Problems recruiting pharmacists and locum cover
- Issues recruiting and retaining g counter staff due to low pay
- Not getting enough time to do core job properly
- Having to ask people to pay for services (e.g. pill packs) disadvantages those who are already disadvantaged
- adherence pharmacists are being employed when community pharmacy should be delivering that service but are unable because there is no resource or time

Lobbying and advocacy

- See a role in relation to raising the profile of pharmacy as a vital service
- Feel less visible that GPs and less values
- Lobbying to secure contract
- Ideally some forum where knowledge about patients could be shared and used to inform support

Relationships:

- Relationships are core to pharmacy
- Trust is built over period
- Allows you to begin to address complex issues such as addiction to prescription meds
- Good way to uncover root causes and help with them
- Becoming harder to do because of time constraints
- Also, harder to do as part of a generic brief intervention

- Some examples of good ways to engage: MUR's and BCPP – provide a platform for discussion about wider issues
- BCPP seen as a mechanism for creating more equal and lasting relationships – "BCPP is a wonderful way of connecting with people and getting on a level, opening up that exchange of views and supporting change"
- People talk to the pharmacist about things they won't talk to the GP about

Issues for social workers

Main feelings: frustrating, demoralising, tensions, disincentivised, heart-breaking, love the job, committed, passionate,

Understanding of inequalities:

- Social economic deprivation
- Structural inequalities
- Poverty, employment, housing all important
- Inevitability of ill health in deprived area "my father died of cancer, so will I"
- Money can buy treatment
- People are the experts in their own health and wellbeing
- Culture of acceptance that if you live in poverty you won't live long
- Overwhelming – where do you start

Main issues

Crisis management

- "I think social work should be concentrating on the bigger things – injustices, we have maybe individualised the problem too much whereas we should be looking at the bigger issues
- No time to look at bigger issues
- Overwhelmed by crisis
- No resource or time to do preventative work
- Becoming reliant on community organisations to do early intervention work
- Disconnect between policy and practice – strategic solutions that don't match what will work locally
- Starting at a very low level "wading through faeces and urine"

Hr and recruitment

- Significant HR issues relating to recruitment and retention of staff
- Huge difficulties in replacing practices social workers (6 months to 1 year to replace)
- Massive impact on workload and crisis management
- Outsourcing of HR to BSP has created additional layer of bureaucracy
- Inconsistencies between teams in Trust areas, and between Trust areras in Hr practices

Relationship building

- in key worker allocations – change regularly
- huge impact on client- you build up relationship then workers changes, valuable information is lost
- spend a lot of tiem building up a case and advocating for peole
- no space to advocate for groups of peole, only individuals
- no time to engage with the local community, third sector

Need for time for critical reflection:

- no time to analyse bigger case load
- no time to share or discuss practice
- use supervision for this

Need for practical support

- need to see return of the home help service that is properly valued and remunerated working in smaller local areas
- inconsistencies in service provision – e.g. older peoples service get cleaning, shopping service etc
- been a big shift away from practical support – seen as "creating a dependency"

Bureaucracy

- there are blocks in the system at DoH AND Board level –
- it's become a very top down system
- role of private providers is an issue – absorbing a lot of financial resource
- 80-90% of time is spent filing out form
- Often only spend 1 -2 hours a week face to face with a client
- Paperwork is a disincentive to create referrals
-

Challenge function

- SW do see it as their job to challenge the system
- "frustrating and tension filled working environment"
- Feel supported by immediate managers
- Everyone agrees that SW should be more proactive and preventative

Screening and Signposting role

- Screening to try and get a good fit – lots of people outside of criteria for other teams – all have their own specific criteria
- No generic social work teams now – people can fall through gaps
- Method for taking referrals are different across teams and trusts – some manage their own, others call centres
- Do lots of signposting to benefits, counselling, GP, housing etc

Information sharing

- Huge amount of information gathered. Could be as much as 70 pieces of paper for one complete assessment
- Huge amount of tacit knowledge that is not recorded and often not shared – not enough time / not seen a s relevant
- Opportunities to share recorded information with other health professionals if permission is granted
- Inconsistencies in how information is recorded – some computerised, some paper based
- Fear that SW will end up being deskilled because they are not getting the face to face time with the client

Issues for District Nurses:

Main feelings:

Overwhelmed, frustrated, unrecognised, undervalued, standard of care is exceptionally high, but dedicated, committed

Understanding of inequalities:

- Inequality generated by where you live
- Access to services, education - important factors
- Inequalities caused by disease or illness or age – access to services impacts
- Social isolation
- People are less "compliant" with treatment programmes and more resistant to authority
- Housing stock – damp and poor insulation
- Role of food poverty, access to fresh fruit and veg etc.

Main issues

Crisis management

- Huge demand for services but not enough staff to cope
- Natural carers are not at home anymore, i.e. Family
- Centralisation of service means people have to travel, but don't necessarily have access to transport so the District Nurse has to visit at home
- A lot of what is done is reactive, not proactive – its fire fighting
- Dealing with the "culture of expectation" – puts a lot of pressure on the system – can be attributed to lots of issues, "I paid my tax so I'm entitled" and also the legacy of the troubles.

Hr and recruitment

- Staff are underpaid in relation to the rest of GB
- This impacts on recruitment and retention
- Issues regarding career progressions – have to go into specialisms
- This leads to experienced staff being lost to more specialist roles

Underinvestment

- Lack of recognition for the many specialist roles carried out by District Nurses
- Underinvestment in District Nursing role - cheaper equipment, no new funding for extra staff or support; "perception of being the poor relative"
- Tensions between District Nursing and other community based nursing models, e.g. Acute Care at home – due to different roles, levels of investment and expectations on behalf of the patient (i.e. why can the District Nurses not do all that the Acute Care at home team can, e.g. collect prescriptions etc.)

Relationship building

- District Nursing involvement in a family can be catalyst for other forms of support and referral
- Less and less time for building and maintaining these relationships
- Very natural part of a District Nurses role to go into a house, make a cup of tea and build trust
- You don't treat the person in isolation – you think about the whole family and everything else that's going on

Bureaucracy

Paper work to be completed causes huge capacity issues – time and resource

Challenge function

- Somewhat limited as you can't stop providing the service, so no leverage as such
- District Nursing Framework try to address challenges regionally

Screening and Signposting role

- Clear signposting role – especially for other family members who are not the primary client
- Frustrating not to be able to do anything other than give information and advice
- Wider health promoting activity is not always recognised
- Signpost and make referrals to benefits advisors for e.g.
- Strategically it is recognised that District Nurses should engage with the wider community infrastructure, but they don't have time in practice

Information sharing

- Some opportunities for better information sharing through the development of integrated team