The role of primary care in tackling the social determinants of health

Ideas for action – a framework and case studies

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Primary care in England - context

- **GP practices in England:**
  - In January 2024, there were approximately 37,000 full time equivalent GPs in England, 17,000 nurses, 17,000 direct patient care staff, and 75,000 administrative / non-clinical staff.
  - They work across just over 6,500 GP practices.
- **Primary Care Networks:**
  - Since 2019, individual GP practices have come together into geographically-based 'Primary Care Networks' (PCNs), each covering a population of 30,000 to 50,000 people.
  - While GP practices remain independent, PCNs provide integration and co-ordination, and deliver 7 national service specifications in return for additional funding from NHSE.
- **An expanded workforce:**
  - More than 36,000 additional 'direct patient care' staff were working in primary care at the end of 2023, compared to March 2019.
  - This is mainly due to the 'additional roles reimbursement scheme' which provides funding for 17 new roles within multidisciplinary teams, such as clinical pharmacists, social prescribing link workers, health and wellbeing coaches, care co-ordinators, physiotherapists, occupational therapists, and dieticians.

Summary

- Primary care plays a vital role in improving the health of the population, and reducing inequalities in health outcomes.
- As well as their primary contribution of delivering healthcare, primary care staff and organisations can play a role in tackling the Social Determinants of Health (SDOH), including early years development, education and training, employment, housing, social isolation, poverty and others.
- Primary care staff know and understand the holistic needs and assets of local populations, and are often highly invested in providing support on a wide range of issues, including non-medical, SDOH-related needs.
- This presentation provides some ideas for action, in the form of a framework and case studies. The ideas presented here are not based on systematic research, but operate as a resource for those interested in the role of primary care in tackling SDOH. The aim is to provide inspiration and information.
- The potential 'domains for action' suggested within this presentation fit into 4 themes. Each theme has 2 or 3 domains for action, shown on the following slide.
- Other frameworks and guidance can also help to inform primary care action, such as this Health Foundation Framework for NHS action on SDOH, which provided a basis for the framework on the following slide.

The World Health Organisation defines primary health care as - *"a whole-of-society approach to health and well-being centred on the needs and preferences of individuals, families and communities. It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental and social health"*

Primary Care's role in Tackling the Social Determinants of Health – Framework

THEMES	Pre-conditions for action	Individual patient actions	Connecting to wider support	Community and collaboration
DOMAINS FOR ACTION	Tackle inequalities in access	Identify patient's SDOH needs	Refer patients to SDOH support	Act as an anchor institution
	Provide SDOH education and training	Adapt treatment based on SDOH factors	Co-locate with SDOH services	Build place or topic-based partnerships
		Directly deliver SDOH interventions		

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1. Tackle inequalities in access

The Health Foundation state that:

"Some demographic groups have worse access than others. Health needs and consultation rates are higher in more socioeconomically deprived areas, but general practice in these areas is underfunded and under-doctored relative to need.

Disabled people, carers, people from Bangladeshi and Pakistani ethnicities, people from socioeconomically deprived areas and people who identify as LGBTQI+ all report worse overall experience of accessing general practice.

Patients in deprived areas tend to spend less time in GP consultations, and have seen a bigger increase in remote appointments (and decrease in face-to-face appointments)."

While increasing equity in primary care access is not a SDOH intervention itself, it can help to ensure other activity described in this framework has a positive impact on equity.

Specific actions include:

- Conducting outreach and supportive activities to encourage specific groups of patients (for example, refugees and asylum seekers) to register at GP practices.
- Advocating or campaigning at a national level for a more equitable funding formula for primary care.

Case study - Patients not passports

'Patients not passports' is a toolkit – i.e a set of resources, campaigns and activities - developed by Docs not Cops, Medact, and Migrants Organise. The aim is to support health workers and community members "*in advocating for people facing charges for NHS care, and in taking action to end immigration checks and upfront charging in the NHS."*

The toolkit includes information for healthcare workers (including those in primary care) on how to support individual patients, a step-by-step advocacy guide, and suggested actions healthcare workers can take in a wider context (e.g. policy advocacy).

Source: Patients not Passports

2. Provide SDOH education and training

In order to feel confident, skilled and knowledgeable in acting on the SDOH, medical and other primary care staff should be taught about the SDOH, their links to health outcomes, and potential actions that can be taken within the primary care context.

