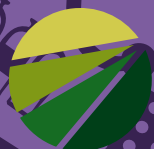

Working for Health Equity: The Role of Health Professionals



UCL Institute of Health Equity

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 - Music therapists
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 - Occupational therapists
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 - Physiotherapists
by the Chartered Society of Physiotherapy
 - Paramedics
by the College of Paramedics
 - Radiographers
by the Society and College of Radiographers
 - Speech and language therapists
by the Royal College of Speech and Language Therapists

Foreword

The Merseyside Fire and Rescue Service made a lasting impression. When conducting the Marmot Review of Health Inequalities, published as *Fair Society Healthy Lives*, we partnered with the North West Region of England. On one of our visits to Liverpool, we were hosted by the fire fighters. Their compelling story was of going outside their core professional practice of fighting fires to preventing them, which entailed engaging with the local community. They then became involved in looking at quality of housing, and at smoking, which are fire risks, to more general issues that benefit the community, including activities for youngsters and older people.

“If the fire fighters can do it, why not the doctors?” was a question I posed to the British Medical Association, during my time as President. Doctors are involved in treating illness but most accept they have an important role in prevention. If illness arises from the conditions in which people are born, grow, live, work, and age – the social determinants of health – should the doctors not get involved in the causes of illness and, indeed, the causes of the causes. The BMA picked up the challenge and produced a report on what doctors could do about the social determinants of health. But why stop at doctors? Other health professionals have key roles to play on improving the conditions of people’s lives and hence could have profound effects on health inequalities. This report builds on the BMA’s report and the inspiring work of health professionals.

Fair Society Healthy Lives laid out the evidence and made recommendations of what should be done on the social determinants of health in order to reduce health inequalities. Many of the recommendations were aimed at sectors other than health. But the medical and health professions are well placed to take action on the social determinants of health – they are trusted, expert, committed, and great powerful advocates.

One response to the evidence on social determinants of health is weary reluctance – it is simply all too difficult. The response we have had from colleagues who helped us with this report has been far from that. Nineteen organisations have contributed, including medical Royal Colleges, nurses, midwives, medical students, and several allied health professions. We appear to have struck a chord. And it is hugely encouraging.

The response can be summarised as: not only *should* we be taking action but there is ample evidence that we *can*. This report shows the evidence

base for actions, the case studies present examples of organisations with effective strategies, and the statements for action put forward practical actions.

The report and statements make clear that action on the social determinants of health should be a core part of health professionals’ business, as it improves clinical outcomes, and saves money and time in the longer term. But, most persuasively, taking action to reduce health inequalities is a matter of social justice. The enthusiastic response from medical and health professionals to the challenges of a fairer distribution of health contributes to what I have described as my evidence-based optimism: we are making progress in a good cause. Join us.



Professor Sir Michael Marmot
Director of the UCL Institute of Health Equity

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Executive Summary

Those in the health sector regularly bear witness to, and must deal with, the effects of the social determinants of health on people. This report will demonstrate that the health care system and those working within it have an important and often under-utilised role in reducing health inequalities through action on the social determinants of health. The health workforce are, after all, well placed to initiate and develop services that take into account, and attempt to improve, the wider social context for patients and staff.

This report launches a new programme of activities to tackle health inequalities through action by health professionals on the social determinants of health. It draws on many examples of inspiring and excellent practice which demonstrate what can be done. The report describes areas where greater action is necessary and possible and makes some practical suggestions about how to take forward action on the social determinants of health.

The report contains recommendations and analysis in six core areas, described below. It also contains nineteen Statements for Action about actions health professionals can take to tackle the social determinants of health through their practitioner role. These have been written by Royal Colleges and other representative organisations, and set out, for each profession, a rationale for action, practical guidance on what activities to engage in, and relevant case studies and further reading. Working with the authors of these statements, and other organisations, the Institute of Health Equity (IHE) will support and encourage health professionals to take greater action to tackle health inequalities.

The report also sets out a series of commitments made specifically for this report and future work programme, from twenty relevant organisations. These cover each of the six priority areas in this report, and display an impressive ambition to take forward action on the social determinants of health. Organisations have committed to work in partnership to implement the recommendations of this report by producing educational materials, developing new research and publications, setting up networks, embedding the social determinants of health in current work and disseminating information to health professionals. These commitments are described throughout the document at the ends of chapters, and a full list can be found on the IHE website (1). They will form the basis for an on-going programme of work led by IHE in partnership with Royal Colleges, the Academy of Medical Royal Colleges (AoMRC), the British

Medical Association (BMA), the Canadian Medical Association (CMA), the World Medical Association (WMA), and other organisations and institutions. These commitments will extend and develop over time, but are included in the full report in their current form in order to give an indication of future steps. As we continue the programme of work over the next few years, these will be developed, tested and implemented further.

Background

Evidence presented in the Marmot Review 2010 (2), and many other evidence-based analyses of health inequalities (3-6) show a clear social gradient in health outcomes, which closely relates to social and economic factors: the conditions of daily life. Most of the factors influencing health lie outside the immediate reach and traditional remit of the health system – early-years experiences, education, working life, income and living and environmental conditions. The recommendations of the Marmot Review were therefore mainly focussed on actions which could be taken outside the health care system to reduce health inequalities. This report now focuses on actions and strategies that can be developed within the health care system, and particularly the health workforce, where there is great scope. It builds on and learns from other recent initiatives (7-9).

While inequities in access and care within the NHS do exist, they do not account for a large proportion of health inequality, particularly when compared to the powerful influence of social and economic factors on health (10-12). This report demonstrates that there is much that the health system can do to influence these wider social and economic factors, beyond ensuring equity of access and treatment. Those working within the health system have an important, albeit often under-utilised, role in reducing health inequalities through action on the social and economic factors: the social determinants of health. Tackling health inequity is a matter of social justice; it is also essential in order to provide the best care possible. Preventive measures that improve the conditions in which people live can lengthen people's lives and years spent in good health, improve services and save money (2).

The report is based on literature, case studies, and other evidence about how health professionals and organisations can influence social determinants and tackle health inequalities in a systematic and

effective way. Many relevant organisations have had direct input into the report, and this input forms much of the basis for the analysis and recommendations. We organise this analysis into six areas in which actions will be particularly effective: education and training, working with individuals, action by NHS organisations, working in partnership, workforce as advocates, and opportunities and challenges within the health system. These are described briefly below and in greater detail in the main report, where they are also accompanied by case studies, recommendations and commitments.

Part A
Ways for health professionals to take action on health inequalities

1 Workforce education and training

In order for the health workforce to successfully tackle health inequalities and take action on the social determinants of health, the right education and training are essential. Good education on the social determinants of health will not only inform but also empower the health workforce to take action. Changes should take place within undergraduate education, postgraduate education, Continued Professional Development, and other forms of training.

There are two important actions in this area. Firstly, professionals should be taught about the nature of the social determinants of health, and what actions by those within, and outside, the health system have been successful in tackling them. Education should include information about the graded distribution of health outcomes, how social and economic conditions can help to explain these unequal outcomes, and what practical actions can be undertaken by health professionals to decrease these inequalities. This teaching should take the form of dedicated compulsory and assessed modules, and should be included in other specialised courses, for instance a course on cardiovascular disease should include information on the social determinants of that disease (13).

This first area can then be supplemented by a second action, the teaching of skills: that is, how to reduce inequalities within professional practice areas. Some necessary skills are more general and have broad application – for example, skills of communication, partnership and advocacy are all essential for tackling health inequalities. There are also specific strategies which have been shown to be effective, for example, taking a social history and making patient referrals to external support services. Teaching skills in these specific practice-based areas should be a core element of all health courses.

Seeing the effects of social and economic inequalities will ground and ‘realise’ the knowledge described above. For this reason, student placements are central to learning. They should take place in a range of non-clinical settings, for example with social services or with a debt advice service, and should be designed to expose students to disadvantaged areas and needs. It is also important that access to health professions is made more equal.

Within England, action across the areas discussed above is the responsibility of Health Education England, Local Education and Training Boards, the General Medical Council, medical schools, NHS organisations, and professionals and students in advocacy roles. IHE will work with these organisations to embed the recommendations below.

Key recommendations:
Workforce Education and Training

Knowledge

A greater focus on information about the social determinants of health, and information on what works to tackle health inequities, should be included as a mandatory, assessed element of undergraduate and postgraduate education.

Skills

Communication, partnership and advocacy skills are all general areas that will help professionals to tackle the social determinants of health. There are also specific practice-based skills, such as taking a social history and referring patients to non-medical services, which should be embedded in teaching in undergraduate and postgraduate courses.

Placements

Student placements in a range of health and non-health organisations, particularly in deprived areas, should be a core part of every course. This will help to improve students’ knowledge and skills related to the social determinants of health.

Continued Professional Development

Both knowledge about the social determinants of health and skills to tackle these should be taught and reinforced as a compulsory element of CPD.

Access

Universities should take steps to ensure that students from all socio-economic backgrounds have fair access to health care careers.

2 Working with individuals and communities

The Marmot Review showed that if the conditions in which people are born, grow, live, work, and age are favourable, and distributed more equitably, people would have more control over their lives in ways that will influence their own health and health behaviours, and those of their families. Individual health professionals can tackle the social determinants of health by helping to create the conditions in which their patients can have control over their lives.

It is important that health professionals build relationships of trust and respect with their patients. This is good for the patient as control and reducing stress can have direct effects on health (14). It can also improve the uptake of public health messages and other strategies to reduce inequalities. Greater communication and better relationships can also enhance practitioners' knowledge and understanding of their patients and the local community, thereby improving the care that they are able to offer. Techniques such as motivational interviewing, a method that increases communication and collaboration between patients and providers, can help to build these relationships on an individual level. On a community level, professionals should be promoting and engaging in collaboration and communication with the local population.

In taking action to reduce inequalities, health professionals can focus on two key activities: gaining information, and providing information. Gaining information about patients is important in order to understand how social and economic factors are impacting on a patient's health. Taking a social history can enhance a medical history and enable professionals to provide the best care possible. This type of information is also essential on an aggregate basis, as it can help to influence and inform local commissioning and provision, both of health care and of other services within the community. Longitudinal social data can also enable organisations to measure progress and the effectiveness of interventions against health equity indicators.

Giving information that can help to improve the social determinants of health mainly consists of referring patients to non-medical services. These should cover a broad range of sectors and issues, beyond lifestyle and disease management programmes. For example, referral to Legal Aid, Relate, CAB, employment programmes or housing advice services can help patients to tackle the sources of ill health. By connecting patients to professional advice about state benefits, health professionals can ease patient anxiety and stress (15) and improve the context in which they live. Other referrals can help to tackle other social determinants of health. Such activity may reduce the number of consultations with and prescriptions from GPs (16). Referral of this type is particularly successful where the services are readily accessible or medical and non-medical services are co-located – for example, where Citizens Advice Bureaux are situated in GP surgeries.

There will be two types of changes needed: those

requiring increased resources of time and money, and those that can be accommodated within existing structures and constraints. In the first case, professionals should be advocating for change and helping to build an evidence base to support the case. However, some changes can and should be made within existing structures and constraints.

Key recommendations: Working with Individuals and Communities

Relationships

Health professionals should build relationships of trust and respect with their patients. They should promote collaboration and communication with local communities to strengthen these relationships.

Gathering information

Health professionals should be taking a social history of their patients as well as medical information. This should then be used in two ways: to enable the practitioner to provide the best care for that patient, including referral where necessary; and at aggregate level to help organisations understand their local population and plan services and care.

Providing information

Health professionals should refer their patients to a range of services – medical, social services, other agencies and organisations, so that the root causes of ill health are tackled as well as the symptoms being medicated.

3 NHS organisations

In addition to actions taken to improve the health and wellbeing of their patients, NHS organisations have a responsibility to ensure that health inequities among their employed staff are also tackled. The NHS is the largest employer in the country with 1.4 million staff (17), plus staff employed in non-NHS commissioned services. Health professionals have opportunities in their roles as managers, commissioners and employers to ensure that workforce health and wellbeing are central to their activities.

Firstly, NHS organisations should be places of good quality work. Evidence has consistently shown that employment is better for mental and physical health than unemployment. However, this only applies to good quality work (2). Good quality work is characterised by a living wage, having control over work, being respected and rewarded, being provided with good quality in-work services such as occupational health services, and with adequate support to return to work after absence.

The importance of these areas was recognised by Carol Black's review of the UK's working age population (18), and was applied to NHS workplaces in the Boorman Review (19). Managers should be ensuring that all staff, including contracted staff, are provided with good quality work in line with the recommendations of the Boorman Review. IHE have produced a strategy for Barts and the London Trust which set out how to implement the recommendations of the Boorman Review and the Marmot Review (22). Implementing these strategies across the workforce is likely to reduce inequalities as there is a gradient in quality of work: those from lower socio-economic groups currently tend to experience worse quality work.

NHS organisations, and therefore their staff, have considerable influence through their sizeable purchasing power, both as employers and contractors of staff and as commissioners of services. One literature review found that the health sector often accounts for 15–20% of a local community's employment and income (20). This gives health organisations significant power to affect the health and wellbeing of their local population. Public bodies also have a legal duty to consider how procurement might improve the economic, social and environmental wellbeing of their area (21). Employment should be designed to be particularly beneficial for those from lower socio-economic groups, as this will reduce inequalities. In addition to providing a good quality place of work, this can be achieved by ensuring that there is security and flexibility of employment and retirement age, and that jobs are suitable for lone parents, carers and people with mental and physical health problems (22).

This report outlines many actions that can be taken by individual health professionals. They can start to take most of these actions straight away. However, in order for action to be comprehensive, systematic and sustained, these actions must be supported at every level. For this reason, managers and leaders should ensure that strategies on

organisational health inequalities that incorporate the areas in this report are in place, with dedicated leads and budgets. They should be auditing proposed actions, monitoring progress and sharing good practice.

Key recommendations: NHS Organisations

Health professionals should utilise their roles as managers and employers to ensure that:

- Staff have good quality work, which increases control, respects and rewards effort, and provides services such as occupational health.
- Their purchasing power, in employment and commissioning, is used to the advantage of the local population, using employment to improve health and reduce inequalities in the local area.
- Strategies on health inequalities are given status at all levels of the organisation, so the culture of the institution is one of equality and fairness, and the strategies outlined elsewhere in this document are introduced and supported.

4 Working in Partnership

In order to take effective action to reduce inequalities, working in partnership is essential. Evidence shows that effective action often depends on how things are delivered, as much as what is delivered (2). A key element of this is collaborative, cooperative work that is either delivered jointly by more than one sector, or draws on information and expertise from other sectors. Since many of the causes of ill health lie in social and economic conditions, actions to improve health must be taken collaboratively by a range of agencies that have the potential to affect social and economic conditions.

Many health professionals work extensively and successfully with other health care staff. These partnerships within the health system often extend across primary, secondary and tertiary care; between nurses, psychiatrists, doctors, surgeons and more; and are a core part of day-to-day business for practising professionals. Partnerships should occur between different organisations, for example hospitals and community health services, and different professionals in the same organisation. They can help to improve patient experience and practitioner knowledge, and reduce inequalities in outcomes.

However, perhaps more importantly, partnerships between health and non-health professionals and organisations should be established, supported and extended. Integrated work should be broad, and include partnerships with local government, other public sector partners, the police and fire service, charities and other third sector organisations, private companies and places of work, and schools (2). There is a legal duty on Clinical Commissioning Groups and the NHS Commissioning Board to integrate services where this would reduce inequalities (23), and other professionals should work to support and extend this. Information-gathering and monitoring systems should be collaborative where possible. Joint planning, commissioning and delivery are particularly important for effective partnerships. Collaborative local strategies can provide effective ways of reaching shared goals and providing excellent services, as well as reducing inequalities, although partnerships must be carefully designed and assessed in order to ensure effectiveness (24).

Early years and childcare health are important examples of the value and necessity of partnership working. In order to tackle the root causes of ill health effectively, action early on in life is essential. This can change the conditions in which children are born and grow, and the care and opportunities that are made available to them. In order to take action in this area, partnerships should be established between Children's Centres, schools, social care, health visitors, midwives and other health professionals. When these different sectors communicate effectively, deliver joint programmes and tackle individual problems in a collaborative way, outcomes tend to improve (25).

Since the passage of the Health and Social Care Act 2012, a new form of partnership has been established – Clinical Commissioning Groups

(CCGs). These are locally based consortia, made up of GP practices, which will commission care for the local community (26). The doctors and nurses who sit on CCGs have three important ways to tackle health inequalities: through their actions as health professionals; in their role on the CCGs, which includes making commissioning decisions; and in the way they use the CCG as a local advocacy and community asset. If CCGs and professionals are aware of and responsive to the social determinants of health in their local area, they will be able to tackle health inequalities while delivering clinical services.

Key recommendations: Working in Partnership

Within health sector

Partnerships within the health sector should be consistent, broad and focussed on the social determinants of health.

With external bodies

Partnerships between the health sector and other agencies are essential – they should be maintained, enhanced, and supported by joint commissioning, data-sharing and joint delivery. They must, however, be well designed and assessed for impact.

Clinical Commissioning Groups

CCGs should make tackling health inequalities a priority area, and should measure their progress against this aim. They can do this via their role as commissioners, in partnership (particularly with Health and Wellbeing Boards), and as a local community employer and advocate.

5 Workforce as advocates

Every health professional has the potential to act as a powerful advocate for individuals, communities, the health workforce, and the general population. Since many of the factors that affect health lie outside the health sector – in early-years experiences, education, working life, income and living and environmental conditions – health professionals may need to use their positions both as experts in health and as trusted, respected professionals to encourage or instigate change in other areas. The medical Royal Colleges have a clear advocacy function, and regularly petition government for policy changes on behalf of their members and their patients. However, advocacy is also powerful and important for health students, qualified professionals, CCGs, NHS organisations and other professional bodies such as unions.

Acting as an advocate for individual patients and their families is often particularly helpful to improve the conditions in which people live. Professionals can use their understanding of the factors that are influencing a patient's health, and act as advocate in order to help these patients to access services both within and outside the health service. In a similar way, advocacy on behalf of communities is also important.

The actions proposed in this report will be most effective where they are adopted widely and supported at all levels – from central to local and individual arenas. This will ensure that strategies are in place to instigate change, to regulate action, to measure and reward progress, and to learn from others. This will require, in some cases, action that is beyond the remit of the individual professional. In these cases, professionals should use their position to advocate for the changes that are necessary, both within their organisation, and within other local bodies or central systems. For example, changes to education, as outlined above, will need the support and backing of health students and professionals.

Health professionals have great authority and expertise, and should also be using this to advocate for policies that will reduce health inequalities and against policies that will widen them. This should be targeted at central government departments as they consider policy change, but also towards newly formed bodies such as the NHS Commissioning Board, which are currently considering what to prioritise and what strategies to adopt. With concerted pressure from health professionals and the bodies that represent them, we have a great opportunity to ensure that tackling health inequalities is a central concern across the policy spectrum, and that all bodies consider the health equity impact of new and existing policies.

Key recommendations: Workforce as advocates

For individuals

Individual health professionals and health care organisations should, where appropriate, act as advocates for individual patients and their families.

For changes to local policies

Individual health professionals and health care organisations such as local NHS Trusts should act as advocates for their local community, seeking to improve the social and economic conditions and reduce inequalities in their local area.

For changes to the health profession

Individual health professionals, students, health care organisations such as NHS Trusts and professional bodies such as medical Royal Colleges and the BMA should advocate for a greater focus on the social determinants of health in practice and education.

For national policy change

Individual health professionals, students and professional bodies such as medical Royal Colleges should advocate for policy changes that would improve the social and economic conditions in which people live, and particularly those that would reduce inequalities in these conditions. They should target this advocacy at central government, and bodies such as the NHS Commissioning Board.

6 The health system – challenges and opportunities

The Health and Social Care Act of April 2012 has led to significant changes in structure, provision, incentives, regulation, commissioning and monitoring within the health system (23). While the changes are challenging and disruptive, there are also new opportunities to tackle health inequalities and to embed an approach based on the social determinants of health across the new system. The new legal duties in the Health and Social Care Act can act as an important lever in encouraging action. In exercising their functions, the NHS Commissioning Board and Clinical Commissioning Groups must have regard to the need to reduce inequalities, both in terms of access and health outcomes of patients. They must also secure integrated provision of services, both within the health system and beyond it, where this would reduce inequalities in access or outcomes. In addition, there are duties on the Secretary of State, Monitor and NHS Foundation Trusts, all of whom must integrate these duties into their plans and report progress on them annually (23). The Equality Act 2010 states that public sector bodies “must, when making decisions of a strategic nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage.” (27).

These duties mean that work by the NHS workforce to tackle health inequalities should be integrated into organisational strategies and plans, as well as being incentivised and monitored. Unfortunately, other mechanisms may make this harder. For example, the Quality Outcomes Framework is a powerful incentive system but tends to measure certain outputs rather than patient outcomes, weakening its potential to reduce health inequalities. On the other hand, the Public Health Outcomes Framework includes important social determinants of health indicators, but is not linked to financial incentives or requirements, decreasing its potential to leverage change and increase impact. There are other mechanisms which may provide opportunities or challenges: the NHS Commissioning Board and the NHS mandate, the NHS constitution, funding and allocation arrangements, monitoring and data-sharing procedures, and various mechanisms that impact on health education. This chapter in the full report sets out some initial conclusions from a working paper, which is available on the IHE website (1). IHE will be developing this analysis as part of the ‘Working for Health Equity’ programme.

Part B

Professions: Statements for action

The analysis set out in this report has been largely welcomed by health professionals and their representative organisations. But there is a need for health professionals to have brief, practical guidance for tackling health inequalities through the social determinants of health. To inform this report we asked Royal Colleges and other organisations to provide statements for action, to give practical accessible guides for particular professionals to develop and use in their roles. The result of an enthusiastic response, nineteen statements for action by different organisations are set out in the main report. These statements also include a rationale for action, case studies and further reading. During the implementation phase of our programme of work, we will be working with various organisations to drive uptake of these practical actions.

There are statements for each of the following professional groups:

- Nurses
- Social workers and social care
- Clinical Commissioning Groups
- General practitioners
- Paediatricians
- Midwives
- Obstetricians and gynaecologists
- Hospital doctors
- Dentists and oral health teams
- Psychiatrists
- Medical students
- Allied health professionals
- Music therapists
- Dieticians
- Occupational therapists
- Physiotherapists
- Speech and language therapists
- Paramedics
- Radiographers

Commitments and next steps

This report also sets out a series of commitments by the health workforce and other organisations to embed and develop action on the social determinants of health. These form the basis of an on-going programme of work led by IHE in partnership with Royal Colleges, the Academy of Medical Royal Colleges, and the British Medical Association among other organisations and institutions. The current commitments are placed throughout the document at the ends of chapters. These commitments will be added to over time. Please see the IHE website for an up-to-date list of commitments (1).

