Acting on the social determinants of health to reduce health inequalities: innovative approaches by provider trusts

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UCLPartners

> *It's interesting isn't it, as health providers, we have always focused on the problems that present to us, rather than focusing on the causes that caused the problem in the first place... and a part of you thinks, what is our function as large statutory organisations, because if we continue to do the old thing, we will continue to get the same results...*

Contents

Foreword

People's life chances differ greatly depending on the level of deprivation of the area in which they live, their level of education, income, ethnicity, level of disability. The result is inequalities in health.

In several reports, my team at the UCL Institute of Health Equity (IHE) have brought together the evidence that demonstrates that social determinants of health are substantially responsible for these health inequalities. In *Fair Society Healthy Lives*, our 2010 Marmot Review, and again in our 2020 publication, *Health Equity in England: the Marmot Review 10 Years On*, we laid out six domains of recommendations. They start with giving every child the best start in life, through education, working conditions, income, housing and environment, and determinants of health-related behaviours.

Commonly, the reaction from health care providers is along the lines of: we are convinced, but what do you expect us to do; we deliver health care; social determinants of health call for major social changes, but we in health care are treating the sick. What can we do?

One of the principles set out in this learning report is "thinking big and starting small". The report lays out compelling examples from four provider trusts of tangible steps that illustrate this principle. The steps taken will reduce health inequalities for patients, staff and local communities. Implemented at scale, these steps to address social determinants of health will be important in building healthier societies – thinking big and starting small.

Each of the four trusts featured in this report have pursued innovative action on social determinants of health in their own way:

- Great Ormond Street Hospital are focussed on air quality and primarily on their patients, with a strong link to advocacy.
- Barts Health NHS Trust have harnessed their role as an employer to increase good quality work for the local population.
- Mid and South Essex NHS Foundation Trust have considered their role as an 'anchor institution' in the local area and their civic responsibility to local partners and the population.
- East London Foundation Trust have taken on my work, considering what actions they can take to embody the Marmot principles in their care delivery and how they function as a business.

Engaging healthcare institutions is an important contribution to local action for health equity as seen, for example, with Marmot Cities. Such local action does not let central government off the hook. We need policies from central government that address each of our domains of recommendation. But we need action at every level. What these trusts show is that they can be important actors on social determinants of health to achieve greater health equity. The examples contained in this report, and the lessons laid out will, I hope, be the inspiration for health care providers more widely to be more active in addressing the causes of the causes of health inequalities to the benefit of their patients, their communities and their society.

Professor Sir Michael Marmot CH, *Director, Institute of Health Equity – University College London*

Introduction

Health inequalities are, in large part, the product of inequalities in the conditions in which we are born, grow, live, work and age – the **Social Determinants of Health** (SDOH). This learning report focusses on innovative approaches taken by four provider trusts within the UCLPartners geography that are acting on the SDOH within their healthcare settings, and common lessons from their work.

UCLPartners

UCLPartners is a health innovation partnership, with a mission to help our population live longer and healthier lives. We cover a diverse population of five million people, living across North Central London, North East London, Mid and South Essex and spanning urban, rural and coastal geographies.

More than a third of the catchment are Londoners born outside the UK and nearly half identify as belonging to an ethnic minority. In partnership with our providers and through the Academic Health Science Network (AHSN), we aim to improve the lives of those living in some of the UK's most deprived boroughs, where adverse environmental and socioeconomic factors drive poor health.

The UCLPartners geography includes 17 provider trusts, a number of which are tackling the SDOH using innovative approaches.

This learning report

The trusts in this report were selected to represent a range of types of organisation (acute, specialist, mental health and community), trust size, and focus of their SDOH work. The work we have explored at Great Ormond Street Hospital (GOSH), for example, has focussed more on patients, whereas the Barts Health and Mid and South Essex NHS Foundation Trust (MSE) case studies are more focussed on staff and the local community as key populations. East London NHS Foundation Trust (ELFT) have developed a 'Marmot Trust' approach that crosses all these groups.

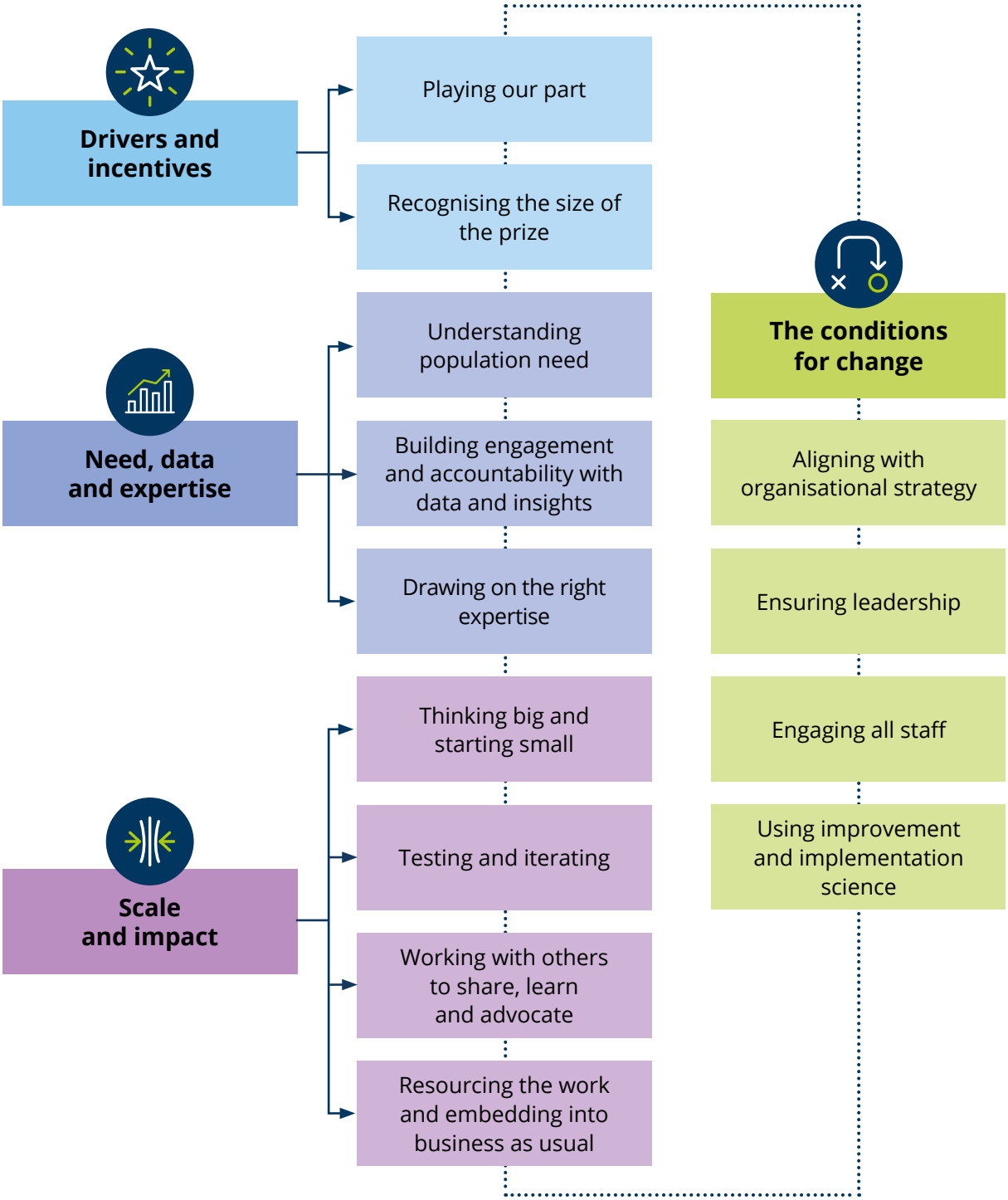
The featured trusts are also focussing on a range of different social determinants – including income, employment, education, and air quality. We refer to their approaches as 'SDOH work' although not all trusts use this terminology.