This teaching can take place in medical school, specialty training, non-medical training and education, and throughout professional practice via CPD.

There may also be opportunities for more formal 'joint' training – for example, the Faculty of Public Health and the General Medical Council have recently accredited dual GP and Public Health training.

Ongoing training and education can also take place via more informal networks, as described in the case study here.

Case Study - 'Deep End' virtual community for health equity in London

The London Deep End Health Equity community is an 'innovative digital intervention' to create a 'vibrant interdisciplinary network of learning and health activism'.

The group was initially set up by GPs in 2020 in response to the health equity impacts of Covid-19, with the purpose of "trying to reduce the impact of longstanding health inequity, racism, and social exclusion, to address climate change and to promote fairer systems and healthier places to live and work." It now has over 200 members including a range of health professionals, academics, and those working in VCSE organisations.

The community shares ideas and information on WhatsApp, organises workshops, events (including 6 virtual or hybrid 'Health Equity Festivals', and quality improvement initiatives. Some projects started or enhanced by the network include:

- Undergraduate medical education modules created at Queen Mary University of London and Imperial College London that focus on health equity
- 'Hospitals without walls' – a trauma surgeon who is a member of the group has introduced an initiative to support victims of trauma (particularly gang-related violence) post-discharge, to reduce readmission.
- 'Health Equity Fellowships' funded by the North East London ICS, enable GPs to attend Deep End workshops and take part in supported quality improvement work

Sources: https://bjgplife.com/creating-a-deep-end-virtual-community-for-health-equity-in-london-collaboration-through-connection/ and https://www.fairhealth.org.uk/deep-end-london

3. Identify patient's SDOH needs

Sometimes referred to as 'screening', primary care offers an important opportunity to identify patients' SDOH-related needs.

Understanding and capturing information on social determinants such as housing (security, quality, affordability, etc.), employment, income, social isolation and other issues can help primary care to understand and respond to the SDOH in their population. Capturing this information is also important to facilitate the other domains of action in this framework, particularly the other individual patients actions, and connecting to wider sources of support.

Specific actions include:

- Sharing small area population-level information on the SDOH with primary care staff (for example, area-level deprivation measures).
- Gathering additional patient-level information on the SDOH – for example, primary care staff asking patients if they have trouble making ends meet at the end of the month.
- Including automatic 'alerts' within the electronic patient record or other IT systems to remind practitioners to ask about or discuss SDOH – for example, asking about cold or damp homes or exposure to air pollution for patients with asthma.
- Including integrated systems for recording information about SDOH within the patient record, so that the information gathered is coded and can be analysed, rather than just entered as 'free text'.

Case study - Leeds GP confederation – health inequalities template in the clinical system

Linked to the work in Leeds to become a 'Marmot City', a GP in Leeds is integrating information and alerts on health inequalities into the primary care clinical system

4. Adapt treatment based on SDOH factors

To ensure that all patients are equally able to benefit from primary care treatment, it may be necessary to apply a ‘SDOH lens’ and adapt either how or what treatment is provided, depending on the patient or community’s SDOH-related needs.

Individual actions include:

- Changing *how* care is delivered – for example, not scheduling appointments during working hours if a patient has an insecure job that would not pay them for the hours missed.
- Changing *what* care is delivered – for example, considering if there is an alternative to medication that needs to be refrigerated, if a patient is homeless.
- Changing *when* care is delivered – for example, providing extended consultations for patients with more complex or higher SDOH needs.

5. Directly deliver SDOH interventions

Once primary care staff have identified a SDOH-related need, it may then be possible for them to provide an intervention themselves, as well as (or instead of) referring to further services (see domain 6).

While the specific interventions delivered will depend on local population need and primary care resource, staffing and skills, some examples include:

- Advocating for individual patients, for example by writing a letter setting to a housing provider setting out how their housing conditions are negatively impacting on their health.
- Directly employing staff to offer support or advice, for example, on finance and benefits (see case study).

Case Study - Deep End advice worker project

The Scottish Deep End Project is a collection of GPs working in practices serving the 100 most deprived populations in Scotland. The project has involved a range of activities, including bringing primary care staff together to learn from and support each other, and testing, evaluating and rolling out specific interventions including outreach nurses, training schemes, and community link workers.

Source: The Scottish Deep End Project, the University of Glasgow

In 2017, a study was conducted of the Deep End Advice Worker Project, which directly employed and embedded an advice worker in GP settings, to provide support to patients on finance, debt, social security and housing issues.