IHE will lead a programme of work to disseminate the messages in this report, encourage their practical application across the workforce, and to extend the evidence base. We have been sent many examples of excellent practice already taking place,

and the ‘Working for Health Equity’ programme will be focussed on increasing the systematic and sustained implementation of this activity across the health system. This will be undertaken in partnership with organisations that have already been involved in the project by writing statements for action and commitments. IHE also welcomes other organisations to join the programme and share their experience, working together to achieve greater health equity through actions by health professionals and related organisations.

Introduction

Report rationale, background and structure

This report builds on the 2010 report *Fair Society Healthy Lives* (The Marmot Review) (2), the World Health Organisation's 2008 Commission on the Social Determinants of Health (3) (CSDH) and the 2013 WHO European Review of Social Determinants and the Health Divide (29). These reports compiled the best available evidence about the factors, in other words the conditions of daily life, which shape health. Most of these factors lie outside the immediate reach of the health system – in early-years experiences, education, working life, income, and environment and living conditions. The reports made recommendations on how best to reduce health inequalities, which were mostly focused on actions which could be taken by those working *outside* the health care system. This report now focuses on actions and strategies that can be developed by health professionals in their roles in the health care system.

Those in the health sector regularly bear witness to, and must deal with, the effects of the social determinants of health on people. This report will demonstrate that the health care system and those working within it have an important and often under-utilised role in reducing health inequalities through action on the social determinants of health. The report explores literature, case studies, and other evidence that shows how health professionals can influence social determinants and tackle health inequalities in a systematic and effective way. The health workforce are, after all, well placed to initiate and develop services that take into account and attempt to improve the wider social context for patients and staff.

The report sets out a series of commitments by health professionals and other organisations to embed and develop action on the social determinants, and these form the basis for an ongoing programme of work led by the Institute of Health Equity in partnership with Royal Colleges, the Academy of Medical Royal Colleges (AoMRC), the British Medical Association (BMA), the Canadian Medical Association (CMA), the World Medical Association (WMA), and other organisations and institutions. These commitments will extend and develop over time, but are included in their current form throughout the document at the ends of chapters, in order to give an indication of future steps.

The report is structured as follows:

Part A – Health professionals: Ways to take action on health inequalities

1 *Workforce education and training*

Here we discuss ways to embed an awareness of and ability to affect social determinants of health in the future workforce through development of the curriculum, placements, and Continued Professional Development. We also discuss the issue of more equal access to health education.

2 *Working with individuals and communities*

We set out practical ways for health professionals to improve the social determinants of health of their patients and related to that, propose ways to gather information on the impact of social and economic conditions on people's health.

3 *NHS organisations*

The role of the NHS as an employer is assessed, and actions are proposed to improve health outcomes and reduce health inequalities of the approximately 1.4 million NHS staff. This includes management practices and specific strategies to improve health along the social class gradient.

4 *Working in partnership*

We discuss the important issue of partnerships and co-working, both within the NHS and with external partners such as social workers and local authorities. This includes the role of Clinical Commissioning Group (CCGs), and the importance of cross-organisational partnership and community involvement.

5 *Workforce as advocates*

We outline the potential of individual health professionals and professional groups such as Royal Colleges and unions to act as advocates for individuals, for communities, for the health professional workforce, and for the whole population through policy change.

6 *The health system – challenges and opportunities*

We discuss some mechanisms within the health system that can be used to leverage change and increase action on the social determinants of health, and also discuss other mechanisms that may prove obstructive or unhelpful.

Part B – Professions: Statements for action

The report also provides statements for action developed by health professional organisations, which seek to give practical accessible tools for particular professionals to develop and use in their roles. We also outline actions for those such as social workers and commissioners who are not health professionals. The statements prepared for this report include the following:

- Nurses (*by the Royal College of Nursing*)
- Social workers and social care (*by the Social Work and Health Inequalities Network*)
- Clinical Commissioning Groups (*by the Royal College of GPs*)
- General practitioners (*by the Royal College of GPs*)
- Paediatricians (*by the Royal College of Paediatrics and Child Health*)
- Midwives (*by the Royal College of Midwives*)
- Obstetricians and gynaecologists (*by the Royal College of Obstetricians and Gynaecologists*)
- Hospital doctors (*by the Royal College of Physicians*)
- Psychiatrists (*by the Royal College of Psychiatrists*)
- Dentists and the oral health team (*by the Faculty of Dental Surgery, Royal College of Surgeons of England; Dental Faculty, Royal College of Surgeons of Edinburgh; Dental Faculty, Royal College of Physicians and Surgeons of Glasgow; Faculty of General Dental Practice, Royal College of Surgeons of England; The Dental Schools Council; British Association for the Study of Community Dentistry*)
- Medical students (*by Medsin*)
- Allied health professionals (*by the Allied Health Professions Federation*) with sections on:
 - Music therapists (*British Association of Music Therapy*)
 - Dietitians (*British Dietetic Association*)
 - Occupational therapists (*College of Occupational Therapists*)
 - Physiotherapists (*Chartered Society of Physiotherapy*)
 - Paramedics (*College of Paramedics*)
 - Radiographers (*Society and College of Radiographers*)
 - Speech and language therapists (*Royal College of Speech and Language Therapists*)

It is intended that this report will develop further the arguments, evidence and practical ideas for health service staff to take more action on the social determinants of health. There has been huge interest in the report from all sectors of the health workforce and many outstanding examples of existing activities have been relayed to us. Some of these are included as case studies in each section of the text and we hope that as this programme of work unfolds we can begin to build, disseminate and support implementation of these activities. Throughout the report we have synthesised the information we have gathered to form key recommendations. These suggest ways to develop action within the workforce, and are variously targeted at individual professionals,

medical students, local organisations (e.g. CCGs and NHS trusts), national bodies (e.g. the NHS Commissioning Board or Department of Health), and professional organisations (e.g. Royal Colleges).

The social determinants of health and health outcomes

Health inequalities

In England, health has improved for the whole population in the last two decades and life expectancy at birth in England and Wales rose by 10 years for men and eight years for women between 1960 and 2010 (30). However, as can be seen in Figure 1, below, health follows a social gradient. Both life expectancy and ‘disability-free life expectancy’ (the number of years someone lives without a disability) relate to levels of deprivation – the more deprived a neighbourhood is, the lower the average life expectancy and disability-free life expectancy. This figure also shows that the gap in life expectancy between the best- and the worst-off is seven years. There is an even steeper gradient of 17 years for disability-free life expectancy. The gradients show that although people living in the most deprived areas have the worst outcomes, everyone below the very top experiences lower outcomes than the best-off, to some degree. Health inequalities are not only relevant for the most vulnerable or socially excluded: they apply across all groups within society.

The social determinants of health

Figure 1 demonstrates the close relationship between life expectancy, health and area deprivation. The Marmot Review described the gradient in health outcomes: the lower your social economic status, the worse your expected health. A gradient in health is found in some form in all countries across the world for which data is available (3; 4). The Marmot Review described evidence showing that health inequalities do not arise by chance and cannot be attributed simply to genetic makeup, ‘bad’ unhealthy behaviour, or difficulties in accessing medical care, important as those factors may be.

Differences in health status largely reflect inequalities in the social determinants of health. The social determinants of health are the conditions in which people are born, grow, live, work and age; and the structural drivers of those conditions – the inequitable distribution of power, money and resources. What happens within an individual’s social and economic context, during the early years and education, and in terms of income, skills development, employment and work, and within communities, all impact on that person’s health and life expectancy. The Marmot Review presented evidence of interventions that could contribute to reducing health inequalities. The review recommended six main policy objectives:

- 1 Give every child the best start in life
- 2 Enable all children, young people and adults to maximise their capabilities and have control over their lives
- 3 Create fair employment and good work for all
- 4 Ensure a healthy standard of living for all
- 5 Create and develop healthy and sustainable places and communities
- 6 Strengthen the role and impact of ill-health prevention

The Review showed that action in these six areas needs to be proportionate to need, but universal – ‘proportionate universalism’. Action must have the ambition to level up the gradient, so that those towards the bottom of the gradient improve proportionately more than those towards the top, thereby reducing health inequalities. The report contained many examples of good practice to reduce health inequalities and made a series of proposals for action under each of the six policy objectives.

Very often the focus of action to improve health and reduce health inequalities has been on ‘unhealthy behaviours’, particularly smoking, alcohol, poor diet and lack of exercise. While these unhealthy behaviours are found across the population, they often ‘cluster’ further down the social gradient – for example, people with no qualifications are more than five times as likely than those with higher education to smoke, drink, have a poor diet and lack exercise (31). This concentration of unhealthy behaviours down the gradient is also worsening:

in 2003 the probability was only three times more likely. These behaviours are often the immediate causes of poor health, but evidence shows that the causes of these causes lie in the social determinants of health.

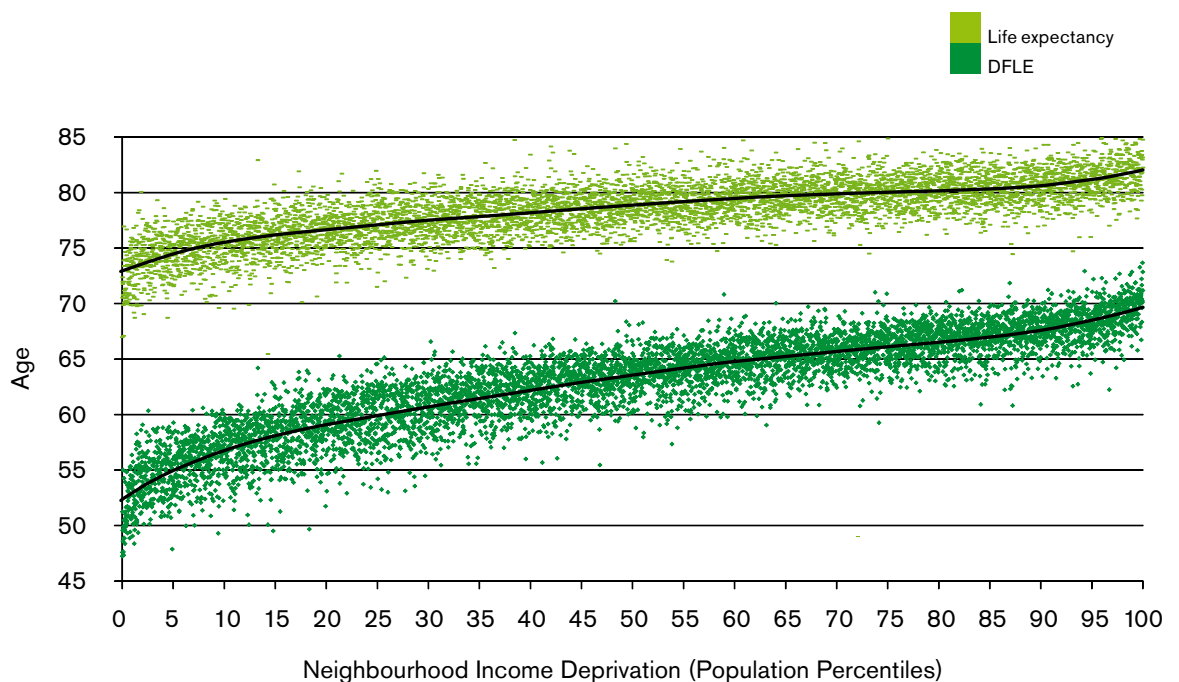
Health professionals

Health professionals have many opportunities to take action in each of the six policy areas described by the Marmot Review, working to reduce health inequalities through action on the social determinants of health.

Firstly, health professionals have unique access to the population. In terms of numbers, on average the NHS deals with one million patients every 36 hours. That’s 463 people a minute or almost eight a second (32). There are also 1.4 million people working for the NHS (33). Health professionals not only see large numbers of patients, they see them at key points during their life course; for example before, during and after birth (e.g. doctors, midwives, health visitors), during schooling (e.g. school nurses, dentists) and at times of illness (e.g. primary and secondary care teams). This enables health professionals to take a life-course approach to interventions – taking action across the life course, at key junctures, in order to positively affect later health outcomes.

Secondly, health professionals are highly trusted (34) and have established, well-recognised positions in local areas. This further increases their opportunities to understand and support patients within

Figure 1 Life expectancy and disability free life expectancy at birth, persons by neighbourhood income level, England (1999–2003)



Source: The Marmot Review (ONS) (2)

their social context and in some cases to improve their social and economic situation. There is good evidence, presented throughout this report, that health professionals have made a significant impact on health outcomes through tackling the social determinants of health. Furthermore, action on these social determinants will have a broader effect – improving a range of other outcomes, such as in education and employment, also reducing inequalities in these areas.

As well as the demands of social justice, action on health inequalities is economically sensible, resulting in savings for the NHS. The Marmot Review reported that inequality in illness accounts for, annually, approximately £31–33 billion in productivity losses and lost taxes, and in higher welfare payments in the range of £20–32 billion, and additional NHS health care costs associated with inequality well in excess of £5.5 billion (2). If no action is taken, the cost of treating the various illnesses that result from inequalities in the level of obesity alone will rise from £2 billion to nearly £5 billion per year in 2025 (2).

We have chosen to focus on health professionals in this report, and have not included the role of *public* health professionals. This is because the actions that we are proposing are not just a public health issue for public health professionals – they concern all medical staff. IHE will be publishing a separate report specifically around the work of public health professionals.

Despite their undeniably important role, we have also not addressed in detail the many contributions of support staff, such as receptionists and porters. Nor have we addressed the huge contributions to be made by the wider health workforce – those working in arenas outside of health, but whose work dramatically affects people’s health – town planners, employers, the early-years workforce, teachers, trainers, transport managers and so on. Existing IHE activities cover many of these sectors and we envisage that future work will also develop in these areas (28).

We have not addressed the issue of *access* to health services, as this has been discussed in detail elsewhere (35; 36). It should also be noted that the report focusses primarily on England, although sources are drawn from a range of countries, and most of the recommendations may also apply to the wider UK, Europe and global contexts. We plan to develop this broader programme of work following the publication of this report.

The report, particularly the many commitments and statements for action from a variety of organisations, represents real momentum and a high level of interest from across the health sector. Health professionals and organisations are already involved in a wide array of inspiring and positive actions. This report, and the ‘Working for Health Equity’ programme, will build on this, and will, we hope, begin to make a real difference to the ways health professions work to reduce health inequalities.

Commitments

For this report, commitments to further action have been made by the following organisations:

- Institute of Health Equity (IHE)
- Academy of Medical Royal Colleges (AoMRC)
- Royal College of Midwives (RCM)
- Royal College of Physicians (RCP)
- Barts and the London NHS Trust (Barts Trust)
- British Dietetic Association (BDA)
- Royal College of Paediatrics and Child Health (RCPCH)
- Royal College of General Practitioners (RCGP)
- Royal College of Speech and Language Therapists (RCSLT)
- Chartered Society of Physiotherapy (CSP)
- Dental Schools Council (DSC)
- Royal College of Obstetricians and Gynaecologists (RCOG)
- British Association of Occupational Therapists and College of Occupational Therapists (BAOT/COT)
- Royal College of Psychiatrists (RCPsych)
- Royal College of Nursing (RCN)
- Allied Health Professionals Federation (AHPF)
- Medsin
- British Association for Music Therapy (BAMT)
- British Medical Association (BMA)
- NHS Alliance
- Social Work and Health Inequalities Network (SWHIN)

Commitments which are general or relate to implementation of the ‘Working for Health Equity’ programme are listed below. The other commitments have particular relevance to each of the six priority areas, so can be found at the end of the relevant chapters. A full list of commitments to action, arranged by organisation, can be found on the IHE website (1).

General and programme implementation

The *Institute of Health Equity* commits to continue to lead and support a programme of implementation activities following on from this report, as follows:

- Work in partnership with Royal Colleges, BMA, WMA and other stakeholders to realise the aims of the Working for Health Equity programme and support their commitments to action
- Work with DH, NHS Commissioning Board and other organisations to support Royal Colleges and other stakeholders to commit and deliver on actions
- Set up an implementation group of stakeholders and an advisory group
- Seek funding to ensure implementation

The *Institute of Health Equity* commits to undertake additional ‘workforce’ analysis on:

- The wider health workforce: Expand remit of work to include public health organisations – work with Public Health England, Directors of Public Health, the Faculty of Public Health and others.
- The wider non-health workforce: Expand remit of work to include the social determinants of health workforce – for example: early-years workforce, probation officers, Citizens Advice Bureau, debt advisors, climate change organisations, private and public sector employers, employment advisors, social and economic policy decision-makers.

The *Academy of Medical Royal Colleges* commits to:

- Work with and support IHE’s programme of work to embed action on social determinants of health across the workforce.

Barts Trust commits to:

- Support the IHE programme going forward, including in potential partnerships with CCGs and other acute trusts.

The *Royal College of General Practitioners* commits to:

- Ensure that health inequalities are taken into account across all areas of RCGP activity and policy.

The *Royal College of Speech and Language Therapists* commits to:

- Support the IHE’s programme of work to embed action on social determinants of health across the SLT workforce.

The *British Association of Occupational Therapists and College of Occupational Therapists* commits to:

- Feature an article in their monthly magazine, ‘OT News’, distributed to approximately 28,000 members. They will highlight this programme of work, reiterate the importance of developing the evidence base for the occupational therapy role, as well as of evaluating the outcomes of interventions, and invite members to contribute their own case studies. They will also draw attention to their Professional Code of Conduct, which requires occupational therapists to provide an equitable service.

The *NHS Alliance* commits to:

- Contribute as a stakeholder to the programme of implementation activities.

The *British Medical Association* commits to:

- Continue collaboration and partnership with IHE and others to deepen health workforce activity on the social determinants of health and health inequalities.

Medsin commits to:

- Continue to engage with national and international stakeholders (including but not limited to IHE, the International Federation of Medical Students (IFMSA), the BMA, DH, the National Health Inclusion Board and the Academy of Medical Royal Colleges and their Health Inequalities Forum), to further this agenda.

Part A

Health professionals: Ways to take action on health inequalities



1

Workforce education and training

Key recommendations

Knowledge

A greater focus on information about the social determinants of health, and information on what works to tackle health inequalities, should be included as a mandatory, assessed element of undergraduate and postgraduate education.

Skills

Communication, partnership and advocacy skills are all general areas that will help professionals to tackle the social determinants of health. There are also specific practice-based skills, such as taking a social history and making referrals to non-medical services, which should be embedded in teaching in undergraduate and postgraduate courses.

Placements

Student placements in a range of health and non-health organisations, particularly in deprived areas, should be a core part of every course. This will help to improve students' knowledge and skills related to the social determinants of health.

Continued Professional Development

Both knowledge about the social determinants of health and skills to tackle these should be taught and reinforced as a compulsory element of CPD.

Access

Universities should take steps to ensure that students from all socio-economic backgrounds have fair access to health care careers.

In order for health professionals to successfully tackle health inequalities and take action on the social determinants of health, the right education and training are essential. This chapter discusses the two most important actions in this area – firstly, knowledge: that health professionals should be taught what the social determinants of health are and what works to reduce health inequalities; and secondly, skills: that health professionals should be taught how to develop strategies and reduce inequalities within their practice area. Both of these apply to undergraduate education, postgraduate education, Continued Professional Development, and other

forms of training. Change in these areas not only informs but also empowers the health workforce to take action on this agenda. It should also lead to appropriate attitudes to health inequalities and the social determinants of health. We also include, at the end of the chapter, information about the issue of fair access to the health professions, in order to create a workforce that helps to break cycles of economic disadvantage and exclusion from professional positions.

Effective education on the social determinants of health has received much attention not only within England but also internationally (37; 38). Within England, action is the responsibility of Health Education England (HEE), Local Education and Training Boards (LETBs), the General Medical Council (GMC), medical schools, NHS organisations, professionals and students. Organisations have made commitments to develop materials and advocate for change for education and training of health professionals. These can be found at the end of this chapter.

Knowledge

All courses for health services professionals need to result in learning about the social determinants of health so that health professionals understand the many ways in which the health of their patients is affected by the circumstances in which they live. Without this, taking action on health inequalities becomes much harder.

A greater focus on social determinants in both undergraduate and post-graduate programmes is supported by many Royal Colleges, including the Royal College of GPs (RCGP) (8), the Royal College of Nursing (RCN) (39) and the Royal College of Physicians (RCP) (40). The Faculty of Public Health (FPH) has been working with the Royal Colleges with the aim of including more public health aspects in the common foundation year that all doctors complete (41). Public health education, specifically on social determinants of health, should also be widely available to primary care practitioners (42;43). *Tomorrow's Doctors*, published by the GMC in 2009, sets out the required knowledge and skills to be taught in medical schools. It states that doctors' training must include reference to health inequalities (44). However, courses must do more than make reference. In order to train professionals who can tackle the social determinants of health, medical schools and universities must instead include a substantial course that covers:

- The social and economic conditions that affect health such as housing, education, and the other determinants discussed in the Marmot Review (2)
- How and why social determinants affect health and wellbeing, including data on morbidity and mortality
- How these effects are distributed across society, that is the socio-economic gradient in health, gender differences, and excluded groups
- How and why different populations are more vulnerable or more likely to be excluded
- Variations in health outcomes within and across local areas, regions and countries, and how the social determinants of health can explain these variations.

Education should also cover information on what works, in practice, to reduce health inequalities. Students should be taught what actions have been taken by the health workforce, where they have been successful, and why. While the literature on this is not hugely extensive, there are some strategies that are likely to have positive effects:

- Building a relationship of trust and respect with patients (see Chapter 2 for more information)
- Collecting, interpreting and using information (see Chapter 2)
- Referring patients to external services that will help to improve the social and economic conditions (see Chapter 2)
- Working in partnership with other sectors and organisations (see Chapter 4)
- Advocating for patients, communities and the general population (see Chapter 5).

It is also important to ensure that courses include strategies to ensure these topics are learned effectively. Evidence suggests the efficacy of problem-based learning (45; 46) – an active learning that tends to involve small groups of students solving problems collaboratively. The features of this approach – interactive small group sessions, project work, presentations, and debates – should work as an effective supplement or alternative to lectures.

This knowledge, combined with the skills detailed below, should result in health students developing an appropriate attitude to health inequalities. This will affect behaviour and practice, better enabling them to tackle inequalities when they are qualified (44). In Chapter 4, we include a case study on tackling the health outcomes of homeless people at University College Hospital, London (47). For programmes like this to work effectively, the appropriate attitude of health professionals is essential.