We have deliberately not focussed on activities to tackle inequalities in patient care – for example, projects seeking to improve equity of access to care or equity of patient experience. Instead, we focus on those addressing the wider structural, economic and environmental determinants of health through innovative approaches.

In addition to our four cases studies, we include 13 lessons, based on 22 interviews with those leading and implementing these approaches in these organisations. These aim to supplement the 'what' to do demonstrated by the case studies, by reflecting in more detail 'how' to implement SDOH work in a healthcare context, which is vitally important when introducing innovation and complex change.

Whilst this is not a comprehensive evidence review, we hope that this learning report will provide a helpful basis for other provider trusts keen to establish or build similar work, and demonstrate that there is a potential role for provider trusts to tackle health inequalities through action on the SDOH.

Figure 1: 13 lessons on adopting an innovative approach to tackling the social determinants of health



Background

It has been estimated that **medical care makes up a small contribution to our overall health outcomes**. Therefore, much of the responsibility and opportunity for action on the SDOH sits outside of healthcare. Despite this, there has been increasing recognition that healthcare systems and institutions can take important action to proactively improve health and reduce inequities. At a national policy level this was outlined in the 2014 **NHS Five Year Forward View**, the 2019 **NHS Long Term Plan** and the 2022 **Health and Care Act**. These recognise the role of the NHS in working with local community and institutional partners to plan and co-ordinate local services, improve population health, and address wider determinants.

Some, but not all of the trusts within this report, are tackling SDOH through the lens of '**Anchor Institution**' work, which refers to large, often public sector bodies that are 'anchored' in place, and have an opportunity and a responsibility to improve the health, wealth and wellbeing of their local population by focussing on employment, procurement, land and buildings, environmental sustainability, and partnership work.

There is also a clear overlap between action on the SDOH and an increasing focus on sustainability and decarbonisation within healthcare, including the '**Greener NHS**' agenda, which includes statutory obligations on NHS providers.

Case studies of social determinants of health action

Case studies of social determinants of health action

Barts Health NHS Trust: Increasing local employment

Background

Barts Health NHS Trust (Barts Health) is a group of four major hospital sites (The Royal London, St Bartholomew's, Whipps Cross and Newham) and community locations (including Mile End hospital). Barts Health employs over 18,000 people and delivers a wide range of clinical services, including local and specialist services.

Barts Health hospitals serve a population of approximately one million people in East London. In the three main boroughs in which Barts Health operates (Newham, Tower Hamlets and Waltham Forest), 60% of the population belong to an ethnic group other than White British (compared to 20% average nationally), two-thirds of local residents live in the most deprived 20% of neighbourhoods in England, and unemployment is double the national average.

SDOH work

Barts Health have established a range of innovative programmes to tackle the social determinant of employment, including activities focussed on young people and local residents, recognising that access to good quality work is a key determinant of better health.

Specific activities

'**Healthcare horizons**' is a widening participation scheme that has been running for four years, working with 37 local schools and colleges to support local young people into employment. The programme consists of two main components:

1. Raising career awareness in secondary school pupils by providing work experience, online information and support, online mentoring, and careers events in schools.
2. Providing pre-employment training through two pathways – one for administrative positions, and one for people with no or limited previous care experience to access healthcare support worker vacancies (New2Care).

'**Community works for health**' is a programme to provide better routes into entry-level NHS jobs, focussed on people living in Hackney and the City of London, Tower Hamlets, Waltham Forest, and Newham. Activities include:

- Hosting open days online or on site to give information on healthcare careers at Barts Health
- Inviting interested local people to take part in an assessment (numeracy and literacy level 1)
- For those that pass this assessment, one week training is offered, during which time, participants are supported with the application process including filling out the application form and the interview process
- If needed, some are offered a 6-week placement in the trust to gain experience
- Once the process is completed, they enter the talent pool as 'job ready candidates'

'**Barts Health Futures**' is a partnership between Barts Health and Newham College to provide a skills hub within Newham College, providing support to local people to secure employment in the NHS and upskilling those already employed. Activities include:

- Community outreach via open days, joint recruitment events, and workshops
- Supporting candidates referred by Barts Health who have applied for vacancies in the trust but have not been successful due to a lack of functional skills, communication skills, or other skills or knowledge gaps that the College could fill
- Providing online functional skills for existing Barts Health staff, to improve progression

Approach

Across these programmes, a key approach has been to change hiring systems or processes to provide opportunities to those who have received support. For example, each hospital in the Barts Health group has been asked to set aside a particular number of dedicated vacancies that could be filled from the 'Healthcare Horizons' talent pool. This target was based on skill mix and vacancy levels. Those who have completed the 'Community Works for Health' programme get priority access for one week to new Barts Health Band 2 and 3 vacancies (alongside internal advertising), and guaranteed interviews are provided for candidates who have completed healthcare programmes at the skills hub at Newham College or anyone who was referred by Barts Health for functional or communication skills courses.

Partnership has also been essential to the Barts Health approach. This includes close working with schools and colleges for 'Healthcare Horizons', with local authority employment teams for 'Community Works for Health', and joint delivery with Newham college for the skills hub.