The study found that for the 165 people who engaged with the service from December 2015 to May 2017, almost £850,000 was gained through income maximisation work, and over £150,000 of debt was identified and managed. Approximately half those accessing the service were also referred on to additional support.

Source: The deep end advice worker project: embedding an advice worker in general practice settings. Sinclair, J.

Based in part on the Deep End project, in 2021 The Scottish Government announced over £3m funding for dedicated welfare rights advisors, embedded in 150 GP surgeries in deprived areas.

Source: Welfare advice and health partnerships, Scottish Government.

6. Refer patients to SDOH support

Alongside or instead of directly providing support to patients, many GP practices refer people to external sources of advice or support.

Probably the most common mechanism for this referral is through social prescribing link workers, employed as part of the 'additional roles reimbursement scheme'. While social prescribing can serve an important SDOH-related function, this likely requires a deliberate and explicit focus, to ensure that patients are not only referred to 'lifestyle' or health-related support such as exercise or diet interventions.

Specific actions include:

- Identifying a mechanism and structure by which primary care staff can easily and seamlessly refer patients to external sources of support.
- Ensure that 'link workers' or another mechanism for referral are integrated into the primary care practice and have access to relevant information about the referral.
- Build networks and connections between link workers and wider sources of support such as VCSE organisations operating locally.
- Focus referral pathways on SDOH rather than (or as well as) 'lifestyle' interventions.

Case study – AWARM (Affordable Warmth Access Referral Mechanism)

In 2008, AWARM was set up, a programme that allowed GPs to refer patients facing fuel poverty into further support.

AWARM is a single point of contact health and housing referral service, taking referrals from a range of partners, including GPs. AWARM staff carry out a 'Healthy Home Check' on people's homes, and then refers out to partners who can provide:

- Benefit entitlement checks
- Home repairs and improvements including draught proofing
- Advice on energy switching, fire safety and heating and insulation schemes.

In 2014, the Wigan AWARM scheme developed an additional approach to target support at residents with poor health outcomes associated with cold homes. Target residents were identified by combining data on deprivation, privately rented terraced accommodation, people over 65 receiving council tax reduction, and people over 65 who had a higher risk score of being admitted to hospital in winter.

20 hot spots were identified and AWARM then worked with GPs to select patients from their lists who had coronary heart disease, COPD or asthma.

Source: Wigan Council's Affordable Warmth Access Referral Mechanism (AWARM) – the original single-point-of-contact health and housing referral service for people living in cold homes, NICE

An evaluation of the wider programme across Greater Manchester found that:

"warm housing interventions in targeted populations are almost certainly cost effective and that they can be considered a good use of public resources. The benefits gained in the UK are likely to be mainly from comfort taking and a consequent improvement in mental wellbeing."

Source: 'Understanding the costs and benefits of fuel poverty interventions: A pragmatic economic evaluation from Greater Manchester', Greater Manchester Public Health Practice Unit.

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7. Co-locate with SDOH services

Locating SDOH-focussed services or activities in primary care spaces can help to tackle the SDOH, both by facilitating easy referral through more formal routes (see no. 6), and allowing patients to more easily access support without a formal referral (for example, by 'dropping in').

Specific activities include:

- Allowing or inviting SDOH-focussed activities or organisations to use primary care space at low cost or for free on a long-term basis.
- Developing new multi-use primary care services, or adapting existing spaces, where co-location is 'designed in' to the estate (i.e. primary care is one of a range of permanent services all available in one space).
- Identifying space for a range of local organisations to use on an ad hoc basis for outreach activities.

Case study – Liverpool Citizens Advice on Prescription

This service provides free welfare advice at all GP practices in Liverpool (as well as being based in mental health services and taking referrals from a wide range of partners including the fire service, pharmacies and the VCSE sector).

From 2018 – 2022, the service received around 50,000 referrals, of which a third were from the most deprived neighbourhoods and 70% were living in poverty.

"In 2018, welfare advice raised £4.2 million of income and helped reschedule or write off £1.8 million of primarily priority debts for the clients. The service also benefited local authorities, with data showing that welfare advice saved them £1.05 million."

Evaluation has shown that having the service located in GP practices was an important factor, meaning it could engage with those most in need, and facilitate better working relationships with healthcare staff.

Source: Liverpool Citizens Advice on Prescription, UCL Health Justice Partnerships.