Professions outside, but integral to, health and wellbeing, have also recognised the importance of teaching on health inequalities. Social workers often deal with the most vulnerable in society, and have recognised that teaching on health and illness, the social determinants of health and health inequalities should be core to social work education at both qualifying and post-qualifying levels (48; 49). Given that collaborative work between health care and social

care is integral to action on the social determinants of health (50), a shared understanding and collaborative approach to tackling health inequalities would benefit successful joint-working greatly. Part B of this report contains a statement on social workers. The Chartered Institute of Environmental Health has also developed a clear public health strategy and made a number of contributions to the field, including in education (51).

Undergraduate

In undergraduate education, the social determinants of health should be a mandatory, core element of all courses. Modules on this should be taught and examined with the same weight as other core areas, rather than included as an optional or unexamined ‘extra’, as it often is at the moment (52). This will give all students a basic understanding of the ways in which social and economic inequalities and conditions impact on the health of the population. This can be usefully linked to global health or human rights teaching. However, it should not be reduced to a ‘subsection’ of these modules, but constitute a separate module. Students should be taught, in these modules, about what works to reduce health inequalities in their practice. They should also be encouraged to identify health inequalities that they see in practice or training, and reflect on their impact on the individual, their family and community, and the wider population.

Postgraduate

In postgraduate study, more advanced and in-depth modules on the social determinants of health should be made available in all courses, in order to extend and elaborate on the core knowledge already supplied. In order to ensure that this reaches all students, the social determinants of health should be included in the GMC-approved curricula for postgraduate clinicians, and assessed appropriately in relation to this. In addition, consideration should be given to health inequity and the social determinants of health within each subject area – for example, when training in cardiology or respiratory medicine, information should be included on inequalities in cardiovascular disease occurrence, and the ways in which these are influenced by the conditions in which people live (13). Educators can also take advantage of specialist courses to identify and teach about specific strategies within specialist areas that have helped to reduce health inequalities.

Currently, there is no dual accreditation offered in public health and other clinical specialties. All health care practitioners should be offered the opportunity to be ‘qualified’ in public health alongside their main specialism. This would build on teaching as outlined in the text above. Dual accreditation would help enhance understanding about the social determinants of health and health inequalities for health care practitioners in training. This has been suggested by Wright *et al* (53) with particular reference to employees in hospitals, where public health can be low on the agenda, and also supported by the Darzi Review (54) and the FPH (55).

Placements

Placement opportunities for future health professionals should regularly include non-clinical placements that increase students' knowledge about health inequalities and the social determinants of health. Seeing the effects of social and economic inequalities will ground and 'realise' more traditional bio-medical learning. For this reason, student placements in non-clinical settings should be central to learning. They should also take place in a range of sectors, such as social services or a debt advice service. This may be facilitated by a database of practitioners and placements that students can be referred to (56; 57). Placements should be designed to expose students to the social and economic causes of ill health and to disadvantaged areas and needs, as there is evidence that this can be successful in ensuring that training addresses health inequalities (58). Placements should also expose students to programmes that are successfully reducing health inequalities, where possible. It should be ensured that placements are supported on location by an appropriate number of experienced practitioners. LETBs, discussed below, may provide an opportunity to refresh and widen clinical placement opportunities.

Skills

As well as teaching the health workforce about the nature of the social determinants of health, the ways in which these issues may affect their patients, and likely successful strategies, students need to be taught useful skills in implementing these strategies.

Practitioner education is largely made up of learning medical skills. However, students also learn non-medical skills. Many of these can be harnessed and better linked to reducing health inequalities and action on the social determinants of health. In other areas, further development may be needed. Relevant skills can be grouped into three broad categories: practice-based skills; communication skills; and partnership skills. Practice-based skills include things such as how to take a social history, or refer a patient to another agency such as debt advice. These practices that reduce the effects of the social determinants of health, and the skills needed to support them, are discussed in more detail in the next chapter. Practice-based skills should also increasingly involve teaching about how to commission services effectively, particularly for GPs. Some principles to guide commissioning are set out in Chapter 4, under 'CCGs', and in the CCG statement for action by RCGP in Part B.

Communication skills are also important. Good general communication will increase the information available to the patient – for example, public health advice and referral to services. Good communication can also increase the information that is available to the practitioner. Successful communication can help health professionals to gather information about the patient, and then advise them about what may be done in relation to their social context. Students should be taught how to take a holistic approach

when in conversation with patients, including asking general questions about social circumstances as well as medical symptoms. Building relationships, gathering and giving information are all discussed in the next chapter.

There are also specific communication issues that can be overcome by good education. For example, there may be barriers to communication with patients with disabilities, or those who do not speak English. Students should also be taught about the range of communication issues that different patients may have, and how best to work with these. Overcoming these communication barriers requires support, for example by translators, but also an effective understanding of communication skills.

Additionally, students should be taught how to communicate in an advocacy role. Advocacy for action on the social determinants of health, as well as on behalf of individuals and communities, should be a key role for health professionals and the bodies that represent them. Advocacy is discussed further in Chapter 5.

Finally, partnership skills are also essential. In Chapter 4, we discuss the importance of partnership work both within and outside the health sector. This will become increasingly important for some health professionals, particularly GPs, as they become more involved in commissioning. Current education could be extended to include content on the value of partnerships and how they can help to reduce health inequalities. This 'knowledge' teaching can be supported by education on how to work effectively in partnership, including the skills of information-sharing, collaboration, co-production and commissioning.

Partnership skills can be learnt through placements, and also through training delivered to different professionals together (either in the community or in the classroom), which has shown positive results in fostering inter-professional attitudes and understanding (59; 60). For example, joint-teaching a module on child poverty and its effects to students of midwifery, health visiting, paediatrics, obstetrics, and nursing could have extra benefits in building an understanding of other professions and shared issues, thereby increasing partnership skills. Some courses also have visiting lecturers who are practising professionals in a related area such as social work. This sort of cross-professional learning can increase the chances of successful partnership work in future, and can also be reciprocated – for example, a medical lecturer teaching to planning students, to highlight the health consequences of planning decisions.

Undergraduate

In undergraduate education, where communication skills are already being taught, they should include specific features related to crossing socio-economic and ethnic barriers to communication such as language barriers, and how communication can support strategies to reduce health inequalities.

Case study: Leeds School of Medicine (61)

Leeds School of Medicine is one school in which the social determinants of health and health inequalities teaching have been given greater attention. This includes:

- Bringing in external expert organisations to give workshops and teaching on the social determinants of health
- Visits for first and second year students to voluntary and community groups close to GP placements
- Placements for second and third year students with voluntary and community groups
- Podcasts for students on poverty and the social determinants of health
- An emphasis on the importance of communication and interpersonal skills
- A requirement that pupils understand the social and environmental factors that determine disease

Postgraduate

Partnership and practice-based skills vary according to profession, so are most appropriately targeted at postgraduate students. Core modules should include theoretical and practical teaching on strategies, as set out in Chapters 2 and 4. Communication skills should also continue to be taught at this level.

Placements

As discussed above, non-clinical placements in the community help students to understand the nature of the social determinants of health, but they can also help them to learn how best to tackle them, both through practice-based skills, communication, and working in partnership. Placements in a range of sectors and organisations can provide opportunities to learn how best to work in partnership, a skill that can then be used throughout the practitioner's career. They can also provide a perfect opportunity to practise and improve communication and practice-based skills.

Case study: Delphi consensus project: devising a core curriculum for learning about health inequalities in UK undergraduate medicine

The Delphi consensus project is led by the Health Inequalities Standing Group (HISG) of the RCGP, in collaboration with IHE.

The aim is to positively influence learning about health inequalities across all medical schools in the UK. Medical schools are complex organisations, with a range of curricula, systems and teaching traditions. The following approach will encourage medical schools to adapt the findings for their own context.

The project's first activity was to tap into the expertise of the members of HISG: GPs and patient representatives who have an interest in tackling health inequalities, many of whom teach undergraduate medical students. They devised a 'starter' list of intended learning outcomes (ILOs), mapped to those in the GMC's Tomorrow's Doctors 2009 report, that might represent core learning for all medical undergraduates. These ILOs were in the areas of knowledge, skills, and attributes – what would we wish all new medical graduates to have acquired so they are equipped for working as FY1 doctors and for life-long learning?

The project was launched in December 2012. The project leaders targeted medical educators who had a role or interest in health inequalities.

The project asked participants if these 'starter' ILOs should be core learning, are additional competencies for interested students, or are irrelevant. They asked participants to suggest further core or additional ILOs, and for descriptions of current examples of good practice that others can use to work from.

Twenty-two medical educators representing 19 UK medical schools took part in the first round. There was a positive response to the 'starter' list and some excellent examples of good practice described. The next round is to ask participants to comment on their collated responses. The result will be a consensus statement on the core ILOs for learning about health inequalities with additional ILOs for student-selected/elective learning, illustrated with examples of good practice.

Continued Professional Development

Continued Professional Development (CPD) is an important tool for reinforcing and extending the knowledge and skills that professionals have learnt during training or while working. Successful CPD should be “flexible, practice-based, and work-based” (56). If CPD involves skill learning, it will provide practical outcomes for the daily practice of qualified professionals, and therefore be increasingly relevant and important for professionals, although this must also be supported by ensuring that CPD is free, universally available, and there are incentives for professionals to take part.

Most professions have compulsory training while in the job, which varies in extent between professions. For example, dental nurses must demonstrate 150 hours over five years, psychiatrists and GPs 50 hours each year. Nurses and midwives must complete 35 hours every three years, while surgeons currently have no mandatory CPD, although there are plans to introduce a 50-hours-a-year requirement (62). Most requirements include formal CPD, for example accredited training modules, some of

Case study: Bridging the Gap – A health inequalities learning resource (64)

NHS Education for Scotland has produced an online health inequalities learning resource named *Bridging the Gap* aimed at nurses, midwives, and allied health professionals. The resource is primarily aimed at pre-registration students, but could also be used as a CPD tool for qualified practitioners. On completing the course, students will be able to:

- Outline the wider determinants of health and their significance for understanding the causes and the effects of health and social inequalities
- Describe some of the key features of the health inequalities gap in Scotland
- Explain underpinning concepts for understanding of disadvantage and inequality, such as: identity and difference, prejudice, stereotypes, discrimination, stigma and other barriers
- Outline legal and policy drivers for eliminating discrimination, promoting equality, human and patient rights in NHS Scotland
- Discuss cultural, institutional and cultural actions that NHS Scotland can take to challenge health inequalities
- Outline personal and professional role, responsibilities and rights in relation to eliminating discrimination, promoting equality, human rights and good relations
- Discuss personal and professional actions that can help challenge (rather than reinforce) the causes and effects of health and social inequalities.

which are mandatory, and informal CPD such as journal reading. While ‘informal’ CPD on the social determinants of health is valuable, it must also be included as a formal, and ideally mandatory element. This provision should be a broad assessment of social and economic conditions that affect health, rather than focussing only on issues of access. It should also focus on strategies and successful practices within the profession to reduce inequalities. There is currently a mandatory NHS ‘equality and diversity’ module in CPD training for nurses (63). Health inequalities and social determinants of health could be included in modules such as this, or in a new mandatory module specifically devoted to the social determinants of health. For doctors, CPD on the social determinants of health should be documented as part of the revalidation portfolio.

CPD on the social determinants of health and health inequalities can be particularly beneficial for those professions where training has traditionally not included discussions of this type. For example, CPD training for surgeons could be seen as just as much in need of a social determinants element as health visitors’, as surgeons may not have been taught about these subject areas in their original training.

Access

Unlike some other sectors, access to health care professions is still largely dominated by those from a higher social class. This is, to a certain extent, true across all professional workforces, but a 2009 government commission, ‘The Panel on Fair Access to the Professions’, showed that access to medical careers is particularly restricted (65). The commission also reported that in 1980, approximately 50% of medics were from independent schools. In 2000, this figure had not altered. Doctors born in 1970 typically grew up in families with an income 63% higher than the average family’s income (65). In addition there is a gender bias, with women making up 40% of all doctors but only 28% of all consultants (66), although this has improved recently. The figures above apply to doctors, and it is the case that some other health professions are more equitable in access. While nurses have generally grown up in families with above-average income, the difference is only 10%, compared to the 63% quoted above for doctors. However, the figures for both nursing and ‘other medical professions’ in this report have shown an increase from the 1958 to the 1970 birth cohort – that is, these professions “have become more, not less, socially exclusive over time” (65).

A 2012 progress report from the Cabinet Office looked at access to medical careers, and showed that recently there has been a great diversification of the medical workforce in terms of age, gender and ethnicity. Women now make up 60% of entrants to medical school. However, the same change has not been seen in socio-economic background. In the 2010/11 intake into undergraduate medicine, only 7% of successful applicants were from the bottom three socio-economic classes (67).

The main focus of this report is on how the health workforce can tackle the disadvantages experienced by their patients as a result of their background. However, action on this agenda is undermined when the medical profession themselves still, in part, demonstrate the results of social and economic privilege. Broader access may also improve action on the social determinants of health: as the BMA has stated, “Doctors should be as representative as possible of the society they serve in order to provide the best possible care to the UK population” (68). A more diverse workforce is of course partially dependent on improvement across the social determinants of health – for example, addressing inequalities in early child development affects educational attainment, which will then increase the chances of a professional career (2). However, considering that medical careers are particularly un-diverse, more can and must be done by the medical profession to broaden access to medical school. While there are some excellent individual efforts made by universities and other bodies as in the case studies below, these must be assessed, evaluated and, where appropriate, standardised and universalised.

A concerted effort across the profession is needed so that the success experienced in broadening access for women and ethnic minorities can be replicated for lower social groups. This is the responsibility of universities, through their access requirements and outreach programmes; healthcare organisations, through the support they offer staff and the opportunities for in-job progression; and individual professionals, through their advocacy work and accepting work experience placements. Work experience placements are important for medical applications to university, but since there is no centralised system to allocate these, it is often those students whose parents work in the profession who are most likely to find placements. In this way, disadvantage is inherited. More detailed recommendations to bring about change can be found in the Cabinet Office professionals report (67), and the BMA report *Equality and Diversity in Medical Schools* (68).

Case study: Kings College London

The Outreach for Medicine programme (69) works with students from non-selective state schools to raise aspiration and encourage them to pursue careers in medicine and health care

Kings College also offers an extended medical degree programme (70). This is a six-year degree aimed at students from non-selective state schools in London and Kent to study medicine at a slower pace and with greater support for the first three years.

This combination of greater outreach, and a high level of support once in university, aims to increase the diversity of the medical student body and remove barriers to accessing medical courses.

Case study: University College London

The University College London Target Medicine (71) programme is a widening participation project delivered by UCL medical students, supported by academic staff. The aim is to inspire students from non-selective state schools and support them to apply to medical school. The scheme involves:

Mentoring

UCL medical students run sessions with sixth form students who would like to study medicine. These sessions include information and support on personal statements, interview skills, assessments and A-level revision classes.

Outreach activities

Aimed at younger, pre-GCSE pupils (Years 8 and 9), current medical students give presentations to inspire school students to consider studying medicine.

Summer School

This is a week-long scheme for Year 11 pupils who have the opportunity to take part in mentoring activities, meet patients, nurses and doctors, visit a hospital and engage in simulated emergency clinical situations.

Conclusion and next steps

There are a number of mechanisms which may help to leverage change to education and training. In 2012 the Department of Health outlined the roles that will be played by Health Education England (HEE) and Local Education and Training Boards (LETBs). While HEE will provide leadership, oversight and broad strategy, the LETBs “will be the vehicle for providers and professionals to work with HEE to improve the quality of education and training outcomes so that they meet the needs of service providers, patients and the public”, putting “employers and professionals in the driving seat”(72). Health professionals should use this opportunity to embed an approach based on the social determinants of health across workforce education and training, as discussed above. This document also sets out five ‘high level’ education outcomes:

- 1 Excellent education
- 2 Competent and capable staff
- 3 Adaptable and flexible workforce
- 4 NHS values and behaviours
- 5 Widening participation

The last of these aligns closely with our recommendations for widening access to health care careers (see above). However, the others are a little too broad to be effective levers. HEE is currently developing indicators against these outcomes, which should provide more detail. IHE would urge that a broad and clear understanding of the social determinants of health, and how to tackle them, is included as a key outcome indicator of workforce education and training. It is also important that teachers and educators are enabled to deliver the changes suggested here, through appropriate education, training and resources of their own.

Systematic change across the workforce to deepen action to tackle inequalities is partially dependent on an education system that encourages future professionals to learn about the social determinants of health, and empowers them to act on it. In undergraduate and postgraduate education, curriculum content should cover certain key areas – the nature of the social determinants of health, what effect they have on health, and what can be done by health professionals to mitigate this effect. This will be more successful if linked to key skills education, which should teach students how to adopt practices such as gathering information, how to communicate effectively, and how to work in partnership. Placements in non-clinical settings are essential, as is CPD, both of which will enhance knowledge and capacity. Finally, issues of access to medical education should be addressed, to work towards a more equitable workforce. These issues have been recognised in the commitments below, which show an enthusiasm to take action on this agenda. Many of the statements in Part B also provide further discussion of education and training, particularly ‘Medical Students’, produced by Medsin.

Education and training commitments

The *Institute of Health Equity* commits to:

- Work to develop new educational materials for use in training, accreditation and CPD
- Establish pilot social determinants of health modules with one or more medical colleges.

The *Academy of Medical Royal Colleges* commits to:

- Work with medical schools (and other training bodies), Royal Colleges and examining bodies to ensure that health inequalities are clearly addressed in undergraduate, postgraduate and Continuing Professional Development.

The *Royal College of Midwives* commits to:

- Advocate for a greater focus on the social determinants of health in midwifery education and training
- Look at ways to inform its members about the social determinants of health, such as by developing a course on its i-learn platform.

The *British Dietetic Association* commits to:

- Ensure the curriculum for training dietitians explores the social determinants of health and the practical ways in which the profession can support any actions.

The *Royal College of Paediatrics and Child Health* commits to:

- Encourage increased participation in its e-learning healthy child and adolescent health programmes, as well as continue to promote engagement in its courses in obesity management and the ‘How to Manage’ series (on nutrition, obesity, mental health)
- Continue to provide a range of education provision for paediatricians and child health care professionals, through both e-learning and face-to-face courses. It will look to widen this range by including more topics and also expanding international education provision such as the Global Links volunteer programme
- Review the existing commitments it makes regarding to curriculum. These commitments (to advocacy; management of behavioural, emotional and psychosocial aspects of illness in children and families; understanding growth, development, health and wellbeing in paediatrics; health promotion and public health issues; clinical governance activities; audit, refinement of evidence-based clinical guidelines; commitment to effective multi-agency and multi-disciplinary team working) are designed against the assessment system to ensure adequate coverage within paediatric examinations and workplace-based assessments.

The *Royal College of General Practitioners* commits to:

- Continue to ensure health inequalities are embedded into the curriculum. The RCGP’s enhanced and extended training bid highlights the need for GPs to be involved in community

leadership, public health and leading integrated teams as a means to reduce health inequalities. Within the educational bid one of fourteen outcomes identified for enhanced GP training over a four-year period is improved health promotion and disease prevention.

The *Royal College of Speech and Language Therapists* commits to:

- Liaise with higher education institutions to influence undergraduate and postgraduate curricula and ensure that health inequalities and social determinants of health are included in pre-registration education and training and CPD.

The *Chartered Society of Physiotherapy* commits to:

- Continue to provide its members with CPD opportunities related to the social determinants of health and the factors underpinning health inequalities
- Advocate for a strong focus on the social determinants of health within pre-registration physiotherapy curricula.

The *Dental Schools Council* commits to:

- Encourage all dental schools to embed a greater understanding of the social determinants of health into the undergraduate dental curriculum.

The *Royal College of Obstetricians and Gynaecology* commits to:

- Develop a public health module in its core curriculum to ensure that postgraduate medical trainees are knowledgeable about the impact of public health issues (e.g. maternal obesity) on O&G services.

The *British Association of Occupational Therapists and College of Occupational Therapists* commits to:

- Work to influence the pre-registration occupational therapy curricula to include discussion of the social determinants of health.

The *Royal College of Psychiatrists* commits to:

- Produce training materials on health inequalities suitable for medical students, trainees and CPD. The focus will be on how inequalities increase the risk of mental disorder, how mental disorder results in a range of further inequalities and interventions to address such inequalities.

The *Royal College of Nursing* commits to:

- Develop the workforce in terms of emphasis on the awareness of public health and social determinants of health in pre- and post-registration training following work from the Wills Commission, and in preparing nurses for the future. In addition, it will work to support staff in the meantime with motivational interviewing and behaviour change skills.

The *NHS Alliance* commits to:

- Help to support the development of new educational materials

The *British Medical Association* commits to:

- Support development of tools to embed social determinants of health approaches into education and training.

Medsin commits to:

- Work with medical schools, the GMC and other relevant stakeholders in medical education to ensure that health inequalities are clearly addressed in undergraduate curricula
- Continue to provide local, regional and national educational events, on the topics of the social determinants of health and health inequalities, to students across the UK
- Gather together educational resources suitable for students about the social determinants of health and health inequalities at local, national and global level, and to provide these free of charge to students across the UK.

The *British Association for Music Therapy* commits to:

- Support music therapy training at MA level, with its emphasis on leadership skills, autonomous practice and dynamic input to multi-disciplinary teams. It is also committed to supporting research into current developments in practice through its research network and journal
- Ensure that members of the public, professionals in the health, education and social services and those within the profession of music therapy have excellent access to information, research, illustrative case studies, training and events about music therapy, via the new website www.bamt.org and other media.

The *Social Work and Health Inequalities Network* commits to:

- Produce learning materials for use in Higher Educational Institutions internationally which will support the inclusion of health and social inequalities on social work qualifying curricula. SWHIN will also develop case studies of social work interventions to develop the knowledge and skills of student social workers of what can improve health and social care outcomes.



2

Working with individuals and communities

Key recommendations:

Relationships

Health professionals should build relationships of trust and respect with their patients. They should promote collaboration and communication with local communities to strengthen these relationships.

Gathering information

Health professionals should be taking a social history of their patients as well as medical information. This should then be used in two ways – to enable the practitioner to provide the best care for that patient, including referral where necessary; and at aggregate level to help organisations understand their local population and plan services and care.

Providing information

Health professionals should refer their patients to a range of services – medical, social services, other agencies and organisations, so that the root causes of ill health are tackled as well as the symptoms being medicated.