Resources

All of the employment work at Barts Health, to varying degrees, has required external funding – for example, the Healthcare Horizons programme is primarily funded by the Barts Health Charity, with contribution from the Prince's Trust. In addition, Barts Health have dedicated significant internal staff resource – both at executive leadership and programme delivery levels – to supporting and implementing the work.

Impact

Barts Health are measuring the process and impact of their employment work, including on key metrics such as retention rates. Some specific measures from the work include the following:

- The Healthcare Horizons programme has engaged with over 3,000 students and over 500 have completed pre-employment training. 227 young people have progressed into employment and 303 into health-related degrees.
- For the youth employment work, the retention rate for new employees is over 90% at three months.
- As of 2022-23, Community Works for Health has trained 119 local candidates in pre-employment skills, arranged 60 work placements, and produced 88 job outcomes for local candidates.
- 10% of staff at the trust have come through the Community Works for Health Programme.
- For the New2Care courses (that provide a route into nurse associate apprenticeships), a recent evaluation found that retention rates were similar to 'standard' recruits who had experience in the sector. The evaluation also found that feedback from supervisors was positive and participants were reported to be more engaged with learning than those with more experience.
- Barts Health Futures has more than doubled the number of students studying health and social care qualifications and pathways at Newham College.

Future plans

Future plans at Barts Health include:

- Sustaining work that is externally funded
- Using capital schemes such as Whitechapel Life Sciences and Whipps Cross Redevelopment to maximise local employment from these investments and develop career paths to high quality jobs

Further information

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East London NHS Foundation Trust: A Marmot Trust

Background

East London NHS Foundation Trust (ELFT) provides mental health, community health, and primary care services and specialist services to areas of Bedfordshire, Luton and inner North East London, Hertfordshire and Essex. ELFT employs over 6,000 staff, operates services from over 120 community and inpatient sites, and has 900 general and specialist inpatient beds.

The local population includes areas of high deprivation, cultural diversity and has some of the fastest growing populations in England, with significant health inequalities. For example, in Luton, there is a nine-year gap in male life expectancy and in Tower Hamlets, 30% of children are living in poverty.

SDOH work

In 2021 a new **ELFT strategy** was published, which included a strategic objective to improve population health and address the SDOH. ELFT have been working closely with the **UCL Institute of Health Equity** (IHE) to become the first NHS 'Marmot Trust' as one way of achieving this ambition.

Priorities for action are based on principles developed by Professor Sir Michael Marmot and IHE, which describe the health impact of eight major SDOH, and identify evidence on the best ways to tackle these.

Figure 2: The Eight Marmot Principles

*Source: '**A Healthier and Fairer Waltham Forest: Equity and the Social Determinants in Waltham Forest**', Reproduced with permission from the UCL Institute of Health Equity*

While work has taken place across a wide range of social determinants, there has been a particular focus on employment, income and poverty, and children and young people.

Specific activities

One of ELFT's first activities was to map their existing work against the eight Marmot principles to understand current impact and identify opportunities to scale work, or fill gaps. Much of the work has taken place within two strategic and geographical areas: employment in Luton and children and young people in Newham.

Examples of innovative interventions:

- The 'Healthier Wealthier Families' pilot – which provides financial and benefits advice within a **specialist children and young people clinic** (SCYPS).
- Child and Adolescent Mental Health Services (CAMHS) in Newham have been helping 17- and 18-year-olds who use their services, and their families, to access employment support through **London Works**. This support includes CV preparation, mock interviews and communication skills.
- Addressing financial exclusion among homeless people by partnering with HSBC's 'No Fixed Address' service to enable ELFT's homeless teams to facilitate access to bank accounts for homeless patients.
- Embedding social value in procurement to increase local wealth investment and ensure suppliers are having a positive impact on the SDOH. When bids are evaluated, 15% of the scores are allocated to social value, which includes paying a real living wage, being a Voluntary, Community and Social Enterprise (VCSE) or local organisation, and having plans to achieve net zero.
- Promoting access to employment and apprenticeships for service users and other disadvantaged groups, including through a healthcare support worker partnership with Luton Borough Council's employability programme.
- Working with local employers to advocate for good quality work and mentally healthy workplaces, including developing a mental health training offer for employers to support the recruitment and retention of employees with mental health conditions (in partnership with Luton Borough council and Total Wellbeing Luton).

Approach

ELFT had a strong history of community co-production and quality improvement, both of which have been key methodologies used in the Marmot Trust work.

Partnership work has also been essential, and has included work with ELFT suppliers (for example, the employment support service and soft facilities provider), multiple teams in Luton Borough council (including public health, inclusive economy and community engagement) and London Borough of Newham (early years, family hubs, children and young people's commissioning), and the VCSE sector.

Partnership working with ELFT's internal teams (for example, with the Quality Improvement (QI) team, HR, procurement, and clinical teams such as CAMHS and SCYPS) and with the UCL Institute of Health Equity (IHE) has also been vital. IHE have partnered with ELFT in an advisory capacity including providing input into developing approaches and strategic direction, working with the public health team and director of population health, liaising with the Board, and sitting on the working group.

Resources

This work has taken place across many teams in the trust (a working group was formed and started meeting from late 2021), but the leadership of the public health team and the director of population health has been a key enabler. The work has been guided by input from IHE and Professor Sir Michael Marmot, as described above.

Impact

The ELFT board receives reports on progress on population health. In addition, metrics are being captured at intervention or project level within the Marmot Trust programme. Specific impacts include the following:

- 112 service users have been recruited by ELFT between 2021 and 2023
- 68% of ELFT suppliers pay the Real Living Wage in 2023, compared to 22% in 2020
- ELFT have provided £1.8m of grant funding to VCSE organisations in 2021-22 for projects to address health inequalities
- The first families accessing healthier wealthier families advice secured on average over £17,000 (per year) in additional benefits and back-payments
- There has been an increase of £185 in average monthly take home pay for a domestic cleaner or porter after the recommissioning of a new soft facilities contract
- ELFT's Individual Placement and Support (IPS) service supported 324 people with severe mental illness into work in 2022-23

Future plans

ELFT's focus in the coming year will be on three key population health priorities:

1. Local employment
2. Income maximisation
3. Promoting the physical health of people with severe mental illness

ELFT will also be further developing its approach to measuring and reporting the impact of its population health work.

Further information

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Great Ormond Street Hospital: Improving air quality

Background

Great Ormond Street Hospital (GOSH) is a dedicated children's hospital in the London Borough of Camden and has the widest range of specialist services for children provided by the NHS on one site. In 2022-23 there were 238,719 outpatient visits and 44,994 inpatient visits. GOSH employs over 5,000 members of staff.