8. Act as an anchor institution

The Health Anchors Learning Network defines anchor institutions are "organisations which are rooted in place and connected to their communities, such as universities, local authorities and hospitals".

UCLP states that Anchor Institutions *"have an opportunity and a responsibility to improve the health, wealth and wellbeing of their local population and reduce inequalities, in the way that they strategically and intentionally manage their resources and operations. By shifting and targeting the way they employ staff, procure goods and services, use their land and buildings, contribute to environmental sustainability, and work in partnership, anchors can have a positive impact on the social determinants of health."*

While much of the NHS focus on Anchor work has been on hospitals, due to their size and therefore potential for large-scale impact via hiring and procurement for example, there are opportunities for primary care (including PCNs) to adopt anchor principles and activities.

Specific activities include:

- Supporting local and/or target populations (for example, long term unemployed, people living in the most deprived wards, inclusion health groups, etc.) to access training and employment opportunities in primary care.
- Being a good employer – for example, by paying a living wage, tackling inequities in pay by gender, ethnicity, or other protected characteristics, and providing support for staff including with career progression.
- Work with local and/or target organisations (for example, small businesses or VCSE organisations) to access opportunities to provide their good or services to primary care.
- Use land and buildings for community benefit – for example, by allowing local community groups free use of primary care rooms or outside space when they are not otherwise being used.
- Reduce emissions – for example, by supporting active travel for staff and patients.

Case study – Primary Care Anchor Network

As part of the NHS London Anchor Network, a sub-network of London Primary Care Anchors has been set up, and have been engaged in a range of activities, including:

- Working with an employment service based in Islington local authority, to ensure the local community are aware of primary care roles and are supported with applying for jobs (for example, with interview preparation).
- Bromley by Bow Centre are employing and training local people with a learning disability in their on-site café.
- Working with The Health and Social Care Academy, which engages with young people coming out of school to encourage them to consider working in health and social care, and provides access to training and courses.

Source – 'Primary Care Anchor Network (PCAN) Promotional Video', BHR CEPN

Case study – Lambeth GP Food Coop

This project has created community gardens on the land of 8 GP practices in South London, with the aim of tackling social isolation, building confidence for patients, and bringing people together to grow food.

Food grown in the gardens is also sold back into the NHS (directly to staff and to hospital caterers), and GPs have reported that it has reduced the number of appointments patients need.

Source – Lambeth GP Food Coop, Health Anchors Learning Network.

9. Build place or topic-based partnerships

Finally, working in partnership with other organisations (both within and outside of health and social care) can help to increase understanding of and action on the SDOH.

Primary Care can be an important partner in these co-operative arrangements, bringing (for example):

- Data and understanding of local population need and assets
- A connection to individual community members
- An opportunity to provide space, staff, or other resources to support partnerships

These partnerships can be focussed on particular geographical areas, or on particular social determinants - for example, housing or early years development.

Specific actions can include:

- Sharing information, data, knowledge and understanding between partners
- Integrating services and aligning pathways
- Delivering joint interventions
- Sharing financial and other resources (e.g. staff time or buildings)

Case study – Healthier Fleetwood

"Fleetwood is an area of widespread social disadvantage and life expectancy is lower than the average for England. In 2016 local healthcare services in Fleetwood were struggling. There was a severe shortage in GPs, with the three GP practices missing half of their 16 GPs. This staffing crisis, and the need to address local health inequalities, prompted one local GP to reach out to local partners to establish a cooperative solution. It was agreed that mobilising partnerships and working collaboratively offered the best chance of success, so Healthier Fleetwood, a strong partnership of residents, healthcare providers, local government, housing organisations, the VCFSE sector and other groups, was established.

The GPs have moved from managing illnesses to helping people to preventing illnesses from developing. Healthier Fleetwood has had many successes in supporting positive changes in the town. Partners have listened to residents and worked to facilitate activities."

Source: 'A Hopeful Future: Equity and the Social Determinants of Health in Lancashire and Cumbria', UCL Institute of Health Equity

Fleetwood PCN has also focussed specifically on young people's mental health, using their ARRS funding to employ mental-health focussed roles, who then work in partnership with a local youth hub, running monthly sessions on self-esteem and managing stress, alongside wider support such as courses in English and Maths run by the local college.

In 10 months, 100 local young people used the youth hub service, 20 were helped back into employment and 20 into education.

Source: 'Working together to improve health in Fleetwood', NHSE