This chapter looks at how individual health professionals can tackle the social determinants of health in their interactions with patients. This can happen effectively through efforts to improve people's social and economic situation, for instance via referrals to debt counsellors or housing support services.

Also important are efforts to foster people's meaningful control over their lives. Here we discuss the ways in which a relationship of trust and respect can be built and nurtured by health professionals. Two key activities are then addressed: gaining information, and giving information.

Building relationships with patients

Many health professionals build relationships with patients that enable them to understand how their patient's health needs are affected by the conditions and context in which they live. Midwives, for example, visit people's homes and build a relationship with the patients they work with. GPs will often

have contact with the same patient for many years, enhancing their understanding of the factors affecting them and their family. Staff in hospitals and emergency services see patients at times of crisis, when they are, potentially, most vulnerable; and it is a central concern within mental health work to discuss and come to understand the circumstances of a patient's life. These examples highlight the fact that for most health professionals, developing a relationship of trust and respect with their patients is possible and desirable. It may also be essential for delivering the best care possible.

The importance of relationships between patients and health staff has been recognised by projects such as 'GPs at the deep end' (73). The health visiting workforce are also key professionals on this agenda – health visitors aim to respond to the health needs of children, families and communities in order to enable them to achieve good health and reduce health inequalities (74).

Relationships also need to be two-way in order to ensure that patients have control over the decisions that affect them. This has been recognised in the Public Health White Paper, which takes as one of its three main aims, "strengthening self-esteem, confidence and personal responsibility" (75). Initiatives which use local health trainers, community health champions and community development work "show encouraging signs of empowering individuals to participate and take control of their health and wellbeing" (2).

The RCP has outlined the importance of patient–doctor relationships which involve partnerships with patients, and joint decision-making where needed, without leaving those with lesser health literacy to make decisions they are not comfortable making. Central to this approach is communication and expansion of role – the RCP argues that doctors should be 'interpreters and advisors' as well as 'diagnosticians' (76). The charity Nesta has set up a People Powered Health programme which aims to develop innovative services for people living with long-term health conditions (77). One of its reports discusses co-production as a way to manage long-term conditions and consequently reduce health inequalities (78). Co-production emphasises a co-productive engagement between health professionals and health consumers, based on engagement, connections between sectors and health organisations, and an understanding of local needs and assets (78). Studies have shown that the actions and/or attitudes of professionals in their normal interactions with

patients can impact positively on empowerment and health (79). Some of the strategies that are particularly useful when working with families are outlined below:

- Anticipatory guidance (preventative advice by professionals in health care settings) can be effective in reducing parents stress and increasing confidence.
- Promotional interviewing (working in partnership with families to help them make informed decisions and develop problem-solving strategies) is effective, studies suggest, in enabling professionals to identify family need/problems.
- Including fathers in interventions is beneficial.
- Working in partnership with families by listening effectively is beneficial.
- Identification of post-natal depression and domestic violence is most successful when professionals ask just one to three simple questions such as, ‘have you experienced a low mood’.

(Adapted from a DCSF report on health-led parenting interventions in pregnancy and early years (79))

Motivational interviewing is a form of patient-centred care which seeks to motivate and facilitate health behaviour change through enhancing the interpersonal communication skills of health providers, thereby increasing collaboration between patient and practitioner (80). This has shown positive results (80), including increasing prevention and intervention in paediatric practice (81), reducing alcohol use (82) and tobacco use (83), and promoting oral health (84).

It is important that health professionals are supported and empowered to undertake these sorts of strategies where they feel it is appropriate in the every-day clinical encounter. This can be enhanced through education and training (see Chapter 1). It is also important that the importance of communication and relationship-building is recognised in official documents – for example, the code of conduct for health and adult social care support workers has seven key requirements for workers, one of which is to ‘build trust’, and another of which is to ‘communicate effectively’ (85). While incentives can be useful, too many or wrongly targeted incentives in this area can result in the inappropriate giving of advice, and could potentially lead to a breakdown of trust.

Effective relationships with local communities can also be beneficial. A powerful way that health services professionals can tackle the social determinants of health inequalities is through their work within the local community – both informed by and in cooperation with local people and groups, facilitating communities to take control. Research suggests that there needs to be a shift from ‘vertical disease oriented programmes’, for example in some primary care, towards ‘horizontal community-oriented approach’, which can tackle the social determinants and build social cohesion (44). One strategy that involve community relationships is asset-based

community development (ABCD), which focuses on the assets of social capital and uses participatory development to effect change in communities (86). While there are potential difficulties, particularly working with marginalized communities who may resist external cultures and values being imposed (43), there is also great potential when support is designed in collaboration with communities. This can help to design services such as screening that overcome cultural barriers within communities (87).

Good relationships with individual patients and communities can help health professionals to improve their understanding of the multiple social and economic factors that contribute to health outcomes, and tailor their work to tackle these disadvantages more effectively. Additionally, people are included in the decisions that matter to them, thus removing barriers to community involvement. Partnerships with communities can be used to determine local need, and can be harnessed to design, commission and evaluate services and activities. The Public Health White Paper states that the vision for public health is that it is “owned by communities and shaped by their needs” (10). This would create an opportunity for the health workforce to increase their activities to empower the communities in which they work.

Case study: Bromley by Bow Centre (88)

Bromley by Bow Centre provides a range of services designed to tackle social and economic inequalities in the local area. These are linked to the Bromley By Bow Health Centre, which takes a holistic approach to health, taking part in the following activities:

- Referring patients to employment programmes, benefits and housing advice, educational opportunities, art and design activities, and social enterprises, all of which are available on site.
- Providing an integrated approach to health services, promoting health and wellbeing, and delivered by GPs, practice nurses, health visitors, district nurses and support staff and administrators.
- Linking with the Children’s Centre, the teenage parent support project and the health trainers programme, which are all also provided by the Bromley by Bow Centre.

Many other local areas have adopted some of these ideas and adapted them to their own local context.

Case study: Family Nurse Partnerships (89)

The Family Nurse Partnership (FNP), run by the Department of Health, is a targeted programme for vulnerable, young, first-time mothers, which involves intensive and structured home visiting from pregnancy until the child is two. The FNP has three main aims – to improve pregnancy outcomes, child health and development, and parents' economic self-sufficiency (89). This is achieved by building a strong relationship between the family and the family nurse, which helps to achieve significant benefits:

- Improved early language development, school readiness and academic achievement
- Improvements in antenatal health
- Reductions in children's injuries, neglect and abuse
- Improved parenting practices and behaviour
- Fewer subsequent pregnancies and greater intervals between births
- Increased maternal employment and reduced welfare use
- Increases in fathers' involvement
- Reduced number of arrests and reduced criminal behaviour for children and mothers.

Recording patient information

In addition to the benefits mentioned above, good relationships between professionals and patients can facilitate a better exchange of information. Information should be passed in two ways: from practitioner to patient (discussed in the next section), and from patient to practitioner. Data gathered from patients is essential to improving care for the individual, passing on effective information to the patient, and setting local priorities and informing commissioning.

The GMC's paper *Tomorrow's Doctors* (44) makes reference to doctors taking a full social as well as medical history as part of the requirements of consultation. It goes on to state that doctors should interpret findings from the history, physical examination and mental state examination, appreciating the importance of social factors, to synthesise a full assessment of the patient's problems. This outlines the need to consider the social determinants of health – such as housing conditions, employment status, income, and education. The Royal Australian College of General Practitioners argues that a data set including education level, housing, or income level or financial issues should be routinely recorded in patients' records (58). Smeeth and Heath also argue for socio-economic status to be recorded in risk assessment procedures (90).

As well as providing a greater resource for individual professionals to understand their patients needs and assets, effective data collection, coupled

with appropriate sharing and use of data, can help to design local services and commissioning (91). For example, local needs and assets can be captured, a programme monitored, and the results fed back into the commissioning process. Data collection by individual professionals is a subset of this larger role for data gathering and use.

More research into this approach is needed, but there are examples of other bodies that have used this to their advantage: for example, the National Treatment Agency collects a standardised and broad data set on drug users through the National Drug Treatment Monitoring System (NDTMS). For young people, they report not only on the numbers accessing services, but their housing situation, educational and employment status, and the incidence of multiple vulnerabilities (other problems relating to substance use – such as alcohol use; or wider factors – such as self-harm, offending, pregnancy, or homelessness.) (92) Similar information gathered by health professionals could help to improve care and reduce inequalities. It is important, however, that data gathering is carefully planned so it is not unnecessarily replicative between organisations, and used in the best way.

Inclusion Health (93), a government programme set up to improve the health of excluded groups, shows that national datasets offer limited monitoring of socially excluded groups. For example, there is little ethnic monitoring of Gypsy, Roma, and traveller communities. NHS hospitals only record ethnicity, age, and place of residence of patients, the General Household survey often uses proxy measures to capture vulnerable groups, and the GP patient survey excludes those not registered with a GP and those who do not have the level of literacy that the survey requires in order to complete it (94). This is an important issue for workforce professionals, as the gap in patient information makes it harder for professionals to respond accurately to local needs. Health professionals should advocate for improved data collection of these socially excluded groups, for example through the JSNA process, and be aware of the potential effects of this exclusion on their patient's health.

There is evidence that lengthening consultation times with some patients could help to tackle health inequalities, particularly for those with complex conditions or communication needs. Increased socio-economic deprivation is associated with a higher incidence of psychological stress (95), but shorter consultation time on average (95; 96). Evidence suggests that providing longer consultation times to patients with complex needs in areas of socio-economic deprivation can increase patient enablement (97). It also seems fair to assume that longer consultation times may increase levels of trust, and give doctors the time and capacity that they need to be able to detect and respond to underlying causes of ill health. UK consultation times have been lengthening over time (98) but some European countries still have significantly longer consultation times than in the UK. One study described that Belgium and Switzerland had average GP consultation times of 15

and 15.6 minutes respectively compared with 9.4 in the UK (99). Despite different health care models between countries, these results suggest that longer consultation times are possible. A greater workload tends to decrease consultation time (99), suggesting that changes to staffing levels or workload allocation might have positive effects. These sorts of changes require high level, long-term intervention, and must be designed effectively: longer consultation times will not necessarily reduce health inequalities; they must be coupled with effective action within the consultation times, as recommended in the rest of this report.

Having had sufficient time to take a social history, the health professional needs to be able to act on the information collected to affect the social determinants of health. As this paper explains, actions can take many forms. Helping individuals take control (see 'Building relationships' in this chapter) and advocacy on behalf of a patient, community or issue (Chapter 5) should be within the scope of health professionals' roles. Part B gives many specific examples for particular professions, in the statements for action. These include many cases studies and recommendations for practical actions that can be taken.

Case Study: Lincolnshire Outcome Oriented Child and Adolescent Mental Health Service (CAMHS)

This CAMHS initiative (100) incorporates session-by-session measurements of outcomes, contributed by patients and practitioners, in order to improve patient experience, reduce 'Did Not Attend' and develop relationships. The guiding principles of the approach include consultation with other agencies and families to address factors such as social context, and ratings of the relationships with patients, as well as measurements of outcomes and information from patients on possible problems or resources they are experiencing. This information is then used to improve individual therapeutic care and to influence broader organisational strategy. Areas which have implemented the model have seen 25% better attendance, and have only referred one patient for inpatient treatment compared with an average of 9.6 in other areas.

Giving information to patients

Having established a relationship with a patient, and gathered information about their social as well as bio-medical history, the next step for a practitioner is to provide the patient with the help or advice that they may need. Often the practical actions to tackle social and economic disadvantage will actually be delivered by another agency. For this reason, it is beneficial if referrals are made to a range of sectors and issues, beyond lifestyle and disease management programmes. When doctors are aware of and

refer patients to wider advice, help and support, for example Citizens Advice Bureau, Legal Aid, Relate, or housing advice services, they are often helping people to tackle sources of ill health such as debt, unemployment, or inadequate housing.

It may also be necessary for health professionals to provide support to increase the chances of referral taking place successfully. This may include following up with a patient or service after making a referral, in order to make sure that patients do not get caught in gaps in the process. Giving information is not always sufficient to ensure patients engage with other services. This support will be easier if professionals have a good referral mechanism in place that includes an up-to-date list of services and established procedure (see the case studies below).

As part of wider anti-poverty strategies, several health sector agencies, in particular primary care organisations, have been experimenting with offering advice about claiming welfare benefits, with a service delivered in health care settings. This aims to address the links between mental and physical health and income inequality, debt and material deprivation (2). By connecting patients to professional advice on benefits, health services professionals contribute to addressing one factor that may cause psychological stress in their patients (15) and improve the context in which they live. Such activity may reduce the number of consultations with and prescriptions from GPs (16). Referral of this type is particularly successful where the services are readily accessible – for example, Citizens Advice Bureaux situated in GP surgeries have been found to be 'a viable and useful adjunct to primary health care teams in terms of information-giving, social support, up-take of benefits and co-ordination of services' (105). Other services can also benefit from co-location; for example, a domestic abuse service in a hospital, as the PATHway case study shows.

Social prescribing, where doctors provide a prescription for a non-medical community resource such as an exercise group, art class, or volunteering, can be useful to mitigate the social determinants of health. Studies have shown that social prescribing can provide a valuable link between primary care and the voluntary sector and strengthen community-professional partnerships (107). Social prescribing deals with social determinants of health issues such as social isolation, housing, benefits and family issues (107). Because social prescribing tends to be linked to local community-based activities, it often has multiple benefits – for example, an exercise group might provide not only improved physical fitness but also increased social contact, leading to greater social cohesion and support. Studies have claimed that social prescription can enhance self-esteem, increase opportunities for social contact, and increase confidence (108), as well as having an impact on general health and quality of life (109).

Health professionals should be as aware as possible of the full range of community and national services available to which they can refer their patients, for instance the local housing advice centre, Children's Centre, counselling, and debt and

Referral case studies

AWARM: Salford City council & PCT – affordable warmth access referral mechanism (101)

Research by the UKPHA Health Housing and Fuel Poverty Forum (102) concluded that a model of local area partnerships that linked health, housing and fuel poverty services was the most effective approach for directing services to the most vulnerable in society.

The model identified the key systems and processes necessary to access the vulnerable poor, identify high risk groups, streamline referral and delivery systems and implement monitoring and evaluation processes.

Over 1000 referrals were made by frontline professionals from social services, voluntary sector, local government, housing and health sectors. The programme trained 1,359 professionals, a third in health, the remainder in social services, local government, housing and voluntary services.

An economic evaluation of the project showed its effectiveness. The model analysed benefits of warmer housing in terms of an increase in quality of life and a smaller increase in length of life. The gain in quality-adjusted life years due to an improvement in quality of life in 82 adults was estimated to range from a minimum 1.67 to a maximum of 31.6, depending on the scenario modelled.

GLOW: Blackburn with Darwen Professional Referral network into Home Improvement Services (103)

The GLOW referral is a systematic assessment of housing and health needs during patient contact with health and social care professionals. The programme recognises that, “a significant proportion of winter hospital admissions can be avoided by preventative measures to improve the quality of people’s homes”.

Between 2010 and 2011, the pilot successfully identified 315 elderly patients requiring coordinated support through local authority and Care Trust Plus partnership, including 124 referred for medicine reviews, 118 for falls assessment and 145 for housing advice and support for energy efficiency grants.

Sandwell Healthy Lifestyle Services (104)

Sandwell has set up a free phone number service for health professionals or other members of the public. This provides up-to-date details of programmes in the local area. The services cover the following areas:

- Confidence and wellbeing
- Alcohol and drugs
- Physical activity, healthy eating and weight management
- Health trainers
- Welfare rights
- Employment

Having a reliable database accessible through one phone number should increase the ability of health professionals to refer patients to services which help to tackle the social determinants of ill health.

Case study: Links Project

The Links Project (110), based in Scotland, was a six-month project which aimed to explore how General Practice can and should be a ‘vital connector’ between patients and sources of local support. This applies not only to GPs themselves, but also to other staff such as receptionists and community nurses who often have valuable local knowledge.

The project created teams which gathered data, case studies, and facilitated discussions on how best to link with communities. During the course of the study, GP practices reported that a significant number of people living in deprived areas in

Glasgow were willing to accept a recommendation to attend a community resource, and a significant number of these people were still attending four to six weeks later.

It was also reported that a personalised, relationship-based approach was important, and that trust in relationships was essential (as discussed above). Finally, it recommended that staff should be made more aware of social prescribing, and that the availability and use of up-to-date local information (possibly online) was necessary.

financial advice services. In order to facilitate this knowledge, it is essential that health professionals have easy access to a directory or ‘hub’ of relevant services. This could be supported and/or run by the local CCG, local authority and other organisations such as children’s services. As the RCGP recognises, an accurate, comprehensive and regularly updated directory of this type would increase practitioners’ confidence in referring their patients to other services (8). Health professionals can also extend the range of services available, or adapt them to improve suitability for their local population, through their commissioning activities. This is covered in Chapter 4.

Health professionals can also widen their health promotion strategy. Often, health professionals will advise their patients to stop smoking, drink less, or change their behaviour in other ways. However, they can broaden and diversify this advice. One good example is advice given to new parents. GPs, midwives, health visitors, nurses and others will often advise parents of young babies how to hold their child, or encourage breastfeeding. These factors affect physical health, and are undoubtedly important. However, cognition, communication and language, and social and emotional development are also important. There is good evidence that a child’s development in these areas is affected by factors such as being read to regularly, having regular bedtimes, and being spoken to and listened to (111). This is

Case Study: PATHway: an independent domestic violence advisory service at St Mary’s Maternity Hospital, Manchester (106)

St Mary’s Maternity Hospital, in Manchester, treats many patients from deprived backgrounds, particularly from the local Pakistani and other minority ethnic communities. It has located an Independent Domestic Abuse Advisor (IDAA) in the maternity ward, so midwives can refer patients to her immediately.

Every female patient was asked routinely by their midwife about domestic abuse. However, it was found that referrals to outside agencies or bringing in an outside professional at a later date were less successful than referral to someone onsite.

In the 15-month pilot during which the IDAA was located on site, 160 women were seen, 57% of whom were Pakistani or from other minority ethnic groups. Other domestic abuse services have been less successful in reaching women from minority ethnic groups. Women were seen very quickly in this case – many of them within minutes.

An independent evaluation reported increased referrals, an increase in outcomes (116 out of 126 women said they felt safer), and a cost saving – the 28 cases referred to a multi-agency risk assessment conference (those at high or very high risk of murder) resulted in an estimated saving to the public sector of £170,800.

linked to later outcomes such as readiness for school and results throughout school attendance. Health professionals, particularly those who have regular contact with parents such as health visitors, GPs, midwives, and paediatricians, are in a good position to support parents on these aspects of parenting.

Case Study: The Royal Free London Foundation Trust

The Trust has placed Public Health and Health Inequalities high on the agenda. Senior leadership support and investment in a Trust Public Health lead has enabled The Trust to develop a program that has initiated a ‘suite’ of public health initiatives, many of which address health inequalities ‘head on’. The program includes the following:

Supporting Healthier Lives

Well at the Free: Is an innovative pilot designed to create a focal point in the hospital providing support to patients, carers and staff. It will provide people with a better understanding of their health and what they can do to lead healthier lives, with a focus on tackling health inequalities. This exploits the value of the “teachable moment” in a hospital setting.

Better Health For All

A&E assault-related violence data sharing: Reception staff has been highly successful at collecting anonymous violence and assault data on those attending the Emergency Department and sharing this with local Community Safety Partnerships in order to inform prevention initiatives. This has made an important contribution to local violence reduction initiatives.

Domestic Violence Screening: The success of A&E assault data collection has led to a domestic violence screening pilots in key areas: Gynaecology, Maternity and Sexual Health.

Taking a Population Perspective

Trust strategy: Population based data and needs assessment has been key to many service developments, leading to a greater understanding of the changing needs and inequalities within the catchment population

Reducing Readmissions

Avoidable emergency readmissions are a problem for both patients (who in many cases could receive more appropriate healthcare outside a hospital) and the hospital; increasingly the readmission rate is being used as a performance indicator. A readmissions audit has identified the factors associated with readmissions.

Conclusion and next steps

There are three key processes which will enable health professionals to take action on the social determinants of health as they interact with and treat patients.

Firstly, a relationship of trust and support can benefit the patient, and the practitioner, as the communication increases control and improves the uptake of public health messages.

Secondly, gathering information, through taking a social history for example, is essential on an individual level, so that professionals can discover the contextual sources of ill health, and in aggregate, to better understand and respond to the needs of the community.

Thirdly, information should also be given from practitioner to patient, in the form of referral or social prescribing. Making sure that patients access services to tackle the social determinants of health can improve health outcomes. Co-location has been shown to improve referral procedures. Public health messages can also be broadened and increasingly focussed on social and economic conditions.

The three actions described above have traditionally tended to take place more in primary and community care settings. However, secondary care and the actions taken in acute trusts, for example, are also very important. Since patients in hospitals tend to be unwell and anxious, they are often more open to advice and referral from health professionals (112). They also tend to be in hospital for a longer single period than they will be in contact with primary care, which gives health professionals in secondary care an opportunity to build relationships with patients and gain understanding about their social and environmental conditions. In Chapters 3 and 4 we have included case studies from acute trusts. Similarly, psychiatrists, psychologists and other mental health workers often help people in dealing with stress and anxiety, gaining information about underlying issues, and are regularly involved in referral mechanisms.

The actions recommended here should be taken not only by GPs, nurses and midwives, but also by a range of other health professionals. Particular actions that are likely to be effective are discussed in greater detail in Part B, where nineteen statements from different organisations give guidance for professional involvement. This includes chapters on hospital doctors and psychiatrists. The broad range of contributions in this section shows that actions can be taken by all health professionals. Additionally, the commitments below demonstrate an impressive level of involvement and intention to implement the sorts of actions discussed above.

Working with individuals and communities commitments

The *Institute of Health equity* commits to:

- Work with Royal Colleges, CCGs and others to inform practitioners about ways to tackle health inequalities and support implementation of best practice.

The *Academy of Medical Royal Colleges* commits to:

- Explore early interventions in childhood to reduce health inequalities and determine how health professionals can be enabled to deliver these (tools for health care professionals to be developed)
- Produce a cross-specialty report looking at evidence for interventions to increase activity and reduce health inequalities.