The majority of patients are referred into GOSH from centres outside London, largely across the UK and some overseas. In contrast to other hospitals, there is therefore less of a clear local 'catchment area' for the hospital, and patients and their carers often don't form part of the local community.

SDOH work

GOSH has recently focussed on the social determinant of environmental sustainability – in particular, air quality. Mortality from long term air pollution exposure has been estimated to cause over 25,000 deaths a year in England.

Following the death of Ella Adoo Kissi-Debrah and a coroner conclusion that this was partly attributable to exposure to excessive air pollution, GOSH became the first London hospital to declare a Climate and Health Emergency. By 2030 they are planning to become a net zero carbon organisation for the emissions they control, and by 2034, emissions they can influence. GOSH has called on staff to "**become a GOSH climate emergency responder and take leading roles on the climate emergency**".

Specific activities

Since declaring a Climate and Health Emergency, GOSH have launched innovations including:

- Partnering with the Medical Research Council (MRC) Centre for Environment and Health at Imperial College London to display annual average air pollution estimates into their electronic patient record (EPR) Epic. The aim of this innovation was to provide an initial step to encourage discussions about air quality between clinicians, patients and relatives.
- A QI approach has been used to develop dashboards to track carbon emissions and increase virtual clinic visits (thereby reducing patient travel-related pollution) and provide access to information on Epic such as medication usage trends over time to track carbon footprint.
- Developing and launching a **clean air framework**, aimed at improving air quality in and around the GOSH site in order to create a healthier environment for patients, carers, staff, and the local community.
- Launching a **communications campaign** aimed at reducing use of single use plastics, in particular disposable gloves.
- Closing the street outside the hospital to traffic and hosting **Play Streets** for patients and families in the local area.

Approach

For the EPR air quality initiative, a research project provided annual estimates of UK residential air pollution using existing nationwide monitoring data from over 80 surveillance sites. This was inputted and combined with other available data sources using a logistic regression model, the results of which were shared with the trust, who were then able to input this into the EPR, mapping home address with air pollution data (Particulate Matter (PM2.5) and Nitrogen Dioxide (NO2) levels).

The EPR now includes a trigger alert for clinicians if a patient's home address PM2.5 or NO2 levels are above World Health Organisation (WHO) 2021 recommendations. Clinicians can then access internal and external resources including the ICD code linking air pollution to a patient's problem list, the Chief Medical Officers 2022 pollution report, information letters for clinicians to send to GPs and patients, and advocacy letters addressed to local councillors and Members of Parliament.

Partnership between GOSH and Imperial College London has been central to this project. GOSH have also partnered with Global Action Plan (particularly during the development of their Cleaner Hospital Framework) and with Camden Council and local community groups to develop further environmental projects including a Podcast Series entitled "**Goshpods Go Green**". Internal partnership has also been key, and the GOSH quality improvement team have been involved in much of the sustainability work.

Resources

This project has relied on individual staff motivation and expertise. The logistic regression model created by Imperial College London mapping air quality data to postcodes was created during a MRC funded PhD project. Updating this model with more recent air quality data requires additional funding.

An in-house member of staff linked and embedded data into the EPR. This was described as a relatively simple process requiring just a few days. For other projects related to air quality and climate, staff at GOSH have had to apply for external sources of funding due to limited resource available in-house.

Impact

Measuring the impact of this work on patients in the short-term is difficult, not least due to the time and resources needed to gather meaningful data. The Air Quality Dashboard went live in November 2022 and impact assessments are currently pending.

A staff and patient survey was conducted at baseline pre-launch of the air quality dashboard. 75% staff had never discussed air pollution with patients and only 15% felt very confident about doing so. 75% of families said they would like to know more about the risks of air pollution in their area. There are plans to repeat this survey later in 2023 and evaluate changes in experience, for example how many young patients engaged with online educational materials.

In terms of impact on other healthcare organisations, there are ongoing efforts to increase awareness amongst clinicians and management colleagues at both local and national levels. Hospitals within Guy's and St. Thomas' NHS Trust will adopt the EPR approach in October 2024 and other hospitals including University College London Hospitals and provider trusts in Cambridge and Manchester have expressed interest in adopting this work.

Future plans

To maximise the impact of the air quality EPR initiative, GOSH are in discussion with the UK Health Security Agency (UKHSA) to explore the development of regional alerts at times when poor air quality may lead to increased health events – for example, an increase in asthma exacerbations during extreme weather.

In July 2023, GOSH developed an additional tool for their EPR named "Slicer Dicer". This will allow staff to filter a symptom or condition against PM2.5 or NO2 levels, contributing to research hypothesis generation. For example, it may be possible to compare A&E admissions on high versus low pollution days for certain respiratory or cardiac conditions, or the number of children accepted for lung transplantation residing in areas above and below WHO target PM2.5 and NO2 levels.

Other potential plans include looking at the number of clicks to educational resources and advocacy letters sent. GOSH aim to work with the UCL Institute of Child Health to further develop outcome metrics. Another potential ambition for the future would be that a cumulative high score from a combination of air quality and healthcare metrics would trigger a particular bundle of care when a patient is admitted to the hospital.

Further information

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Mid and South Essex NHS Foundation Trust: Anchor Institution work

Background

Mid and South Essex NHS Foundation Trust (MSE) is a large acute trust that covers a population of 1.2 million local people in Essex, employs more than 16,000 staff across three major sites and a number of smaller clinics, and spends over £50 million on goods and services each year.