The *Royal College of Physicians* commits to:

- Ensure that the Future Hospital Commission, established to review all aspects of in-patient care, considers ways to optimise access to care for all those in society including the most disadvantaged. In particular the Commission will focus on elderly patients with mental illness
- Ensure that the RCP's patient and carer network (PCN) will work with voluntary organisations to develop a broader understanding of the experience of marginalised members of society when accessing health care, and ensure these views are registered when developing RCP guidance and policy positions. The PCN is looking at ways to ensure that its membership reflects wider society and health service users more broadly
- Collect survey data to understand the perceived barriers its members and fellows encounter when discussing social risk factors and social circumstances with their patients
- Encourage physicians to discuss, record and audit the broader social factors contributing to ill health. The RCP will work with other organisations to ensure that information regarding available services (in particular employment) is available to clinicians to refer their patients.

The *British Dietetic Association* commits to:

- Raise awareness of the important public health role that all dietitians have and ensure that there are increased opportunities to influence policy and practice to improve health outcomes by:
 - Providing guidance for all dietitians as to how they can influence service provision and workplace and community policies to tackle health inequalities
 - Commissioning articles in the profession's magazine (*Dietetics Today*) to raise awareness of how dietitians can work with others to reduce health inequality
 - Develop the BDA website as a resource for information on and guidance for members and as wider communication to the general public.

The *Royal College of Paediatrics and Child Health* commits to:

- Circulate widely information regarding its programmes that look at childhood morbidities. The RCPCH will promote its ongoing projects and campaigns, such as Child Health Reviews – UK, the e-portal for mental health and the AOMRC’s obesity campaign, as well as work to develop others
- Inform clinical practice through its findings and consult with paediatricians in order to use their expertise in this work
- Ensure that the curriculum’s current competences around key determinants of child wellbeing and indices of social deprivation reflect all aspects of health services, while stressing the importance of these determinants and factors to paediatricians
- Continue to facilitate greater participation from children and young people and ensure that clinicians are aware of its Youth Advisory Panel and Parents and Carers Group so they can engage with these groups and pay attention to the voices of children and young people.

The *Royal College of General Practitioners* commits to:

- Focus on social inclusion as one of the RCGP’s clinical priorities. This priority focuses on people from socially excluded groups who have problems accessing primary health care services. This includes key groups such as asylum seekers and refugees, homeless and vulnerably-housed people, travelling communities, offenders and sex workers
- Publish in the near future its vision for general practice in 2022 which emphasises the need to tackle health inequalities by improving access to GPs in deprived areas and reaching out in new ways to vulnerable populations.

The *Royal College of Speech and Language Therapists* commits to:

- Produce a report looking at evidence for reducing social disadvantage and health inequalities for people with communication difficulties.

The *Chartered Society of Physiotherapy* commits to:

- Encourage and support physiotherapy staff to incorporate targeted preventative care into their everyday practice
- Disseminate examples of innovative services, designed to address social determinants of health in the local population, as well as the physical and mental health needs of patients.

The *Dental Schools Council* commits to:

- Advocate for all dentists to be made aware of their responsibilities for the promotion of oral health across all socio-economic groups.

The *Royal College of Obstetricians and Gynaecology* commits to:

- Encourage its members to use maternity (including the postnatal period) as the episode from

which to inform women about the importance of lifestyle factors (such as alcohol intake, smoking cessation, proper diet and nutrition) in overall health and wellbeing

- Work closely with the Faculty of Sexual and Reproductive Healthcare (FSRH) to ensure that public health messages are embedded in community services.

The *British Association of Occupational Therapists and College of Occupational Therapists* commits to:

- Ensure that the social determinants of health are included and referred to, as appropriate, in any new practice guidelines produced
- Promote the public health and health promotion activities that occupational therapists are involved in and develop links with key public health colleagues.

The *Royal College of Psychiatrists* commits to:

- Disseminate widely the JCPMH public mental health commissioning guidance and other key documents including its position statement on Public Mental Health to its members and key stakeholders. This will support efforts to raise awareness of and address the lack of treatment of people with mental disorder as well as lack of provision of interventions to prevent mental disorder and promote mental health, all of which contribute to inequalities. It will also highlight the need for such interventions to be commissioned in a universally proportionate way.

The *Royal College of Nursing* commits to:

- Continue to work to promote the messages in the RCN *Going Upstream* guidance: nursing’s contribution to public health which provides a framework to engage actively in upstream public health. The document provides case studies to support other nurses in developing work
- Continue to raise the issues around the impacts of factors such as mental health and fuel poverty.

The *Allied Health Professionals Federation* commits to:

- Continue to support the work of the National Inclusion Health Board through the active engagement of Paul Hitchcock as the Chair of the Leadership and Workforce working group. The Government’s Inclusion Health programme focuses on improving the health outcomes of the most vulnerable and socially excluded groups in society

The *NHS Alliance* commits to:

- Work with CCGs and the Royal Colleges to inform practitioners about ways to tackle inequalities, and support implementation of best practice.

The *British Medical Association* commits to:

- Promote action on the social determinants of health in interactions between doctors and individual patients, their families and contacts, using clinical tools including social prescribing and brief interventions

- Endorse a holistic approach to medical practice, where doctors consider the patient as a person within the context of their physical, economic and social environment.

Medsin commits to:

- Continue to support students in generating programmes to improve health and reduce inequities in disadvantaged and vulnerable individuals and communities, sustainably, through:
 - health promotion and educational activities to empower the individual
 - advocating for individuals and utilising these examples to provide case studies for other work
 - direct service provision where necessary and appropriate.

The *British Association for Music Therapy* commits to:

- Promote the profession as a means of engaging those in our communities who are vulnerable to exclusion – those for whom English is not their first language, and those whose disabilities mean they cannot speak and are therefore not able to access many psychological therapies. Music therapists engage with people who are traditionally ‘difficult to reach’, which include those with challenging behaviour, personality disorders and those suffering post-traumatic stress.



3 NHS organisations

Key recommendations:

Health professionals should utilise their roles as managers and employers to ensure that:

- Staff have good quality work that increases control, respects and rewards effort, and provides services such as occupation health.
- Their purchasing power (in employment and commissioning) is used to the advantage of the local population, using employment to improve health and reduce inequalities in the local area.
- Health inequalities strategies are given status at all levels of the organisation, so the culture of the institution is one of equality and fairness, and the strategies outlined elsewhere in this document are introduced and supported.

The NHS Constitution states that the NHS exists “to improve our health and wellbeing, supporting us to keep mentally and physically well” (114). This ethos needs to be extended beyond those who are *served* by health services, to those who are *employed* by them. The NHS is the largest employer in the country, with 1.4 million staff (17), plus staff employed in non-NHS commissioned services. Health professionals, through management and leadership roles, have the opportunity to influence the health of the people they employ as well as the people they treat.

NHS organisations as places of good quality work

There is much that NHS institutions and organisations can do to improve the quality of work. Evidence has consistently shown that employment is better for mental and physical health than unemployment. However, this only applies to good quality work (2). Good work is, in part, characterised by a living wage, and in the Marmot Review we advocated for a minimum income for healthy living (MIHL), a calculation which takes into account the need for a healthy diet, physical activity and costs related to social integration. The campaign for a ‘living wage’ has also grown recently (115). Similarly, it advocates for a wage that considers the cost of living in the UK. While most permanent NHS staff receive a MIHL,

contracted, temporary or commissioned staff may not, especially in high-cost living areas. It should be a priority for managers to ensure that *all* staff receive a fair wage. Often these wages will be set centrally, in which case, managers should advocate for changes to occur centrally where needed. However, often managers must also make decisions about which contractors to use. In these cases, they should ensure that the contractors they hire pay their staff a decent wage.

Adequate pay is important, but there are other equally important features of ‘good work’, such as having control over work, including flexibility, security, and protection from adverse working conditions; being respected and rewarded, for example by the provision of in-work development; and being provided with services such as ill health prevention and stress management strategies, as well as support for sick and disabled people that facilitates a return to work (2). Security is a particular issue considering the increasing use of temporary or ‘zero-hours contracts’ (116). ‘Zero-hours contracts’ require individuals to be available for work but employers do not have an obligation to provide any work, and only pay for the hours that they do offer. These, along with temporary contracts, tend to provide workers with variable or lesser employment protection and benefits such as paid maternity leave or sick leave. Zero hours contracts also create uncertainty, insecurity and often lower income for employees (116).

The importance of control, respect, security and the provision of services has been recognised by other studies, such as Carol Black’s review of the UK’s working age population (18), and the Boorman Review (19), which applied the Black Review’s conclusions to the NHS.

The Boorman Review (19) made recommendations in the following areas:

Improving organisational behaviours and performance, including:

- Provision of prevention-focussed staff health and wellbeing services
- Development of NHS leaders and managers to recognise links between staff health and wellbeing and organisational performance
- Assessment of NHS leaders and managers in terms of whether they contribute to or undermine staff health and wellbeing
- Promotion of mental health and wellbeing at work
- Identification of board-level champion and senior managerial support for staff health and wellbeing
- Provision of training and tools for managers.

Achieving an exemplar service, including:

- Consistent access to early and effective interventions for common musculoskeletal and mental health problems
- Engagement with staff to determine specific needs and requirements, and desired services
- Giving importance to risk assessment and proper resourcing
- Giving importance to early intervention.

Embedding staff health and wellbeing in NHS systems and infrastructure, including:

- Placing NHS staff health and wellbeing into the NHS operating framework and national and local governance frameworks to ensure accountability
- Including staff health and wellbeing in Care Quality Commission and Monitor procedures
- Involvement of staff and trade unions in developing support
- Routinely monitoring, reporting and discussing implementation of procedures with staff
- Providing availability on an equitable basis.

These recommendations have been adopted by many organisations, for example, the London NHS health and wellbeing group, working with the aim to take forward recommendations of the Boorman Review (117), but work is still needed to ensure that they are fully embedded and developed for all organisations. In terms of services offered to employees, occupational health services are essential; however, current occupational health provision in NHS organisations is of varied quality and extent, as with other health and wellbeing services (19). All NHS organisations should ensure that their staff have access to good quality occupational health services.

Strategies and services can also tackle wider determinants of health. Carol Black argued that, “more holistic support to address broader determinants of poor health such as housing or financial concerns” would enable individuals to remain in work, or return to work following sickness absence (18). Such activities will also act as support to employees’ families and dependants and should form part of human resource policies and procedures across the NHS. Some services can be provided by the NHS organisation, others should be clearly and consistently signposted. (For a further discussion of referral, see Chapter 2.)

The National Institute of Clinical Excellence (NICE) has produced guidance on promoting mental wellbeing through productive and healthy working conditions (118). The guidance covers issues such as having a strategic approach to mental wellbeing, opportunities to assess mental wellbeing and managing risk, flexible working and the role of managers. Providing guidance on stress management and the active promotion of mental health at work are also important (22). NHS organisations that encourage active travel, exercise and other healthy alternatives for staff will also help to improve health and wellbeing, both mental and physical (2).

As with the Boorman Review, the NHS Future Forum recommends that NHS organisations and

their delivery partners should be held accountable for the mental and physical health of their staff, including developing strategies and reporting annually on progress. They advocate that managers and leaders should be held to account on this agenda in their performance appraisals (113).

Providing good quality work across the NHS workforce is likely to have a proportionately larger effect on those from lower socio-economic groups, as there is a socio-economic gradient in quality of work – those lower down the gradient are more likely to have worse quality work (2). Providing good quality work will improve the health of these groups, thereby reducing the gradient and health inequalities. Taking action will also have a knock-on effect on organisational performance, leading to improved patient satisfaction, stronger quality scores, better outcomes, higher levels of staff retention and lower rates of sickness absence (19).

There is also an economic case: NICE guidance suggests that the annual cost of mental ill health to an organisation with 1,000 employees is estimated to be £835,355 (119), and there are studies that have shown that the cost of worklessness and ill health across all industries is estimated to be higher than the NHS annual budget (18). As such a large employer, changes within the NHS to improve staff health and wellbeing would have clear benefits, both within individual organisations, across the sector, and to society as a whole.

Following the Boorman Review, and building on the considerations set out here, Barts and the London NHS Trust commissioned IHE to explore what actions could be taken in the trust, which could also be applicable across other NHS organisations (22). The recommendations made by IHE include the following:

- Reviewing the Occupational Health policy with a focus on prevention and early intervention
- Progressively increasing the rate of response to the staff survey over the next three years to reach 75% cover
- Ensuring appropriate mechanisms are in place to retain staff and improve their wellbeing
- Changing induction practices to ensure focus on quality of work and improve understanding about what a difference this makes
- Improving the psychosocial work environment
- Dealing with bullying and harassment effectively
- Developing the focus of Occupational Health and Human Resources towards prevention, communication, and accessibility
- Developing an effective active travel strategy
- Developing a healthy food strategy
- Proactively engaging with private sector partners to improve the health and wellbeing of contracted staff
- Developing and sustaining wider health promotion programmes.

The actions of the Barts Trust following the publication of this strategy document are set out as a case study, below.

Case study: Barts and the London NHS Trust

Barts Health has established a public health function under its medical director to address the issue of health inequalities in East London. The public health approach has three themes:

- 1 Making every clinical contact count for patient health
- 2 Staff health and wellbeing
- 3 Community employment and procurement

The first theme includes work on key public health issues relating to smoking cessation, alcohol misuse and obesity, and over time will look to improve access to health and improve affirmative action within routine care. The immediate work is focusing on greatly increasing the numbers referred to smoking cessation services from pre-operative assessments and from in-patients.

The second theme is led by the team's staff health and wellbeing coordinator and will provide staff with comprehensive support to change unhealthy health behaviours and improve wellbeing. A health and wellbeing group has been established, chaired by the chief operating officer. The immediate priority identified is to increase fitness and physical activity among staff on all sites and across staff groups.

The third theme seeks to maximise local employment at the trust, which with 15,000 staff is the largest in England. The Community Works for Health has been highly commended at the Health Services Journal Awards for its successful work in this area, which has particularly focussed on getting under-represented groups into the workforce, including local Muslim communities. Next priorities will be to increase the number of apprentices at the trust and to increase health careers work with East London schools and colleges.

Case study: London Health, Work and Wellbeing Forum (117)

The London Health, Work and Wellbeing Forum is an enabling network for NHS and local authority organisations, supporting workplace health professionals to share good practice on improving health and wellbeing at work. It has a membership of around 90 members, representing over 20 local authorities and NHS organisations respectively.

Since its establishment in June 2010, it has met ten times, covering a range of themes from employee engagement to health inequalities, mental wellbeing and flexible working. Members are part of a sub-committee, set up to agree themes and speakers for future events, in addition to chairing the forums. The network was established by the London Health, Work and Wellbeing programme, with support from the Greater London Authority and NHS London.

Case study: London Workplace Wellbeing Charter (120)

The Workplace Wellbeing Charter is a framework that supports businesses to self-assess their current activities and work environment against recommended standards to improve health at work. It also supports awards for employers against assessment standards at three levels – commitment, achievement and excellence. The assessment standards cover leadership, health and safety, attendance management, physical activity, healthy eating, mental health and wellbeing, smoking cessation and alcohol and substance misuse.

In London, the Charter is being piloted in six boroughs with public health leads engaging with a range of employers. Two NHS hospital trusts are taking part in the phase – Kingston Hospital and Guy's and St Thomas', with a combined workforce of over 15,000.

NHS as employers in the local area

Many managers in NHS organisations will be involved in deciding hiring practices for the workforce. This gives an opportunity to positively affect inequalities within the local area. In order to achieve this, it is important that managers:

- Create a good work environment, as detailed above
- Employ people from the local community
- Develop greater security and flexibility of employment and retirement age (22)
- Provide jobs that are suitable for lone parents, carers and people with mental and physical health problems (22)

In many communities, the local NHS organisation employs a large number of residents, from a range of socio-economic backgrounds. One literature review found that the health sector often accounts for 15–20% of a local community's employment and income (20). This gives health organisations significant power to affect the health and wellbeing of their local population. By using their purchasing power to ensure these residents are decently employed, and then work in a good environment, NHS organisations can affect the health outcomes of these employees and their families.

This purchasing power extends to contracted services, which should also be rigorously assessed on a health equity basis, and even further to services commissioned by health professionals in their position on CCGs. Public bodies now have a legal duty to consider how procurement might improve the economic, social and environmental wellbeing of their area (21). These commissioning issues are discussed further in Chapter 4.

Organisational culture and management

The importance of an approach based on the social determinants of health needs to be recognised by managers as well as health professionals within the NHS. As discussed above, this applies to strategies to improve the health of the NHS workforce. However, it also applies more generally. If the actions that have been discussed in this report (particularly in Chapters 2 and 4) have support at all levels of an organisation, they are more likely to succeed. Support from managers will increase the chances that actions on the social determinants of health are strategic, consistent, coordinated across the organisation and workforce, and appropriately incentivised.

Acute trusts that have a focus on health equity at board level will be increasingly able to tackle health inequalities in all their activities. As well as ensuring that action is taken to tackle health inequalities by the workforce, and putting strategies in place to tackle health inequalities within the workforce, trusts and other NHS organisations can ensure that they are places of best practice, for example by providing healthy food for patients and staff. Boards should be assessing improvement on health equity measures as well as quality of care, equality of access, and

financial performance. The NHS good corporate citizenship tool can help organisations to address issues of workforce health and wellbeing, local procurement, and environmental sustainability (121).

It is also the responsibility of managers to ensure that these strategies are shared with other organisations, in order to help ensure effective partnership work across organisational boundaries. Actions will vary across different sectors of the NHS. CCGs are discussed in Chapter 4, and Royal Colleges in Chapter 5.

Conclusion and next steps

Professionals and institutions have a responsibility not only to the patients they treat, but to the people they employ. Since we know that working conditions are an important social determinant of health, there is great potential to affect the health and wellbeing of the 1.4 million NHS staff, plus other staff in contracted and commissioned services. The Boorman Review addressed the issue of NHS staff health and wellbeing, and all organisations should be using this to build their own strategies to ensure good quality work. NHS institutions should also design their employment, practice, purchasing and commissioning procedures to benefit the local community. Finally, managers should ensure a high-level strategic commitment to tackling health inequalities is in place in their organisation, and has support from the board or equivalent body.

NHS organisations commitments

The *Royal College of Midwives* commits to:

- Pay its staff and contractors the living wage.

The *Royal College of Physicians* commits to:

- Continue to ensure all its 350-odd staff receive a London Living Wage and explore applying for accreditation from the Living Wage Foundation
- Include measures of workplace determinants of health inequality in the RCP organisational audit of NHS trusts' implementation of NICE public health guidance for 2013
- Measure how frequently organisational plans or policies within NHS trusts address the different needs of different staff groups, whether or not trusts measure the uptake of any programmes by different staff groups (by gender, grade or ethnicity), and whether or not programmes are adjusted where there is a clear difference in uptake.

Barts Trust commits to:

- The actions set out by its staff health and wellbeing work group, including:
 - Improving the quality of work across job grades
 - Engaging staff and responding to their needs
 - Widening and improving access to preventative and early intervention occupational health services

- Developing a clear occupational health strategy and SLA across Barts Health Trust, including health surveillance/promotion
 - Improving health behaviours among staff members
 - Supporting staff with their wider needs
 - Integrating and delivering sustainable improvements
- Progressing its position on the good corporate citizenship model.

The *Royal College of Paediatrics and Child Health* commits to:

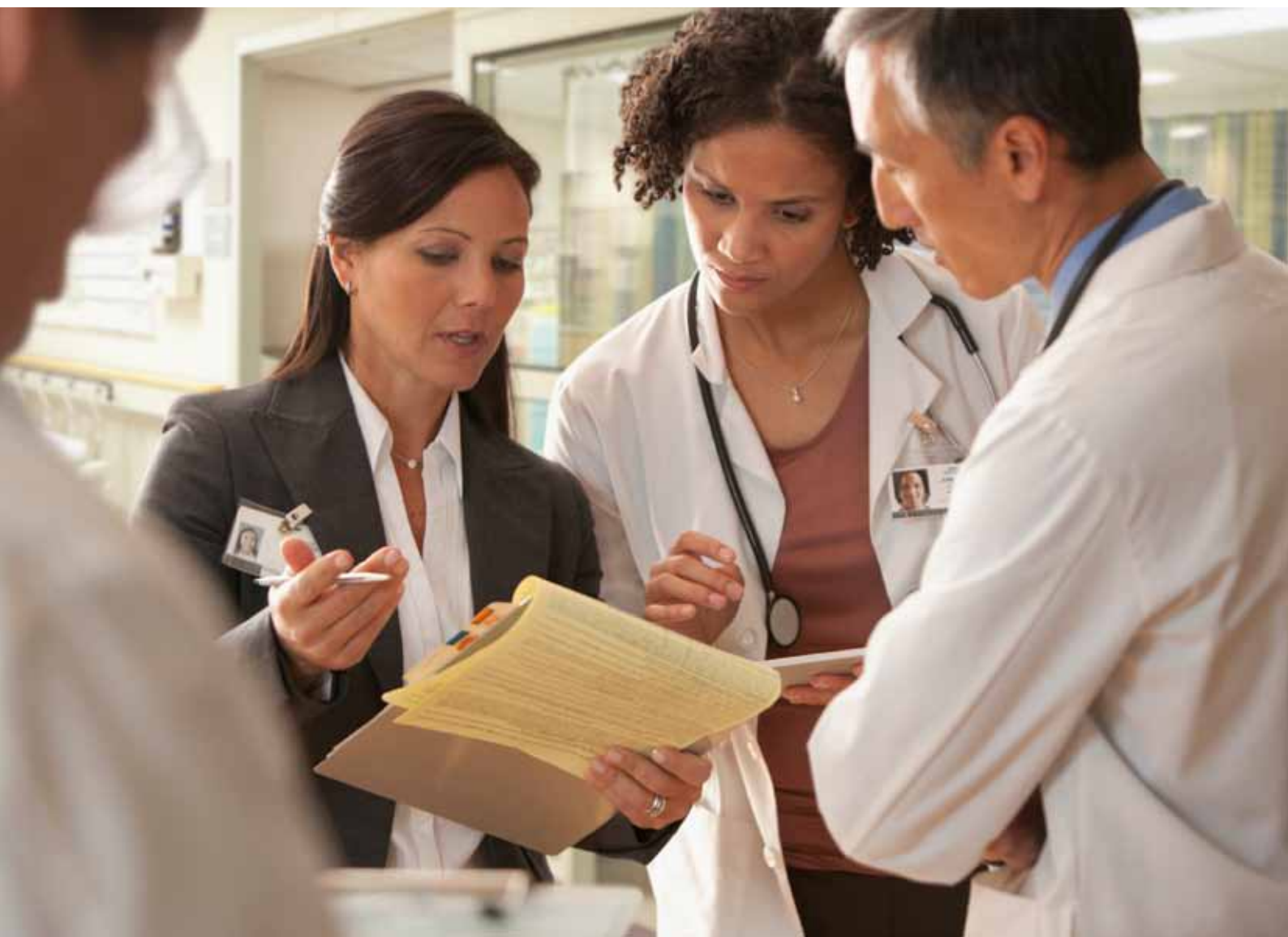
- Canvass for change by promoting and taking part in hospital audits, which could be used to highlight health discrepancies and also as a measure to highlight issues with MPs and government, by:
 - Continuing its work of national audits and highlighting areas for improvement to Trust CEOs. Currently, it is producing a report reflecting the audit of the ten standards for acute paediatric care outlined in the *Facing the Future* review published in 2011. In looking at the current provision of care for children and young people, the College will offer possible solutions to service problems.

The *Chartered Society of Physiotherapy* commits to:

- Advocate for wider uptake of the Boorman recommendations, including fast access to physiotherapy, to improve health outcomes and reduce health inequalities within the NHS workforce.

The *British Medical Association* commits to:

- Continue to work to ensure that NHS employees receive good health and wellbeing interventions in their workplace.



4 Working in partnership

Key recommendations

Within the health sector

Partnerships within the health sector should be consistent, broad and focussed on the social determinants of health.

With external bodies

Partnerships between the health sector and other agencies are essential: they should be maintained, enhanced, and supported by joint commissioning, data sharing and joint delivery. They must, however, be well designed and assessed for impact.

Clinical Commissioning Groups

CCGs should make tackling health inequalities a priority area, and should measure their progress against this aim. They can do this via their role as commissioners, in partnership (particularly with HWBBs), and as a local community employer and advocate.

Working in partnership is essential to taking effective action to reduce inequalities. Evidence shows that effective action often depends on *how* things are delivered, as much as *what* is delivered (2). A key element of this is collaborative, cooperative work that is either delivered jointly by more than one sector, or draws on information and expertise from other sectors. Since many of the causes of ill health lie in social and economic conditions, actions to improve health must be taken collaboratively by a range of agencies that have the potential to affect social and economic conditions. This was recognised in the Health and Social Care Act, which states that services have a duty to integrate, both within the health sector and with external services, where this would reduce inequalities (23).

In the Education chapter (Chapter 1), we discussed the best ways to teach students partnership skills, including joint training placements with other health professionals or non-health sectors, and receiving teaching from a range of professionals in relevant areas. This chapter discusses, in turn, the importance of partnerships between health professionals, and partnerships with those outside the health sector and with patients. We then discuss ways in which Clinical Commissioning Groups, as key

strategic partnerships, can help to tackle inequalities through their commissioning activities.

Partnerships within the health sector

Many health professionals work extensively and successfully with other health care staff. Partnerships and multi-disciplinary teams often extend across primary, secondary and tertiary care; between nurses, psychiatrists, doctors, surgeons and more; and are a core part of day-to-day business for practising professionals. For example, allied health professionals often work very closely both with other allied health professionals and with the wider health workforce. In Part B of this report, the ‘Allied Health Professionals’ statement for action includes sections on seven different allied health professions, and the actions that they take, including those in partnership with other professions. Partnerships within the health sector should, wherever possible, include a social determinants of health approach.

Partnership work can both improve the delivery of clinical care, and potentially assist professionals in understanding and tackling the wider social determinants of health. Multi-disciplinary team work and integrated care pathways are increasingly promoted as an effective strategy for improving patient care (122).

NHS networks bring together a range of health professionals to share information and coordinate action to tackle a particular disease area or patient group. While there have been reorganisations and cuts to some networks, the NHS Commissioning Board has recently published plans to continue supporting this activity by hosting and funding four ‘strategic clinical networks’, in cancer, cardiovascular disease, maternity and children’s services, and mental health dementia and neurological conditions. The rationale is that these are conditions or groups, “where improvements can be made through an integrated, whole system approach” (123). This type of whole-system approach has shown some improvements in outcomes for target groups or conditions (124), although results have varied between local areas (125). Inclusion Health have also proposed setting up inclusion health networks – networks of local experts working collaboratively to address issues of social exclusion and inform local commissioning for the most excluded groups.

We suggest that these multi-disciplinary teams and NHS networks must also have a social

determinants of health approach in order to better inform the participating health professionals and organisations about how the health of those they are treating is affected by social and economic inequalities. This is an important opportunity to share learning and experience in this area, and to ensure that actions taken by health professionals tackle the root causes of ill health as well as their manifestations.

The Royal College of Obstetricians and Gynaecologists has published a strategy that advocates taking a life-course approach to women's health, and focussing on inequalities (126), and has also set up a 'women's health' network, which encompasses maternity and children's services, but also women's health across the life course, with a particular focus on the social determinants of health (see Part B).

Other partnerships, which often occur more informally, are also important. However, in order to make the most of each other's expertise, experience and patient knowledge, professionals should be given the time and opportunity to work together. This means that partnership working should be part of strategic organisational plans, and that partnership, coordination and communication should be facilitated by managers and commissioners as well as actively pursued by individual professionals.

Partnerships with those outside the health sector

While partnerships within the health sector are important, partnerships with external bodies are a bigger, and potentially more important, task. In the Marmot Review, we stated that tackling health inequalities should be a priority across a broad range of areas (2). Actions taken within health services will be most effective where wider policies in areas to tackle the social determinants of health, in other sectors, are also being implemented. There are a several key principles for partnership work on the social determinants of health:

- Partnerships are beneficial across a wide variety of sectors
- Partnerships should include but go beyond information-sharing to facilitate joint planning, commissioning, and delivery
- Partnerships should be carefully designed, facilitated and supported by managers and commissioners.

Variety of sectors

In order to reduce health inequalities, partnerships across a broad range of sectors are beneficial. This includes local government, other public sector partners, the police and fire service, charities and other third sector organisations, private companies and places of work, and schools (2). Having partnerships across sectors enables action to be more holistic and ensures that wider issues are recognised and acted upon – for instance the need for effective partnerships between social care and health has long been recognised (see 'Social Work' in Part B). Co-location was discussed in Chapter 2 as an effective way to

Case studies: homelessness

Some good examples of partnership work have been in programmes for particular excluded groups, such as homeless people.

London pathway UCH (47)

London pathway is a charity that trains and supports GP and nurse-led integrated teams for homeless patients in secondary care. The approach brings together social workers, physiotherapists, drug and alcohol workers, psychiatrists, housing representatives, primary care teams, and discharge sisters in order to coordinate care for homeless people, meeting their complex needs. Although primarily a quality improvement approach, the service has reduced the average duration of stay for homeless patients at University College Hospital (UCH) by 1.5 days, amounting to 1000 bed-days per year, and annual net savings of £300,000.

Partnership working was essential to this success. The programme implemented weekly multi-agency care planning meetings for complex homeless patients and increased the proportion of homeless patients discharged with multi-agency care plans from 3.5% to 35%.

Teams have been trained and supported at UCH, Royal London, Royal Free and Brighton and Sussex University Hospitals.

Housing level service agreement (132)

This collaboration between Homerton Hospital and London Borough of Hackney involved hospital staff working collaboratively with the borough in order to ensure that homeless people were housed by the council for the duration of their TB treatment, thereby increasing the chances of successful treatment.

Great Chapel Street (133)

Great Chapel Street is a walk-in medical centre for homeless people in Westminster. It takes a holistic view to tackling health inequalities, and the team includes GPs, and a practice nurse, substance misuse/mental health specialist, counsellor, dentist, psychiatrist, benefits advice worker, and an advocacy/legal advice worker. They often work with external partners. Their service approach is:

- “To reduce social exclusion – To improve access for homeless people to health services and act as a point of contact for linkage to mainstream medical and social services.
- To reduce health inequality – To improve the health of the homeless population by recognising and addressing the multiple social and medical needs of our patient group.
- To provide continuity of care for patients – To offer a reliable and constant point of contact and follow through to those who lead a transient lifestyle.” (133)

improve the efficiency of referral. It can also improve the delivery of partnership work.

Health professionals could work with local and national employers in order to ensure that employers support people to return to work, improve conditions of contracts and work to produce healthy workplaces, as outlined in Chapter 3 in reference to NHS organisations. The Marmot Review also included information on the health effects of work, and recommendations on how to create healthy work (2).

Early years and childcare health are also important examples of the value and necessity of partnership working across sector boundaries. In order to effectively tackle the root causes of ill health, action early in life is essential. This should include an awareness of and willingness to change the conditions in which children are born, and the care and opportunities that are made available to them (111). This will affect their health, not only as children, but across the life course. In order to take action in this area, partnerships between Children's Centres, schools, social care, and health visitors, midwives and other health professionals are essential. When these different sectors communicate effectively, deliver joint programmes and tackle individual problems in a collaborative way, outcomes tend to improve (25).

Partnership strategies: information-sharing, joint planning, commissioning and delivery

In order to facilitate partnership working, information-sharing between sectors is very important. Effective data-sharing must, of course, be sensitive to issues of confidentiality, and for this reason, individual-level data is not always suitable to share (127). However, sharing aggregate data about a local population can be invaluable in identifying needs and issues that are best tackled by a number of different bodies or professionals simultaneously.

Strategies should go beyond information-sharing and include elements of joint planning, joint commissioning and joint delivery. Policies are stronger when aligned and can achieve greater impact and efficacy in collaboration, leading to cost savings. Joint strategies across sectors can produce multiple benefits in different sectors, for example reducing inequalities in early years, education and health outcomes, as discussed above.

Partnerships with local authorities are particularly important, especially as public health has moved to local government. IHE is supportive of this move, and would encourage health professionals to build extensive partnerships with local authorities. A report on reducing inequity through integration in public health (128) emphasised the importance of co-production, asset-based approaches, a good use of intelligence and data, and mechanisms and infrastructures that are focussed and prioritised.

Strategic design and support

It is important to design and monitor partnership work carefully, as not all partnerships are immediately successful, merely in virtue of being partnerships. A review by the Audit Commission (24) found

that partnerships can bring significant benefits, especially when they are innovative and flexible, but that there is no one-size-fits-all model and they should be governed and analysed carefully to determine whether they are delivering services effectively and realising their potential to address the social determinants of health. It should also be ensured that partnership working does not involve moving 'challenging' patients between services in an attempt to avoid addressing the problems at hand (129), and that partnerships are based on well-defined and understood roles and responsibilities (130). A systematic review of the impact of partnerships on health outcomes and reducing inequalities could not reach strong conclusions due to the lack of evidence available (131). For this reason, it is important that partnerships are carefully monitored and assessed for their impact on health equity, so that best practice is achieved and shared.

There are also often many obstacles and challenges to partnership work. Separate budgets, cultures and organisations and a pervasive silo culture often undermine attempts at partnership. Strategic support is needed in support of partnerships at all levels of the system. At a time of systemic and organisational change, there needs to be closer partnership working between Public Health England and the NHS at the national level, and between local government, directors of public health, and CCGs at the local level (75). Individual partnerships should be cultivated, supported and facilitated by managers and commissioners. Where appropriate, partnership working should be included in staff job objectives and performance management. Many fantastic partnerships have already been set up and are working to deliver effective outcomes and reductions in inequalities. Case studies are available below, and also in Part B.

Clinical Commissioning Groups

Since the passage of the Health and Social Care Act, a new form of partnership has been established – Clinical Commissioning Groups (CCGs). These are locally based consortia, made up of local GP practices, which will commission care for the local community. CCG governing bodies must have, in addition to local GPs, a lay member with a lead role in overseeing key elements of governance, a lay member with a lead role in championing patient and public involvement, a secondary care doctor, and a registered nurse (23). CCGs will commission community health services, maternity services, hospital care, urgent and emergency care, health care services for old people, children, people with mental health conditions or learning disabilities, and some other smaller scale services (26).

The doctors and nurses who sit on CCGs now have two major ways to tackle health inequalities – through their actions as health professionals, and in their role on CCGs – which includes the commissioning decisions they make, and the ways in which they use the CCG as a local advocacy and

community asset. If they are aware of and responsive to the social determinants of health in their local area, they will be able to tackle health inequalities while delivering clinical services. In fact, paying due regard to the reduction of health inequalities is a statutory duty of CCGs in the Health and Social Care Act (23), and the Equality Act 2010 “requires commissioners of services to take account of inequalities stemming from socio-economic disadvantage and to actively try and address them” (27) (see Chapter 6 for a discussion of these legal requirements). There are three main ways that CCGs can fulfil this function, which are summarised below. More information and case studies can be found in Part B, ‘CCGs’.

Commissioning

The Department of Health has announced that there will be a mandatory requirement on local authorities to provide a public health advice service to CCGs (134). This resource should be utilised to ensure that the public health commissioning function of CCGs is robust, extensive, and includes prioritisation of actions to reduce inequalities through action on the social determinants of health.

Members of CCGs should also commission services in response to local need, using their local Joint Strategic Needs Assessment (JSNA). Assessments of need consider not just clinical, but also social and economic drivers of health, and therefore commissioned services should tackle the social determinants of health as well as their manifestations in local health outcomes. Universally commissioned services should aim to level the gradient by being progressively targeted towards those who need them most. CCGs should also ensure that they commission services for all people in the area, not just those who are registered with GP practices. Homeless people, Gypsies and travellers, and vulnerable migrants are often at risk of having difficulty registering.

Local commissioning should be assessed by monitoring and evaluating the effect that commissioned services have on overall outcomes and inequalities in the local area. Rather than merely counting and describing activities, monitoring should enable others to learn from it: research suggests that evaluation of good practice should contribute to a central, systematic evidence base, which can then be disseminated (135). Finally, CCGs should integrate services where this would reduce inequalities. This integration will fulfil many of the positive functions of partnership which are outlined above – including more efficient services, a greater chance of reducing health inequalities, and improved outcomes across the local population. In Part B of this report, there is a statement for action written by RCGP which contains actions and strategies for CCGs to take in order to reduce health inequalities.

Partnerships with other bodies, particularly Health and Wellbeing Boards

CCGs are, themselves, partnerships. However, they must also work in partnership with other bodies. It is a requirement that a member of each CCG sits on

their local Health and Wellbeing Board (HWBB). HWBBs are responsible for conducting the JSNA and producing the local Joint Health and Wellbeing Strategy (JHWBS). In their role on the HWBB, the CCG member should represent their duty to pay due regard to health inequalities, and therefore ensure that the JSNA and JHWBS fully investigate the social determinants of health within the local population, and propose evidence-based strategies to tackle health inequalities. They should also ensure that local strategies such as the JSNA take full account of local assets as well as needs – for example – local third sector organisations that provide services to tackle the social determinants of health. The DH has produced guidance for JSNAs that sets out tools to support JSNAs, and details how to involve stakeholders, engage with communities and use the JSNA to inform local commissioning (136). The NHS confederation, LGA, NHSI and DH are also working together to produce learning sets for HWBBs that cover a range of topics, including joint working, JSNAs, children’s services and improving population health (137).

While some JSNAs are focussed on the social determinants of health, and capture a broad and relevant range of information, there is variation among JSNAs, with some concentrating on information to support health and social care services rather than broader determinants (138). However, a recent brief analysis by IHE showed that JSNA and HWBSs refer to the Marmot Review recommendations in more than 75% of local areas (139). The next step is to ensure that this is translated into action on the ground and into reduced health inequalities within local areas.

CCGs will feed into LETBs about local commissioning intentions to ensure the medical workforce education and training is suitable (72). This provides an important opportunity for CCGs to promote the core role of social determinants of health education for students, and to promote teaching on commissioning skills. There is more information about this in Chapter 1. CCGs will also be working in partnership with NHS trusts, public health professionals, other local authority workers, social care, children’s services, and other organisations. The NHS Alliance and ACEVO have produced a guide for CCGs to use when working in partnership with the voluntary sector, which emphasises commissioning to enable people to live independently, stay healthy, have control over their lives, live with their family, participate as citizens, and have the best possible quality of life (140).

As mentioned above, the Health and Social Care Act (HSCA) states that services must be integrated where this would reduce inequalities. In order to successfully integrate services, CCGs must be willing and able to listen, share information, and collaboratively plan with their colleagues both within the health sector and beyond it. The previous content of this chapter provides guidance on how best to work in partnership, including the importance of careful design, monitoring, strategic support, and joint production.

Purchasers and employers within the local community

CCGs will have large budgets to spend on services for their local population. They should use this economic weight to support local businesses in the most deprived areas, which may lead to greater social inclusion and equity, as well as improved health within the community (2). This should be done on both a national basis, via the NHSCB, and locally, via CCGs. Chapter 3 outlines how health services should be exemplar employers and clauses should be inserted into contracts to ensure that *all* staff working in health services should be supported and receive adequate remuneration.

The inequalities duties in the HSCA should be taken to apply to the services that CCGs commission, and the employment practices that they support through this commissioning. The Social Value Act also places a duty on public bodies to consider how their procurement, including purchasing goods, provision of services and carrying out of works, might improve the local area. This covers economic, social and environmental wellbeing. Public bodies must also consider how they might act in order to secure improvement in these areas (21). In order to fulfil this duty, commissioning contracts should have a stipulation about ensuring a beneficial effect for the local community. IHE will be undertaking further work in partnership with CCGs to analyse contractual mechanisms and to propose ways to tackle health inequalities through contracting, including any qualified provider.

Finally, CCGs should consider themselves a local community asset. This will partly involve using their purchasing power to the benefit of the local community, as outlined above. However the CCG should also advocate for the local population's interests, to central government, the NHSCB, and to other local services. Advocacy is discussed in more detail in Chapter 5.

Conclusion and next steps

Partnerships are not only essential in order to tackle the root causes of ill health effectively: they can also be an efficient and innovative way for organisations to realise the many goals they may share. Integration both within the health sector, and more importantly, with external bodies, is essential. Sharing information, joint commissioning, and joint delivery are all important elements of partnership work. In order to support these activities, NHS staff must be willing and eager to work in partnership, acting as advocates for collaborative work where appropriate (see Chapter 5). Managers and leaders must dedicate time and money to set up formal partnerships, and recognise the value of informal partnerships. It is also useful to have partnership as a key strategic goal on an organisational and system-wide basis. In Part B there are many examples of successful partnership working from a range of professional organisations.

CCGs are a new and key form of partnership. They have the potential to affect social determinants

of health through commissioning, when they can design services to respond to need and inequalities in the local area. This responsibility extends to their role on health and wellbeing boards, where they can influence JSNAs and strategies. Finally, CCGs have power as contractors and purchasers. They can use contractual arrangements to ensure that other bodies provide good employment and benefit the local community.

Partnership commitments

The *Institute of Health Equity* commits to:

Work in partnership with *Barts Trust* to set up two networks:

- A network of CCGs to share good practice in commissioning for social determinants of health, and how best to use contractual arrangements to further this agenda
- A network of acute trusts to develop actions in the acute sector
- Develop partnerships with CCGs and acute trusts across England to support implementation of approaches based on the social determinants of health through commissioning processes.

The *Royal College of Physicians* commits to:

- Promote and support the role of the physicians within the Health and Wellbeing Boards. The RCP will support closer collaboration between HWBBs and their local CCGs. It will ensure that all relevant information and guidance is made available to these individuals and opportunities for sharing their experiences are identified.

The *Royal College of Paediatrics and Child Health* commits to:

- Look into offering more courses that involve working across sectors and disciplines, following the model of its training courses such as 'Child Protection: From examination to Court', which includes social workers, police and lawyers
- Encourage paediatricians to make better use of local opportunities that can benefit patients. These opportunities include children's, health, education and social services as well as local projects and services.

The *Royal College of General Practitioners* commits to:

- Produce guidance for commissioners in 2013 on embedding inclusion health within general practice
- Promote the lessons from the 'Deep End' programme of work in Scotland that was undertaken in partnership with the Scottish Government and the University of Glasgow. The RCGP is also working with Public Health England, the Department for Communities and Local Government and the Department of Health to explore ways to take forward this agenda at the primary care level.

The *Royal College of Speech and Language Therapists* commits to:

- Work with commissioners to ensure that services are planned in an integrated way to meet patients' needs and focus on vulnerable groups including children, people with learning disabilities, people with long-term communication problems and older people with mental health problems.

The *Chartered Society of Physiotherapy* commits to:

- Maintain and develop partnerships with cross-sector organisations, to share knowledge and advocate for pathways of care which promote equitable population health.

The *Royal College of Obstetricians and Gynaecology* commits to:

- Gather robust evidence on NHS obstetric and gynaecological outcomes in order to help CCGs and HWBBs better plan services
- Work closely with its Women's Network to understand the issues affecting disadvantaged women so that its training and development programmes are fit-for-purpose.

The *British Association of Occupational Therapists and College of Occupational Therapists* commits to:

- Use its current programme of road shows to encourage occupational therapists to make links with their public health and health promotion colleagues, as well as to highlight its role to other health and social care colleagues, commissioners and the public. Occupational therapists already work extensively with 'third sector' organisations and charities, but there are likely to be further opportunities. In addition, many of the outcomes recommended in the Public Health Outcomes Framework are relevant for occupational therapy intervention.

The *Royal College of Psychiatrists* commits to:

- Highlight to its members the impact of inequalities on the risk of mental disorder, that mental disorder results in a range of inequalities which can be prevented, and the importance of both localities and government addressing such inequalities. Specifically, it will encourage its members to highlight information about the local levels of the following including in higher risk groups:
 - Risk factors for mental disorder and protective factors for mental health
 - The proportion receiving interventions to prevent mental disorder and promote mental health
 - The proportion with mental disorder receiving intervention
 - The proportion of people with mental disorder receiving interventions to address different health-risk behaviours such as smoking
 - The proportion of people with mental disorder and physical illness receiving appropriate treatment.

Such information, including wider impacts and costs, is important to include in local Joint Strategic Needs Assessments (JSNAs), as they inform commissioning decisions.

The *NHS Alliance* commits to:

- Help to develop partnerships with CCGs to support implementation through commissioning processes
- Help to develop networks of CCGs to share good practice in tackling the social determinants of health and how best to use contractual relationships to further the agenda
- Use NHS Clinical Commissioners CCG development programme and partnerships with CCGs and local authorities to support implementation of approaches to health inequalities in CCGs.

The *British Medical Association* commits to:

- Encourage doctors to tackle the social determinants of health within communities by commissioning measures including health promotion and ill-health prevention, including influencing NHSCB and CCGs
- Disseminate the message that whatever doctors do, it is vital that they act in a cross-sectoral manner, working with others in areas outside the direct health systems they might, traditionally, solely work in.



5 Workforce as advocates

Key recommendations

For individuals

Individual health professionals and health care organisations should, where appropriate, act as advocate for individual patients and their families.