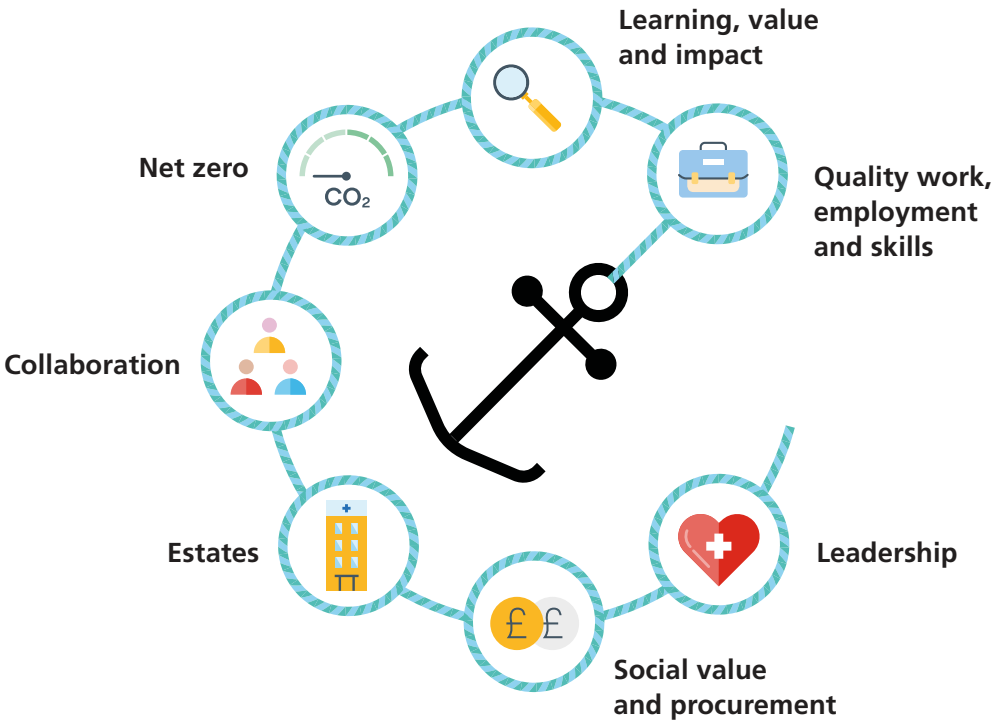
There is significant variation in deprivation and inequalities across Mid and South Essex. Basildon and Southend Hospitals serve populations with an approximate gap of 13 years of healthy life expectancy and in Southend-on-Sea, just under 1 in 5 children live in low-income families. Compared to the England average, the population is slightly older and a higher proportion are White British.

SDOH work

MSE's '**Hospital as an Anchor Institution**' programme started in 2019 and focusses on programmes delivered internally and with local partners that can improve the SDOH for patients, staff, and the local population.

The programme has had a particular focus on the social determinants of employment, education, and sustainability.

Figure 3: Anchor priorities in MSE



*Source: '**Putting Communities at the Heart of What we Do: Our Work as an Anchor Institution 2022/23**', Reproduced with permission from the Mid and South Essex NHS Foundation Trust*

Specific activities

MSE's anchor programme activities or interventions include:

- Essex Pedal Power, which involves a free giveaway of 150 bikes to Basildon hospital's staff from Band 2 - 4 (salary of £22,383 - £27,596). The project, delivered with Basildon Council, Sport England and other partners, helps to reduce emissions, increase active travel, address the cost-of-living crisis and help participants to be physically and mentally fitter.
- The Anchor Ambition 25 project, which helps the unemployed or economically inactive across Mid and South Essex to secure work in the healthcare sector. There is an aim to expand this work to the care sector.
- Work in Basildon Hospital to place youth workers in A&E to identify and refer at-risk youth, with ambition to extend and expand this work to support young people with long term conditions.

Approach

The work harnesses elements of coproduction – for instance its Young Voices project has influenced and informed the programmes pre-employment offer for young people.

A Mid and South Essex Anchors Institutions group meets monthly and includes over 86 members from 25 different partner organisations. The MSE Anchor programme also has strong links to its health providers, county unitary and borough councils (including skills and employment, public health and economic development.) The programme is a key partner in the Essex Anchor Network and in regional and national Anchor forums.

Resources

MSE employ an anchor lead, a post which was originally match funded by Essex County Council Public Health Team, and now by the Council's Levelling Up fund. More recently, the ICS have provided some funding. Senior level support from within and outside the trust has ensured the continuity and impact of the programme.

MSE have undertaken a **cost analysis** and estimated that they have invested £220,000 in the Anchor Programme core team from April 2021 to March 2023. This has secured £835,000 of further support to the Programme from partners and has produced £407,000 of net savings to the trust.

Impact

MSE have a robust approach to measurement, publishing an **annual impact report** and capturing regular data on activity and impact. This includes a workforce dashboard to capture key statistics and their change over time. Some specific outcomes measured include:

- Since January 2023, the Anchor Ambition 25 programme has supported 450 participants (Job Seekers) and close to 100 job offers and in August 2023 has secured a further £278,000 of investment from Essex County Council.
- The youth work programme in Basildon Hospital has resulted in 189 referrals to further support in the last year, and the programme has measured a 16% drop in reattendance rates.
- In 2022-23, 300 of MSE's leaders attended sessions on the anchor programme, and a survey of partners found that over 60% reported that the programme had enabled significant change to the range of their partnerships.
- Participation in pre-employment programmes increased by almost 100% from 2021-22 to 2022-23.

The programme is using the **UCLPartners Anchor Measurement Toolkit** to define and refine its qualitative and quantitative targets and Key Performance Indicators.

Future plans

In 2023-25, the MSE anchor programme plans to spread and scale their existing programme with a focus on:

High-quality work:

- Running the 'Ambition' programme across all trust sites
- Working with young people to develop the workforce pipeline, recruiting more local staff into jobs with low barriers to entry and supporting health and wellbeing of staff already in the organisation, supporting retention

Net zero, social value and innovation:

- Supporting procurement teams to embed and realise social value and the mandatory inclusion of 10% weighting in NHS procurement
- Helping develop net-zero solutions across procurement and innovation, through measurable, research-led approaches that engage clinicians and carbon reduction plans for suppliers
- Collaborating to develop the Basildon Social Innovation Incubator Hub

People and communities:

- Developing the Anchor Youth Partnership to help reduce avoidable admissions of disadvantaged 16-25-year-olds
- Helping the Mid and South Essex VCSE sector to extend its links and delivery of health-related support services through emerging provider collaboratives and social value
- Working with clinicians and community providers to reduce the barriers between secondary and primary care and enabling their workforce to support community delivery

Further information

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Lessons on adopting an innovative approach to tackling the social determinants of health

Lessons on adopting an innovative approach to tackling the social determinants of health

The following section provides 13 lessons based on interviews and information provided by the four provider trusts featured as case studies. These lessons identify common themes and reflections from the trust's innovative approaches to tackling the SDOH. Our aim is to provide practical guidance and inspiration for other trusts who are considering adopting or increasing their work on SDOH, and we have therefore tried to focus on the learning that is particular to SDOH work. However, some of the content will have relevance to other work within trusts. Anonymised quotes from the interviews conducted are also included.

The lessons follow a loose linear order – the *drivers and incentives* may apply to work in early phases, whereas *scale and impact* may be more relevant as work evolves and embeds. *Conditions for change* are cross-cutting. However, it is likely that those implementing this type of work will benefit from considering multiple lessons simultaneously, based on their context and focus, rather than considering them as a step-by-step process.

Drivers and incentives

1. Playing our part

Whilst recent healthcare policy has increasingly focussed on health improvement, provider trusts are not overtly financially incentivised in the short term to tackle the SDOH, and there are no significant or specific requirements on trusts to take this action. Alternative motivations, in most cases the moral or civic case for action on SDOHs, were cited as the strongest motivator for initiating and sustaining this work.

> *"It can still feel very side of the desk unless you tap into the moral imperative of it. If you say, I'm going to make a purely economic case for anchor, it quickly gets swamped by all of the other economic imperatives... trying to say, well, it'll pay off in 15 years doesn't really swing it with a Foundation Trust Board. Whereas the Foundation Trust Board does understand that they have a civic responsibility.*

Our interviewees reflected that going 'upstream' to reduce health inequities was the right thing to do for staff, patients, and the local community. One interview referred to the work as "taking a moral position," and similar language was used in most of the interviews.

> *"Does your hospital want to be located in the area which is clearly surrounded by people who are coming to you prematurely, or do you want to make a difference?*

This moral case often formed an organisational narrative that healthcare organisations should 'play their part' in tackling inequalities. Multiple interviewees referred to acting on the SDOH as a core component of being a good quality healthcare organisation.

> *"It was like, almost like a light bulb moment. That we're not these institutions that sort of don't have a role to play in our broader communities, there are things that we can do. And actually we spend a lot of money, we employ a lot of people, we have hundreds of sub contracts. And we can use all of those mechanisms to make a difference, even if it's in a small way, to build some community wealth locally. So that's where it all came from.*

However, there was also a reflection that national bodies, regulation and requirements could better reflect and support the role of healthcare organisations in tackling the SDOH.

> *"The problem with the NHS is it does what it's told. And we are told to reduce waiting times. We're told to sort out A&E, and the imperative is pretty stark. And we're told to balance our books. There's nobody really telling anybody to do this work... I think there's a discussion to have about how you subtly enable and support this work from the centre, without dampening innovation and diverting from work under way.*

2. Recognising the size of the prize

Interviewees cited a range of additional reasons to act – including the 'business need' to engage in prevention to improve health and reduce inequity.

> *"Given the growth in our populations, and also the communities that we serve, which are some of the most deprived, the pressures are just going to grow and grow and grow. And there just isn't enough money in the world, never mind in England, to throw at this to solve the problem. So unless we address the problem at the source, the issues are just going to get worse and worse.*

Other business reasons for acting on the SDOH included a desire to improve the trusts' reputation and be seen as a better local partner – one interviewee wanted to tackle a view of their trust as "only interested in their own business, and sucking up all the money"; and a view that considering SDOH would improve patient care, as it allowed the trust to consider the patient more holistically.

> *"People don't just walk into a clinic and walk out, in a kind of vacuum. They bring all of those factors that are the cause of poor health there, and if you can do anything to address those and make it better and help them on their recovery, or help them get services earlier, or more preventative approaches, surely that's a key part of healthcare.*

Need, data and expertise

3. Understanding population need

Like many innovations within healthcare, data is a foundational bedrock for any SDOH programme. However, for this work, there was a need to start with population needs and assets rather than service-level or clinical data.

'Populations' in the context of the trust's SDOH work had been geographically or demographically defined, and focussed on patients, communities, staff, or a combination of these groups. Many of the trusts we interviewed also found it helpful to start with staff as a key population group.

> (On exploring staff demographics) *[it was] the most powerful thing... you start to say... what does that mean that the people who are caring for our patients who come into work every day, are dealing with.*

> *So I think I think starting with the people for whom you already have a sense of responsibility morally and legally and using them to mirror the broader socio-economic challenges was probably the breakthrough for us.*

Understanding organisational needs was also seen to be helpful framing in making the case for tackling SDOHs.

> *What I would do is I would talk to the people director and say, what are your problems? I'll start from their problems basically, where they are, rather than lecture them on the morality or who they should be employing.*

4. Building engagement and accountability with data and insights

Common across the SDOH work was the use of data as a communication tool to engage internal and external stakeholders, as well as an essential component of measuring progress and ensuring internal accountability. One interviewee reflected that reporting progress on SDOH priorities to the trust board helped to bring "parity of esteem" with other, more clinical or service-based work.

> *In the same way that I would have a financial performance review, I should be having a sustainability performance review. That should be incorporated into dashboards that say 'how many people have we got waiting in our beds?' and 'what's our financial pressures?', with 'what and how are we doing with our reach for net zero?' They should be on a par and they should be measured in the same way. That's what we need.*

> *A huge number of partner organisations and provider organisations within our system are now involved... So part of getting people involved is demonstrating the impact that it's having, it's building momentum, it's socialising that and then people want to be part of it.*

Measuring the impact of SDOH work can be challenging, given that many of the benefits accrue within other parts of the system ('wrong pocket') and over the long term ('long pocket'). However, interviewees found that measuring proxies and processes, and gathering and sharing insights in the form of narrative and qualitative data, were important for this type of work.

> *A number of case studies have been used to demonstrate impact, which always is really, really well received... it's more impactful than you think as well. People really do take that away, sometimes more so than very large numbers, when it comes to impact.*

Generally, there was an acceptance that using 'non-healthcare' metrics was also essential, especially to reflect the wider nature of this work and its impact.

> *There's a sort of prejudice that if you're a healthcare provider, or if you're a clinician, you're only interested in health outcomes... And part of what we always say is, that's great, but it's possibly a little bit selfish, because actually, we can make a big contribution to lots of other things and should, because we take those things from the local economy, so we should put them back. So it doesn't really matter if we don't see a health outcome straightaway, we shouldn't just be doing things for health outcomes. We're a civic leader, we should be making a contribution to the things that our colleagues and our experts in the wider economy tell us are important.*

Trusts had also found that sharing some headline outcome figures was helpful in showing the impact of the work. For example, the high retention rates seen in employees from Barts Health's employment work was mentioned by multiple interviewees, as were some figures from ELFT's work, such as a significant increase in the proportion of suppliers paying the living wage, and increased take home pay among facilities staff. Bringing key data together into a report that could be shared, for example MSE's annual impact reports, was also seen as an important way to engage stakeholders and understand the impact of the work.

5. Drawing on the right expertise

All trusts interviewed stated that they had benefitted from external expertise or partnerships to bring additional knowledge and skills to tackling SDOH issues, although the source and nature of this varied. In the case of ELFT, national expertise from Professor Sir Michael Marmot and the UCL Institute of Health Equity had provided motivation, evidence and a framework for their action on SDOH, as well as guiding its implementation.