For changes to local policies

Individual health professionals and health care organisations such as local NHS trusts should act as advocates for their local community, seeking to improve the social and economic conditions and reduce inequalities in their local area.

For changes to the health profession:

Individual health professionals, students, health care organisations such as NHS trusts and professional bodies such as medical Royal Colleges and the BMA should advocate for a greater focus on the social determinants of health in practice and education.

For national policy change

Individual health professionals, students and professional bodies such as medical Royal Colleges should advocate for policy changes that would improve the social and economic conditions in which people live, and particularly those that would reduce inequalities in these conditions. They should target this advocacy at central government, and bodies such as the NHS Commissioning Board.

Every member of the health workforce has the potential to act as an advocate. Since many of the factors that affect health lie outside the health sector, in housing, education or benefits for example, health professionals may need to use their positions both as experts in health and as trusted, respected professionals to encourage or instigate change. This role is not a new one – for hundreds of years, health professionals have been documenting and disseminating the effects of poverty on their local populations, and campaigning for changes to the conditions in which people live.

The medical Royal Colleges have a clear advocacy function, and petition government regularly for policy changes on behalf of their members

and their patients. In this chapter, we discuss four types of advocacy – for changes that would affect individual patients, the local community, the health profession, and for the general population. These are the responsibility of individual professionals and students, NHS organisations, and professional bodies. Other organisations such as the BMA, NHS Alliance, NHS Confederation and LGA also have important advocacy roles.

For individuals

Individual health professionals have day-to-day contact with a wide range of people and understand the complex and interrelated factors that influence their health. There is a great deal of work that shows how health services professionals can help to positively affect influences on health which cannot be tackled through clinical actions. In the case of general practitioners, “speaking or writing on behalf of patients is inherent in the role” (91). One study found that the most common role for doctors “was as an advocate – helping people to access services and resources within and beyond the National Health Service. Most frequently, this would involve a request for a GP to provide a letter asking for another service to be provided or complaining about some element of the service already provided.” Examples included letters sent to housing services, educational and/or social services, or to courts (96). For example, health professionals can advocate for unemployed people, both to help them find work, and to mitigate the ill health effects of unemployment (141).

There could be scope to develop this individual advocacy role further, as at present it is underdeveloped due to a number of pressures including short consultation times. However, in order for these sorts of actions to be consistent and systematic, they must be part of a general strategy of support for patients, underpinned by strong links and partnerships with other services. It is not the primary job of health professionals to advocate for individuals. A functional relationship between services, with established protocols, should mean that letters written on behalf of patients become increasingly replaced by systematic and successful referral (see Chapter 4 on partnerships).

For local policy change

Health professionals are in a good position to witness and understand the health of the local community and what is affecting it. Where local policies or strategies are having a negative effect on health, or failing to meet local needs, health professionals can use their influence to advocate for change.

In these cases, health professionals can lobby to encourage change in local bodies. For example, if a health professional becomes aware that their patients are not able to access unemployment services, or are suffering from negative effects of cold, damp housing, they could pass on this information to their local authority and advocate for new or adapted services to meet this need.

This sort of advocacy may take place through a formal route through the links between CCGs and HWBBs. Health professionals can use these links to advocate for HWBB decisions that will positively affect the health of the local population. This is discussed further in Chapter 4, 'CCGs'.

Professional bodies can also advocate for change to local organisations. For example, the Royal College of Midwives (RCM), Royal College of Obstetricians and Gynaecologists (RCOG) and National Childbirth Trust (NCT) have jointly written a guide for CCGs on commissioning maternity services, sent to the chair of each CCG with an invitation to discuss further with the RCM (142).

For changes to the health professional workforce

Throughout this document, we have proposed ways in which health professionals can tackle the social determinants of health. Many of these actions can be taken today, within existing structural arrangements and organisational constraints. However, some require change – within the workforce, health organisations, or centrally through policy change or by the NHS Commissioning Board, for example. Professionals have a dual responsibility, to take those actions that they are able to take, and to advocate for changes that need to take place on a national level. Education advocacy is a good example: in order for the social determinants of health to be tackled successfully by the health profession, there must be a change to current health curricula (see Chapter 1), and qualified staff should help advocate for these changes.

This advocacy can take place on an organisational level. In these cases, health professionals could advocate for the changes to practice within their organisation, such as increased referral or partnership work, that have been set out in the rest of this document. This 'pressure from within' can be effective in encouraging the establishment of new programmes, or a greater focus on health inequalities within organisational plans and strategies. If organisations are making progress in reducing inequalities, or have innovative programmes in place, professionals should ensure that these are shared with

other organisations, and with central organisations such as the Care Quality Commission or NICE, and advocate for change to be replicated more widely.

Advocating for change to professional practice can also be directed at national bodies such as Health Education England. This sort of advocacy can be taken on by individual health professionals, students, NHS organisations or bodies such as the Royal Colleges.

Organisations can also advocate for health professionals to make changes to their practice. For example, The Royal College of Physicians (RCP) among other activities (76) held a conference on how doctors can tackle social determinants, and produced an accompanying policy statement which stated, "the need for change in doctors' attitudes towards the social determinants of health, a change in health care and social systems, and a change in the education of doctors" (9).

The Royal College of Nursing (RCN), which represents the largest single health professional group, held a Public Health Nursing conference and has produced a policy document for its members on health inequalities and the social determinants of health (143). A number of pharmaceutical organisations jointly wrote a practical guide on public health for community pharmacies (144). The Royal College of General Practitioners (RCGP) in England and Scotland has done much work (145, 146, 147) including producing a document *Addressing Health Inequalities: a guide for General Practitioners* (8). The RCM makes an annual award to members who have worked towards addressing health inequalities in their practice. The BMA has written a number of relevant papers (148, 149) and has recently written to its members specifically encouraging them to take action on the social determinants of health in a variety of capacities, from treating patients, to community leadership, and on a variety of levels from local to international (7).

For changes to national policy

The groups discussed above – students, individual professionals, NHS organisations and professional bodies such as medical Royal Colleges – all also have a role in advocating for national policy change that would affect the general population. In many cases, this will take the form of influencing central government on policy decisions. The health workforce, in all its forms, has a voice of authority and expertise, and should use this to advocate for policies that will reduce health inequalities, and against policies that will widen them. The RCGP has discussed the importance of influencing policy, for example on health resource allocation and the use of evidence in developing policy (8). The RCOG has put forward the argument that women's health care should be provided via a life-course approach (150). The RCN has dedicated teams in all nations of the UK who "influence political decision-making and legislation to get a better deal for health care professionals and patient care" (151). As can be seen

from the examples throughout this chapter, many Royal Colleges already do extensive advocacy work, and many have also committed to continue this, with a focus on the social determinants of health. These commitments can be found throughout this document.

Other organisations are also able to influence national policy on the social determinants. The Marmot Review and the UCL Institute of Health Equity advocate for policy change locally, nationally and internationally, and have had influence, for example through the Public Health White Paper (75) and on fuel poverty.

It is also important to influence the newly formed central organisations that are currently deciding priorities and strategies across the health spectrum – the NHSCB, Health Education England, and the Care Quality Commission for instance. The NHS future forum has recommended that Health Education England, Public Health England and the NHSCB “should build a coalition with professional bodies [including Royal Colleges] to agree a programme of action for making every contact count”, which would include disseminating this message among their members (113). ‘Making every contact count’ should include tackling the social determinants of health wherever possible.

Students have an important role in advocating for change. The RCP recommends that “senior medical figures and medical educators should legitimise, encourage and harness the power of student advocacy and action on the social determinants of health” (40). The student branch of the American advocacy organisation Physicians for Social Responsibility has chosen the motto ‘Preventing what we cannot cure’, and has social justice as one of its three focus areas (152). Similarly, the International Federation of Medical Student Associations, which represents 1.2 million medical students, established a global campaign on health inequality, ‘Root out, reach out’, and wrote a commentary on social determinants of health which was published in *The Lancet* (153).

Conclusion and next steps

Advocacy is an important and effective method to reduce health inequalities. It can take place in four focus areas. The first, for individual patients and single decisions that would affect them, may be necessary occasionally but is not a core function of health professionals. Second, local policy change may be essential in order to improve the health of the local community, and advocacy has a formal route through HWBBs. Third, changes need to be made within the health professional workforce – both to individual actions, organisational strategies and national policies. Individuals, students, or organisations such as Royal Colleges could advocate for these. Finally, health professionals and organisations can use their expertise and respected positions to advocate for changes to national policies that have an impact on health.

Advocacy commitments

The *Institute of Health Equity* commits to:

- Work with the NHSCB and inclusion health programme to advise on tackling health inequalities through health professional action
- International partnership with the Canadian Medical Association (CMA) and joint publication and programme, continued work with the World Medical Association (WMA) and International Federation of Medical Students, World Health Organization (WHO) and via European networks and healthy cities partnerships
- Continue advocacy and partnership with central and local government in order to ensure the social determinants of health are considered in policy making.

The *Academy of Medical Royal Colleges* commits to:

- Develop the AoMRC website as a resource for information on health inequalities and as part of a wider communication/dissemination strategy for the Academy Health Inequalities Forum
- Continue its active and reciprocal dialogue with government departments and policy makers in all the UK jurisdictions to ensure an embedded and holistic approach to influencing the social determinants of health.

The *Royal College of Physicians* commits to:

- Continue to press for action to tackle social determinants of health with reference to particular social harms including tobacco, alcohol, obesity, fuel poverty and air pollution. The RCP is working with the Royal College of Psychiatrists to address the issues of tobacco use in patients with severe mental illness. The report *Action on obesity: comprehensive care for all*, released in January 2013, initiates the RCP work to tackle obesity in the UK
- Build on the RCP report *How doctors can close the gap: Tackling the social determinants of health through culture change advocacy and education*, to continue to support its membership to act as individuals, jointly and within the institutions they work in to reduce health inequality.

The *British Dietetic Association* commits to:

- Ensure that the process for the development of any positions statements or guidance published by the BDA will have considered the social determinants of health and taken a progressive approach to improving health equity
- Use opportunities for campaigning to raise awareness of the impact of inequalities on access, availability and affordability of healthier food
- Explore the role of its professional trade union in taking actions to tackle health inequality
- Advocate for progressive public policy to tackle health inequalities by working in partnership with other stakeholders to promote practices that reduce health inequalities and challenge those practices that fail to positively influence the social determinants of health.

The *Royal College of Paediatrics and Child Health* commits to:

- Continue to facilitate and make contributions to the development of the ePCHR (electronic Personal Child Health Record), which aims to improve interaction and engage with patients, parents and carers and to keep up-to-date with the needs of these individuals; this includes listening to the advice of paediatricians to make the PCHR (mainly through the electronic version) easier to use and more accessible for all of its users
- Advise paediatricians to inform patients, parents and carers with the best information possible, building on the education and training elements that address these areas, such as the Healthy Child Programme (0–5 years) and How to Manage Nutrition course.
- Listen to feedback in order to both build upon and improve the current print version of the PCHR, in content, format and presentation.

The *Royal College of Speech and Language Therapists* commits to:

- Continue to work with and influence government departments and policy makers to embed health inequalities and social determinants of health in its work
- Develop a web page with information on public health and health inequalities for members
- Develop an online resource on public health and health inequalities for speech and language therapists.

The *Royal College of Obstetricians and Gynaecology* commits to:

- Continue to advocate the life-course approach in women's sexual and reproductive health care in all its policies.

The *British Association of Occupational Therapists and College of Occupational Therapists* commits to:

- Promote a holistic approach to tackling the social determinants of health, as appropriate, during influencing work with policy makers and key working groups
- Promote the Allied Health Professionals Advisory Fitness to Work Report. This tool has recently been piloted and should be available for all AHPs to use from March this year.

The *Royal College of Nursing* commits to:

- Engage actively in discussions on service reconfiguration and respond to consultations relating to public health and addressing social determinants of health.

The *British Medical Association* commits to:

- Encourage doctors to advocate for change to areas outside traditional medical areas, and to promote the generation of research, especially on the efficacy of prevention measures
- Continue to consider social determinants in all science reports and use an social determinants of health 'model' in looking at the issues

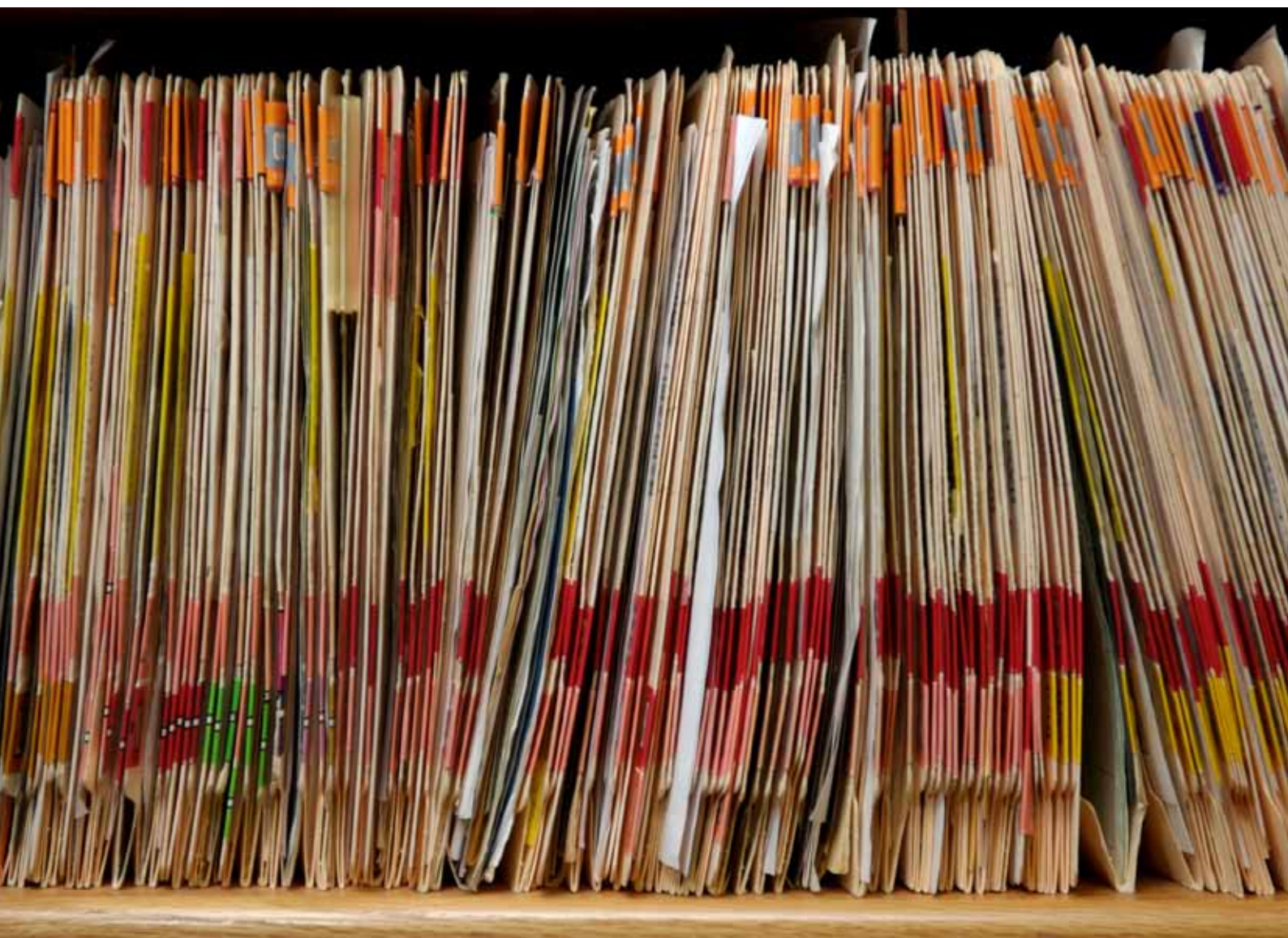
- Advocate for a greater focus on social determinants of health across policy areas
- Lobby relevant decision-makers and opinion-formers in non-health fields on the impacts on health outcomes.

Medsin commits to:

- Continue to train students in a range of advocacy techniques to enable them to effect tangible social and political change towards health equity at local, national and international levels
- Continue to support students from across the UK in producing campaigns to tackle the social determinants of health and to work towards health equity.

The *British Association for Music Therapy* commits to:

- Enable music therapists to have a voice locally and nationally within the proposed new structures in statutory provision. This will be done through its representation on relevant national bodies and through its network of area groups.



6

The health system: challenges and opportunities

The April 2012 Health and Social Care Act (HSCA) has led to significant changes in structure, provision, incentives, regulation, commissioning and monitoring within the health system. For example, Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards (HWBBs) must set local priorities for provision and commissioning of health and public health. While the changes are challenging, and there is concern that they may have negative effects on health inequalities (154; 155), there are also new opportunities to tackle health inequalities and to embed a social determinants of health approach across the health system. Health professionals will have to know how to work within these constraints and opportunities in order to leverage and encourage action on the social determinants of health.

IHE is currently working on an analysis of which mechanisms within the health system may be useful or supportive in action on the social determinants of health, and where challenges will lie or changes be needed. This is a work in progress, which will be built on by the IHE in partnership with other organisations as part of the ‘Working for Health Equity’ programme. The working paper about system challenges and opportunities to accompany this report is available on the IHE website (1). In this section we draw out some initial analyses and emerging conclusions from this working paper.

Health inequalities duties

From April 2013, new legal duties, as specified in the Health and Social Care Act, will come into force. In exercising their functions, the NHSCB and CCGs must have regard to the need to reduce inequalities, both in terms of access and health outcomes of patients. They must also secure integrated provision of services, both within the health system and beyond it, where this would reduce inequalities in access or outcomes. In addition, there are duties on the Secretary of State, Monitor and NHS Foundation Trusts, all of whom must integrate these duties into their plans and report progress on them annually. A description of the content of these duties for each of the relevant bodies is available in the box below.

These health inequalities duties are a potential lever for further action on the social determinants of health. We recommend that as organisations assess progress in fulfilling their duties, they assess activities to tackle the social determinants of health. However, there is a limitation on these duties in that

they only apply to inequalities arising as a result of clinical care, and will not be assessed on inequalities in life expectancy arising from other factors. The King’s Fund states that this shows how this approach differs from the previous governments’: “the NHS will be expected to do more on inequalities and access from its own care, but with less responsibility for tackling overall inequalities in health” (156).

Other legal duties do exist – for example, the Equality Act 2010 states that public sector bodies “must, when making decisions of a strategic nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage.” (27).

These duties, taken together and used in the right way, provide a set of powerful levers to ensure that the actions of various NHS bodies and professionals should be tackling social determinants of health and reducing health inequalities.

Responsibility for tackling health inequalities should be taken by managers, commissioners, and health professionals alike. In this report we have outlined strategies that are likely to reduce health inequalities, and therefore likely to satisfy the duties described above.

Secretary of State for Health

‘Must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service.’

Monitor [the sector regulator for health care]

‘Must exercise its functions with a view to enabling health care services provided for the purposes of the NHS to be provided in an integrated way where it considers that this would [...] reduce inequalities between persons with respect to their ability to access those services, or reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.’ Monitor is also entitled to set or modify licence conditions where this would result in ‘reducing inequalities between persons with respect to their ability to access those services, and reduce inequalities with respect to the outcomes achieved for them by the provision of those services.’

NHS Commissioning Board

‘Must, in the exercise of its functions, have regard to the need to – a. reduce inequalities between patients with respect to their ability to access health services, and b. reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services’. The Board must also ‘exercise its functions with a view to securing that health services are provided in an integrated way where it considers that this would [...] reduce inequalities between persons with respect to their ability to access those services, or reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services’. This duty to secure integrated provision additionally applies to integration of health services with health-related services or social care services.

Clinical Commissioning Groups

Each CCG ‘must, in the exercise of its functions, have regard to the need to – a. reduce inequalities between patients with respect to their ability to access health services, and b. reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services’. Each CCG must also secure integrated provision of health services, and health services with health-related services or social care services, ‘where it considers that this would [...] b. reduce inequalities between persons with respect to their ability to access those services, or c. reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services’.

NHS Foundation Trusts

Trust special administration can be used if “ceasing to provide [a] service under this Act would, in the absence of alternative arrangements for its provision under this Act, be likely to – a. have a significant adverse impact on the health of persons in need of the service or significantly increase health inequalities, or b. cause a failure to prevent or ameliorate either a significant adverse impact on the health of such persons or a significant increase in health inequalities”.

NHS Commissioning Board

There are some ways in which the NHSCB can help to reduce health inequalities, through direct commissioning, in a leadership and oversight role in relation to CCGs, and in an advocacy role. Health staff will work directly with the NHSCB in some of these functions (for example, CCGs); in others they can try to influence the NHSCB to place a concern for health equity at the heart of its functions.

The NHSCB will have to agree and deliver improved outcomes and account to ministers and Parliament for progress, measured against the NHSCB mandate. The mandate, which is based on the NHS outcomes framework (see below), recognises the persistence of “unjustifiable inequalities in [...] health outcomes for patients” and refers to the health inequalities duties in the HSCA: “the NHS commissioning board is under specific legal duties in relation to tackling health inequalities and advancing equality. The Government will hold the board to account for how well it discharges these duties”(157). It also states that it is an ‘objective’ to ensure that “whether NHS care is commissioned nationally by the Board or locally by clinical commissioning groups, the results – the quality and value of the services – should be measured and published in a similar way, including against the relevant areas of the NHS outcomes framework. Success will be measured not only by the average level of improvement but by progress in reducing health inequalities and unjustified variation”(157).

Outcomes frameworks

In order to measure performance and encourage improvement in tackling inequalities across the NHS, outcomes frameworks can be a powerful tool. However, there are a number of factors to consider when assessing an outcomes framework in relation to health inequalities:

- Does it include indicators to take account of health inequalities to a sufficient degree, and encourage action by health professionals and organisations to reduce inequalities?
- Does it measure health outcomes experienced by patients, and the distribution of these outcomes, as well as or instead of outputs from health professionals?
- Is it likely to be effective? Does it affect results and improve performance; does it influence strategies, and decide payments, therefore acting as an incentive?
- Does it create appropriate incentive structures? For instance, are the incentives working in favour of reducing health inequalities; are there perverse incentives?

Some guidance on the first point can be found in IHE’s work: the Marmot Review’s Framework of Indicators (158) gives further indications of what should be measured to assess health inequalities.

The London Health Observatory also produces indicators for IHE on a number of health inequality and social determinants of health indicators(159), and IHE is developing a basket of indicators to monitor the effect of the recession and changes to welfare on health inequalities (160).