> *Sir Michael Marmot has done some amazing work on it... you then start having the conversations, if someone's done the research, can give you the evidence, and he's got fabulous evidence that shows it, you start questioning – so how would we apply our values as an organisation to do something different?*

GOSH had a close working relationship with a local academic partner, Imperial College London, who provided the data required to embed and link air quality metrics to postcodes. For MSE, Barts Health and ELFT, local institutional partners such as public health and employment teams in local government and schools and colleges had been key partners.

> *So there are key people that we've rolled up with us on the journey, and who are supportive of the social determinants of health. That's their natural place and space. And they implicitly get it straight away. And they implicitly get the importance of partnership in that. There's probably a core group of about 15 or 20 people that are able to move with that and work with that.*

The conditions for change

6. Aligning with organisational strategy

Aligning SDOH approaches with the trust's organisational strategy, and ensuring that the organisational strategy reflected and supported a vision for acting on the SDOH, were common themes across our interviews.

> *"So I think the advice [to others] is that they have to look at their strategy and priorities, and make sure that they truly are around improving population health outcomes… Because if that's not what your overarching vision and aims are, then trying to shoehorn this in to just offering better care to people, it actually doesn't really work. You actually have to have a vision that everybody buys into, you can't just start doing it.*

> *"One of the trust values is 'you're not looking after the patient if you're not looking after the environment'. That was made back in 2021 and has been one of our most useful batons to bash down the door. Having that sort of thing to refer to is immensely valuable.*

However, there were differing views on whether strategic alignment could evolve over time, or whether a strategy was a necessary precondition for the work. For some trusts, work on SDOH was seen as a way of realising a new strategic commitment – for example, an increased focus on population health or environmental sustainability, whereas for others, the work had started without a specific strategy behind it.

> *"In acute hospital trusts, very few people turn around and go, Oh, hang on a minute, have we got a strategy for this, otherwise, we shouldn't be doing it. So the strategy almost always comes later.*

Interviewees also referred to confusion between many terms, strategies, priorities and national directives, including (but not limited to) social value, the 'fourth purpose' of ICSs around social and economic development, anchor institution work, and 'Core 20 Plus 5'.

Having a clear and aligned organisational strategy that supports SDOH work could help to overcome this confusion, although it was also noted that there is a need not to get distracted by using the 'right' terminology or language.

> *"You are going to drive people like me out of these conversations, if we obsess over the terminology for whether it's social determinants or its inequality, because actually, somebody like me or my colleagues doesn't spend a huge amount of time studying that terminology, they just need to be held to account for doing something that makes a difference. They call it the wrong thing, let them call it the wrong thing. It doesn't matter.*

7. Ensuring leadership

All interviewees reflected that sustained and impactful SDOH work requires clear leadership to deliver the work. Some reflected on the need to have a whole team to facilitate delivery of initiatives.

> *"You need to resource it, you need people managing the programme, so that there isn't an undue burden on kind of people who've got other day jobs.*

A common feature across many of the interviews was the key role of a specific person, and how their personal qualities (for example, their energy and enthusiasm) and their position or relationships within the trust and with partners had driven the work forward.

> *"It's really flourished here... as a result of [the lead's] presence. And to that extent, there's a degree of serendipity which is not easily reproducible. But it's the sort of thing you need to try and find.*

Visible and practical support for the work from senior leaders was also cited by many interviewees as being a key ingredient for success.

> *"So what helps facilitate it is I think it's having the backing from the execs and other senior colleagues who are keen to kind of progress with this, as well as backing from within your team, as well, to kind of help push that push that agenda.*

> *"You can see how our exec team work. When it comes to looking after staff and thinking about equalities, it's sort of in their DNA.*

In some trusts, the delivery was led by a trust Public Health team, but there was general agreement that this was not a necessary condition – half of the provider trusts interviewed did not have an in-house public health team. In one trust, the work was established and led by clinicians.

Clinical leadership was also mentioned by many interviewees as a key factor to ensuring SDOH work was able to embed and spread internally, although one interviewee reflected that there can be some specific barriers to engagement due to the more political nature of some SDOH work.

> *"Air quality has been deliberately politicised which will make clinicians uncomfortable talking about it.*

8. Engaging all staff

Multiple interviewees felt that while they had good external partnerships, building support and engagement internally had been more of a challenge. Some felt that significant 'translation' had been needed when working with clinical teams, due to the different nature of this type of work and variable knowledge. Others reflected that the most significant barrier to engagement of clinical staff was due to clinical commitments and the pressure of their 'day jobs'.

> *"One challenge for workplaces like ours is keeping up energy levels so people don't get too tired from their jobs while also trying to save the planet! To overcome this problem and make everything easier for everybody involved we should think more about how wellbeing relates directly into addressing climate crisis issues overall – such factors mustn't remain isolated anymore but rather brought together under one umbrella concept instead which will allow us greater efficiency moving forward towards greener future initiatives altogether.*

Some interviewees mentioned their hesitation around bringing further clinical staff into the SDOH work due to a concern with staff wellbeing and burnout and a conscious effort to avoid increasing workload without providing extra resource.

> *I think one of the main issues in the NHS in general is burnout. Some colleagues are very passionate around health, air quality, sustainability in general. And that's coming from them outside of work and they're bringing it to their workplace. And I think not all trusts have people that have that momentum behind them. And I think that's the real issue.*

Despite some of the issues identified in engaging frontline staff, all the trusts reflected on the huge potential for involvement in the work to benefit staff – once they were engaged, many staff felt this was the best part of their job, and it brought them satisfaction and joy. One interviewee referred to the work as helping staff to feel "fulfilled" in a context where their "sense of professional identity have been quite eroded."

> *[staff] are keen to do those things that go beyond the immediate benefit for their role. That's why often people are attracted to working in healthcare… [they] come with that additional kind of commitment and passion.*

> *[staff] are absolutely chuffed about the opportunity to do something different, because this is about leaving behind a legacy… in each of those lives. It's not one person's life change. It's the life of the person, it's the life of the family that surrounds the person and loves the person, it's the lives of the friends who live with the person, and the community this person will go on to serve. So I think it is such a rippling effect.*

9. Using improvement and implementation science

In seeking to implement, sustain and spread their SDOH work, as well as 'making it real' for a range of staff groups, a common theme across our interviews was the benefit of using existing implementation methods, including QI, co-production, and partnership approaches.

> *My view as an improvement person, is you just kind of go where, you make a problem statement, and you go where there's the energy and you try something, and then you learn from trying.*

Interviewees felt that deploying these methodologies in their SDOH work allowed them to benefit from existing internal and external structures, expertise, and dedicated resource (for example, a QI team, or a co-production infrastructure); provided a familiar language to engage staff at all levels; and helped to facilitate good design, implementation and measurement of their activities.

> *[Using QI methodology] was important because that already had all the buy-in with the clinicians and the wider workforce who often are, actually, resistant to being asked to do something else difficult and complicated on top of what they're already doing that's difficult and complicated.*

Good partnership work was also mentioned as a key component of successful implementation of SDOH programmes – not only in understanding the population or sharing learning, but to co-deliver and align interventions.

> *You work with partners… It means you're slower than you want to be. It means sometimes your pace is as fast as the slowest person in the group… if you want to run fast, you run alone. But if you want to run long, you run with others. And I think this is a long game.*

Scale and impact

10. Thinking big and starting small

SDOH work was often driven by a big 'vision' of change, but interviewees reflected on the need to start with small practical first steps, to 'make it real.'

> *I haven't had anyone, in any of the conversations we've had, saying, I don't think we should be doing this. They might say, how are we going to do it? And they might say, well, you know, what does this look like? But no one's really fundamentally disagreed with the role of trying to address some of those drivers of those inequalities in health.*

One interviewee referred to the potential pitfalls of focussing too much on the problems – which could seem like a "blizzard of stuff I can't deal with" – but also on all the options for action – "then there's infinite potential, which becomes paralysing." Instead, finding a mid-way through this to a concrete set of actions enabled engagement and progress. One interviewee referred to the need to "make sure you do something" quite early on, an idea that was reflected in multiple other interviews. This included work focussing on a particular geographical area, staff group, service, or SDOH.

> *You have to be very open to it and, and know that it's practical, because it feels overwhelming. So I think that's a really important point to keep making – this can be done. Takes a bit of time, takes a bit of effort, you're not going to have immediate results. [But] it will support your long-term objectives of efficiency and social justice.*

11. Testing and iterating

Ensuring space for innovation had allowed trusts to rapidly test solutions, ensure improvement and refinement, and understand effectiveness before wider adoption.

> *I also think that we need to have some protected pockets where this work is going on. So that we can showcase the outcomes to motivate people to stay the course.*

Despite the need to 'do something', demonstrate activity in the short-term, and rapidly test and iterate, there was also a recognition that the work must evolve and change, and that this may take place on a longer timescale.

> *The realisation you know so little about what you're doing, it's really shocking. Because you start with the lofty ideas of – I know what I want to achieve. And after one year, you realise, oh my God, there's so much more to do. And by year two, you realise, I don't know half of what I'm doing and it's growing. So being comfortable with an evolving field and being organic about saying, actually, I can keep changing my goalposts, because as it develops, my thinking develops and I'm more mature in understanding what the system does.*

12. Working with others to share, learn and advocate

Local, system, regional and national sharing of SDOH work was seen as essential to scale and build impact, improve delivery, and learn from others. Many interviewees referred to the potential to inspire others to develop innovative ideas and initiatives. In some cases this was achieved through formalised dissemination routes such as conference presentations and educational resources.

> *"So our approach has been unashamedly to just tell as many people about it as possible, get as many other people to copy it as possible. And I hope that someone really clever will come along and do some good outcome analysis or design a nice case controlled between two hospitals or something to make it into something that you'd publish in a journal.*

> *"There's a lot of value in collaborating across different groups and using what you can with to make the best of what you've got. We have to do what we can and then lead others to do what they can, that's how we try and approach our advocacy work. It isn't about reinventing another WHO, it's about utilising knowledge and resources that are out there. If we can be a piece in the jigsaw and work with others to promote good things and encourage them to do good things.*

Other interviewees referred to the potential to build a collective voice that could be used to advocate for wider action on the SDOH, within the healthcare sector but also in other policy or institutional areas.

> *"So the healthcare system, I think, should be a leading advocate for health equity and social determinants of health, in all kinds of forums. Nationally, with local authorities, with other public services, with employers, economic sector, etc.*

13. Resourcing the work and embedding into business as usual

Almost all our interviewees referred to the barrier of insufficient funding, or a reliance on external sources of funding for their SDOH work. In time, they hoped that this work would become more sustainable.

> *"It's not sustainably funded yet. So some of it is about you know, if we went to the board and said, actually, we've got no money and we're going to have to pull the programme, would there be a whole load of people scrambling to keep it? I don't know. I think there probably would be a lot of people very upset about the fact that we would have to stop doing the work. But you know, if I go into a bun fight over the money, am I going to win? Probably not.*

> *"We are up against it, as a trust... any trust will say, you haven't got enough money, there's too much we need to do... it's easy at that point, to go back to the old way of doing things... and start thinking about things as nice to haves, instead of essentials... because now, we can't do everything. Is health inequalities important enough to carry on doing? And the answer is yes... It's not, it's not a nice to have any more, it's actually proved its worth.*

One way to work towards this 'business as usual' integration of SDOH work, was by building or changing internal systems. For example, Barts Health have instituted a process by which participants in their pre-employment programmes get access to vacancies before the general public, and GOSH reflected on the potential value of integrating SDOH data across patient records, so that it became 'normalised'.

Conclusion

When we think about innovation in healthcare, we often think about technical or highly clinical interventions. However, as this report demonstrates, provider trusts are also taking innovative approaches to tackling economic, social and environmental issues – the social determinants of health.

The four case studies featured here show the type of action that can be taken to improve employment, increase income, improve education, and reduce air pollution. Interventions can benefit patients, staff, and local communities; and can be delivered by a range of different types of trusts.

The 13 lessons drawn from our interviews also consider *how* this work can be implemented, summarising common drivers and incentives, considering how need, data and expertise can be used, setting out some common conditions for change, and looking ahead to greater scale and impact.

Learning from what has worked in these trusts and how they have implemented their work is essential to spread this innovation and ensure best practice is shared. We hope that other healthcare providers are inspired to consider how they could establish or increase work on the SDOH in their own contexts.

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Acronyms

A&E	Accident and Emergency
AHSN	Academic Health Science Network
CAMHS	Child and Adolescent Mental Health Services
EPR	Electronic Patient Record
ELFT	East London NHS Foundation Trust
GOSH	Great Ormond Street Hospital
ICB	Integrated Care Board
ICD	International Classification of Diseases
ICS	Integrated Care System
IHE	Institute of Health Equity
MRC	Medical Research Council
MSE	Mid and South Essex NHS Foundation Trust
NHS	National Health Service
NO2	Nitrogen Dioxide
PM2.5	Particulate Matter
QI	Quality Improvement
SCYPS	Specialist Children and Young People Clinic
SDOH	Social Determinants of Health
UCL	University College London
UKHSA	UK Health Security Agency
VCSE	Voluntary, Community and Social Enterprise
WHO	World Health Organisation