Quality and Outcomes Framework

Since 2004, the activity of GPs and their teams are rewarded through the Quality and Outcomes Framework (QOF). There is some evidence that QOF has not resulted in better access to care or interpersonal elements of care (161), may have negative effect on inequalities (162) as it encourages linear care pathways and a ‘one solution fits all’ approach, and is not sufficiently responsive to local needs (163). It has also tended to measure treatment procedures rather than clinical outcomes (164). It seems that QOF may have reduced inequalities in measured outputs, but this has not translated into a reduction of inequalities in the health outcomes experienced by patients. Therefore the potential power of QOF is not being utilised as it should.

The Public Health Outcomes Framework

The Public Health Outcomes Framework (PHOF) (165) published in 2012, has two high-level outcomes for the public health system – increased life expectancy and reduced differences in life expectancy and healthy life expectancy between communities. In addition, one of the four domains into which the indicators are grouped is ‘improving the wider determinants of health’. It states that these are in line with the Marmot Review. Most, but not all are: there are a number of key omissions, particularly around healthy standard of living (Marmot Review policy objective D), which is critical for effective reductions in health inequalities, and as such should feature in the monitoring mechanism. The PHOF also has very limited power: it does not involve financial incentives, or requirements on health service practitioners. It is therefore somewhat of a missed opportunity, as its potential to lever change and impact is questionable.

The NHS Outcomes Framework

The NHS Outcomes Framework (NHSOF) (166), in contrast to QOF, is focussed on patients’ outcomes rather than health professionals’ outputs. Compared to the PHOF, it also has a higher degree of relevance for health professionals, as it will function as the main accountability mechanism for the NHS Commissioning Board and CCGs. It consists of five domains:

- 1 Preventing people from dying prematurely
- 2 Enhancing quality of life for people with long-term conditions
- 3 Helping people to recover from episodes of ill health or following injury
- 4 Ensuring that people have a positive experience of care
- 5 Treating and caring for people in a safe environment and protecting them from avoidable harm.

Outcomes Frameworks

	<i>Inclusion of HI and SDH</i>	<i>Outcomes not outputs</i>	<i>Power to effect change</i>	<i>Appropriate incentive</i>
<i>QOF</i>	Not sufficient	Not sufficient	Yes	Probably not
<i>PH outcomes framework</i>	Yes	Yes	Unclear	Not currently
<i>NHS outcomes framework</i>	Not enough yet, but there is potential	Yes	Yes – CCGs and NHSCB	Unclear

An equity analysis of the NHSOF produced by the Department of Health (167) details which of the indicators can be disaggregated by two equality strands. It is worrying that out of the 53 indicators, none can currently be disaggregated by both, and only 12 could be by one of the two measures.

The three most important outcomes frameworks, discussed above, have some potential but also weaknesses in relation to reducing health inequalities. A brief summary of the discussion above can be found in the table above, further analyses from IHE will be available on the IHE website (1).

Frameworks such as these have the potential to embed action on the social determinants of health, but incentive structures must be carefully designed if they are to have positive effects on health equity. These are all areas that merit further study, which IHE will be undertaking as part of the ‘Working for Health Equity’ programme.

NHS constitution

The Department of Health is currently consulting on some additions to the NHS Constitution (168). However, there are some key statements in the existing consultation which could be used to leverage action on the social determinants of health (169). Firstly, it states that the NHS has “a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.” Effective action on this principle should lead to the sort of strategies proposed in this report. It also contains a principle of collaboration and partnership work across a range of sectors, and states that patients have a right “to expect your local NHS to assess the health requirements of the local community and to commission and put in place the services to meet those needs as considered necessary”. These are relevant to Chapter 4 of this report. Finally, it states that the NHS commits “to provide support and opportunities for staff to maintain their health, wellbeing and safety”. Professionals could use this commitment to advocate for change to organisational strategies, as set out in Chapter 3.

We can see that parts of the Constitution recognise the importance of tackling health inequalities.

There are also suggestions of some strategies that are essential in reducing health inequalities, although they are not described as such. The Constitution is a high-level document, and therefore does not include practical strategies. However, it could be used to lever and justify action on health inequalities by other bodies. Further analysis is available in the working paper on the IHE website (1).

Conclusion and next steps

There are many existing and new mechanisms which affect action on health inequalities. Some seem to have potential to encourage and embed change – for example, the new health inequalities duties in the Health and Social Care Act and elements of the NHS Constitution. However, others pose potential challenges, and may need redesigning, for example, some elements of outcomes frameworks. There are also implications, both negative and positive, in the areas of funding and monitoring – these are discussed in the IHE working paper(1).

Many of the recommendations for change made within this section will not figure in the immediate day-to-day practice of health professionals. However, they can and should be using the opportunities where they do exist, be aware of the challenges and use their positions to challenge the system where it discourages or obstructs action on health inequalities. Professionals can use levers such as the Public Health Outcomes Framework or the health inequalities duties to encourage their organisations to take action, or to inform local strategies. This section should also provide a useful basis for advocacy, to central government and national bodies such as the NHSCB. This important role for health professionals is discussed further in Chapter 5.

Health system commitments

The *Institute of Health Equity* commits to:

- Lead and participate in meetings/events/ foster prioritisation of efforts to embed a social determinants of health approach across the new health system
- Analyse and propose new incentives, regulations and levers to encourage implementation of approaches. In particular:
 - Support appropriate use of health inequalities legislation and accountability mechanisms to foster changes
 - Analyse QOF and what development it needs to ensure implementation of approaches to tackle health inequality
 - Analyse the Care Quality Commission (CQC) and other regulatory bodies for potential to assist in implementation of action
 - Analyse accountable organisations and mechanisms, including the NHSCB, DH, Secretary of State and CCGs.

The *Royal College of Psychiatrists* commits to:

- Draft and propose improvements to the current smoking-related Quality and Outcomes Framework measures with the aim of increasing the number of smokers with mental disorder who are offered and participate in smoking cessation programmes.

The *Royal College of Paediatrics and Child Health* commits to:

- Develop a Quality Improvement training programme and signpost appropriately to this and the e-learning resource on Clinical Audit and Quality in order to encourage participation and increase knowledge about national audits.

The *NHS Alliance* commits to:

- Support the development of incentives and levers to encourage implementation of approaches to tackle inequalities

The *British Medical Association* commits to:

- Continue to engage in dialogue with policy makers, national and local bodies, and practitioners about how best to use mechanisms within the health system to reduce health inequalities.

Conclusion and next steps

In researching and writing this report, we have been encouraged by the wide range of excellent examples of practice that are already taking place across the health professional workforce to take action on the social determinants of health. Committed and ambitious health professionals and organisations have established, participated in, or advocated for programmes to tackle the social and economic causes of ill health. We have gathered together these case studies, literature, and other evidence and recommended actions to achieve greater activity in five areas:

1 **Workforce education and training**

Education and training at all levels, should teach knowledge and skills in order to create health professionals who are enabled and inspired to tackle the social determinants of health.

2 **Working with individuals and communities**

Health professionals can affect the health of their patients and communities by building relationships, gathering information, and giving information. Referral to external services is essential.

3 **NHS organisations**

Health professionals and organisations are also employers and purchasers, and have a duty to improve the health and wellbeing of their own workforce and, by extension, the local community from which they are employed.

4 **Working in partnership**

Partnership working, both with those in and outside the health services, can help to tackle the social determinants of health. Joint planning, commissioning, delivery and co-location all have benefits. Clinical Commissioning Groups are a potential new resource for reducing health inequalities in local areas.

5 **Workforce as advocates**

Health professionals, students and health organisations all have a responsibility to advocate for change across the health system, in education and training and to health workforce regulations, and also beyond it – directed at policies that effect health inequalities. Measurement, monitoring, research and evaluation are valuable tools in greater advocacy.

We have also begun a further piece of work that will address challenges and opportunities within the health system. Some initial conclusions were set out in Chapter 6:

6 **The health system: challenges and opportunities**

The Health and Social Care Act, Equalities Act and Social Value Act all provide leverage for action on the social determinants of health. Outcomes frameworks, the NHS Commissioning Board and constitution have potential but health professionals may need to advocate for change and sustained uptake of opportunities.

The second part of this report (Part B, below), provides practical guidance for particular professions to take action on the social determinants of health through their work. This guidance, written by 19 Royal Colleges and other organisations, provides a resource for a wide range of professionals, including doctors, nurses and midwives, allied health professionals, social work, commissioning, students, psychiatrists and others. Action on the social determinants of health is appropriate for all health professionals, and the contributions that we have received have demonstrated recognition of this important, albeit sometimes underutilised role, across the health professional workforce.

This report is only the first step. In order to harness the potential within the workforce and implement the recommendations of this review, IHE plans to coordinate and lead a programme of work, the ‘Working for Health Equity Programme’. This will be achieved through partnership with BMA, AoMRC, Royal Colleges and other professional organisations, NHS trusts, CCGs, local and national bodies, national and local government, and individual professionals and students. We will also be working internationally, establishing a partnership with the Canadian Medical Association, and collaborating with the World Medical Association.

To develop this programme and ensure changes happen we have asked many organisations to make commitments to action, which can be found throughout the document. The response has been wide ranging and hugely encouraging. The commitments will bring together health professionals and organisations to work collaboratively for health equity in practical and focused ways. With dedication, committed support, and concerted action, change is possible.

Part B

Professions: Statements for action

Introduction

The following 19 statements have each been written by a Royal College, equivalent professional organisation, or other body where appropriate (such as Medsin for medical students). The purpose of these statements is to provide detailed and targeted information for particular professions. Each statement consists of a rationale for action, some key practical actions that health professionals can take, case studies, and further reading. They build on and extend the general analysis provided in Part A, and demonstrate that action is possible and desirable across a broad range of professions.



Allied health professionals

by the Allied Health Professionals Federation



The Allied Health Professions Federation (AHPF) is a federation of 12 allied health professional bodies representing over 130,000 professional members across the UK, of whom 84,000 work in the NHS in England.

The purpose of the AHPF is to promote the value of AHPs and integrated professional working. The AHPF believes that AHPs, as key specialist clinicians, are an essential part of the health and care workforce who are well placed to deliver high quality care to patients, clients and service users across the whole of the health and social care sectors. The AHPF also believes that in the emerging health and social care environment there will be a need to involve AHPs in all spheres of decision making and therefore maintaining and developing professional expertise over time will be important to ensuring the sustainability of the system.

The AHPF is uniquely placed to draw on the expertise and experience within the professional bodies in order to inform and engage with consultations, issues and opportunities impacting upon allied health professionals across the health and social care sectors.

AHPs have a major impact upon the social determinants of health and hence upon the health and wellbeing of the population. AHP services reach out to those groups often considered more difficult to reach and thus provide an important link for disadvantaged groups like the homeless to access other health and care services.

This document provides specific examples from:

- British Association for Music Therapy
- British Dietetic Association
- College of Occupational Therapists
- Chartered Society of Physiotherapy
- Royal College of Speech & Language Therapists
- College of Paramedics
- Society and College of Radiographers

The Allied Health Professions Federation (AHPF) member organisations are:

- Society of Chiropodists and Podiatrists (SCP)
- Society and College of Radiography (SCoR)
- Royal College of Speech and Language Therapists (RCSLT)
- College of Paramedics (COP)
- Chartered Society of Physiotherapy (CSP)
- British Association of Occupational Therapists/ College of Occupational Therapists (BAOT, COT)
- British and Irish Orthotic Society (BIOS)
- British Association of Prosthetists and Orthotists (BAPO)
- British Dietetic Association (BDA)
- British Association of Drama Therapists (BADT)
- British Association of Art Therapists (BAAT)
- Association of Professional Music Therapists (APMT)

Music Therapy

by the British Association for Music Therapy



The music therapist's role in tackling the social determinants of health

To give every child the best start in life

There are over 700 music therapists practising in the UK, many working with infants, pre-school children and those of primary age. Although we are a young profession there is a growing body of evidence for our effectiveness, supported by advances in research into the neuroscience of music and health. Music therapists work within multi-disciplinary teams and complement the interventions of other AHPs, particularly physiotherapists, speech and language and occupational therapists. Music therapists provide a range of easily accessible instruments in regular therapy sessions and use the rhythmic, harmonic and melodic elements of music to help parents and children to develop new ways of communicating and to strengthen family bonds. Where children are disadvantaged by disability or family circumstances, music therapists can assist in assessment and diagnosis and offer a treatment which is creative, effective and recognised as establishing positive building blocks for a healthy life.

The father of a child with a heart defect and significant health problems writes:

'Through these sessions, the music therapist has been laying down the foundation stones which have enabled K to achieve a fullness of life which would have been impossible otherwise. Through this gift of music, K not only has found a way of communicating, but has found a medium of healing and comfort. We have seen a little girl locked in herself being slowly set free. Not only are the foundation stones being laid, but they are being built upon. Music therapy is integral in K's development. Music has given and enabled a quality of life that would not have been achieved by any other way.'(170)

To enable all children, young people and adults to maximise their capabilities and have control over their lives

Music therapy uses the transformative elements of music to engage people in a shared musical experience, frequently using instruments and voices to improvise, according to the health needs of the client. The therapy focuses on each person's achievements and capabilities, offering opportunities for choices, self-determination and the development of confidence. Sessions are tailored to the needs of each person and there is evidence of effectiveness for children on the autistic spectrum; children and adults with

profound and multiple disabilities; adults who are rebuilding their lives following acquired brain injury or trying to find new, healthy structures in the midst of acute or chronic mental health problems; people facing the end of their life and families coping with relatives lost in a confusion of dementia and cognitive deterioration.

A head teacher of a Special School writes:

'We now consider music therapy to be an essential and integral part of the curriculum for the many students at the school who have significant communication difficulties and or autism. Through ensuring music therapy is included in the learning for these pupils we have seen very clear and improved progress [...]. The greatest impact is demonstrated through the children's improved listening, independence, choice making, two-way interaction, turn taking and concentration. The sessions also have a significant impact on alleviating symptoms for those pupils who suffer very high anxiety levels. In addition all involved in the sessions feel a sense of achievement and enjoyment.'(171)

Music therapy does not merely help the child or adult in therapy, but can transform the life of the whole family by highlighting achievement and halting the potential downward spiral of anxiety and despondency. Adults with learning disabilities frequently experience difficulties relating to making and maintaining relationships, challenging behaviour, emotional needs brought about by events such as bereavement or house move, mental health problems and lack of confidence and self-esteem. Cathy Warner, music therapist and researcher at the University of the West of England, has investigated how music therapy can address these issues (172).

Create and develop healthy and sustainable places and communities

Music therapists are engaged in analysing, reviewing and improving care environments to ensure that conditions are conducive to good health.

The children's hospice, Martin House, in Yorkshire has undertaken a study which concludes that "music and music therapy adds substantial value to the care and support we offer and makes a real difference to the children and young people's lives" (173).

A review undertaken by the Chelsea and Westminster Health Charity, "provided evidence that the integration of performing and visual arts into the health care environment induce psychological,

physical and biological outcomes which could have clinical significance. This research has provided, and will continue to provide, the basis of all the work that the Hospital Arts team carry out, from the maintenance of the art collection to the provision of music-based interactions with a huge range of patients.”(174)

Strengthen the role and impact of ill-health prevention

Music therapists are actively involved in early intervention projects which aim to detect and ameliorate indicators for future ill health. An example is Sing and Grow, a 10-week group music therapy programme for marginalised parents and their children aged 0–5 years. Musical activities are used to promote positive parent–child relationships and children’s behavioural, communicative and social development. This programme originated in Australia and is now having a positive impact in the UK. Its effectiveness was examined in a study in 2008. Participants were 358 parents and children from families facing social disadvantage, young parents or parents of a child with a disability. Significant improvements were found for therapist-observed parent and child behaviours, and parent-reported irritable parenting, educational activities in the home, parent mental health and child communication and social play skills (175). This study provides evidence of the potential effectiveness of music therapy for early intervention.

Case studies

Music Therapy Team shortlisted in the Advancing Healthcare Awards, 2012

The Music Therapy Team at Oxleas NHS Foundation together with Alexia Quin, Music Therapist (Music as Therapy) were shortlisted in the category ‘Achieving Excellence in Learning and Development’ with their project designed to reach young people at risk of not achieving their full potential (176).

The Chelsea Community Music Therapy Project receives Arts and Health Award, 2008

This project, initiated by music therapy charity Nordoff Robbins, helps people with mental health difficulties to bridge the transition between life in hospital and their recovery in the community. Music therapists Sarah Wilson (South Kensington and Chelsea Mental Health Centre) and Dr Gary Ansdell (Nordoff Robbins) work in ‘SMART’, a community centre for people living with mental health issues. The project helps patients create ‘musical pathways’ between the hospital and the community through several interlinked music groups. This project won the Royal Society for Public Health ‘Arts and Health Award’ in 2008 in recognition of “significant and innovative contribution made to the field of music and health practice” (177).

Further reading

- The British Journal of Music Therapy (BAMT)
- British Association for Music Therapy (BAMT) website: www.bamt.org
- Nicholson J M, Berthelsen D, Williams K, Abad V and Bradley J (2008) Impact of Music Therapy to Promote Positive Parenting and Child Development. *Journal of Health Psychology* 13/2
- Oldfield A (2007) *Interactive Music Therapy in Child and Family Psychiatry*. Jessica Kingsley Publishers
- Oldfield A and Flower C (eds) (2008) *Music Therapy with Children and their Families*. Jessica Kingsley Publishers
- Staricoff R and Clift S (2011) *Arts and Music in Healthcare: An overview of the medical literature: 2004–2011*. Chelsea and Westminster Health Charity
- Tomlinson J, Derrington P and Oldfield A (eds) (2011) *Music Therapy in Schools - Working with Children of All Ages in Mainstream and Special Education*. Jessica Kingsley Publishers

Dietitians

by the British Dietetic Association



The dietetic's role in addressing the social determinants of health

The British Dietetic Association's role in the social determinants

Unequal access to healthy food contributes to diet-related ill health developed through the life course. Food and diet are among the key social determinants of health in the UK. Food has a role in delivering a range of desirable public policy targets: for example, increasing social inclusion, improving educational attainment, reducing food waste, delivering skills and training, improving physical and mental health and creating local employment opportunities (178).

The BDA has an important role in developing the way dietitians practise, in identifying and supporting dietitians to have a strong advocacy role and by influencing policy that addresses social determinants of food-related ill health.

Dietitians' role in social determinants of health

Understanding the complexity of the relationship between social inequality, food and health and the realities faced by people living constantly on a low income is an important part of the dietitian's competences.

Dietitians have an important role in influencing a range of policies at local level to improve access to healthier food – including food policy guidance for planning, workplace, procurement, food in education settings, workforce development and individual support for clients.

Actions the BDA and dietitians should take

- Promote the profession as a reliable source of expertise and information – provide access to evidence-based best practice and innovation for members, other organisations and the public
- Advocate for improved nutrition. The BDA is promoting its 'Mind the Hunger Gap: stamp out missing meals' campaign, addressing malnutrition in the community and advocating for the continued provision of community meals. Dietitians' expertise, partnership working and leadership skills are essential in protecting current services, to ensure that food is at the heart of community care
- Raise awareness of the important role for a dietitian in advocating for their patients or local community on wider issues
- Widen the spheres of influence and advocacy that the BDA is involved in to support partnerships

/cross sector stakeholder groups to influence the work on addressing social determinants (for example, fuel poverty, universal benefits/free school meals, housing)

- Use the BDA Trade Union partnerships with other unions to campaign for the living wage and healthier workplaces
- Support the BDA specialist groups to provide expert advice to the BDA, its members and the rest of the profession, on key public health nutrition and the wider determinants of health and inequalities; for example, identify/signpost dietitians to resources to understand the health needs of their local population and identify the evidence base to support dietetic interventions that take action on the social determinants of health
- Ensure easy access to nutritional products for those with special dietary needs via community schemes (for example, community pharmacy provision).

Education:

- Ensure greater focus on social determinants of health in undergraduate/post graduate curricula
- Encourage a broad range of placements for students during training to enable students to understand the wider social determinants of health and recognise the importance of public health roles in influencing practice
- Embed behaviour change skills in all undergraduate/post graduate curricula.

Case studies

Food, nutrition and homelessness

This toolkit, developed by a dietitian in partnership with the Queen's Nursing Institute, looks at a healthy diet and the key issues and barriers faced by the homeless (single and families) in the context of food and healthy eating. The purpose of the guidance is to help practitioners recognise and screen for nutritional need among single homeless families. There is a discussion of malnutrition among the homeless population and the tools and references needed to implement them providing the practitioner with detailed information on nutrition and homelessness. It also contains information on tools that frontline workers can use to screen for malnutrition in single homeless or homeless families with dependent children.

Food for Health award

The Food for Health award encourages food outlets, particularly takeaways, to make small changes to the food they sell, to reduce fat, sugar and salt to achieve the award.

A public health dietitian (PHD) works in close partnership with the environmental health officer (EHO) to deliver training to the food safety team, enabling them to use brief intervention techniques to raise awareness of the scheme during routine food safety visits.

Obesity Atlas to target services for Early Years

In Cumbria the public health specialist dietitian worked with data analysts to collate public health data from the National Child Measurement Programme (NCMP) on dental health, breastfeeding, school meal uptake, healthy schools and physical activity levels in school to map the childhood obesity levels in localities to services delivered in that area. Having locality data in this format has enabled the public health dietitian to approach local area committees of the county council to provide funding for a workforce development nutrition programme in the areas of greatest obesity levels. Each of the six district councils provided funding to commission a specialist team including a dietitian, a nutritionist and childcare specialists to develop and deliver training to all childcare providers in the county to improve nutritional knowledge in the early-years workforce and facilitate the development of food policies in all child care centres.

Further reading

Campaigns

BDA Mind the Hunger Gap is an online-based campaign, addressing malnutrition in the community and advocating for the continued provision of community meals. www.mindthehungergap.com/index.html

The website offers downloadable materials and campaign tools to highlight the issue locally, while the BDA will raise the issue on a national level.

Policy and professional consensus statements

The BDA's expert members develop policies in a range of fields including health policy, nutrition policy and practice and dietetics. These evidence-based and referenced policy statements are available to policy makers, the public, media and members to provide clear statement of the BDA's position on a range of important topics.

Examples include:

- Nutritional care of adults with a learning disability in care settings, produced by dietitians working with adults with a learning disability and members of the Scottish Dietetic Learning Disability Clinical Network, supported by the British Dietetic Association Specialist Mental Health Group (revised June 2012).
- Weight management for adults with a learning disability living in the community, produced

by the learning disability obesity group, a task and finish group of the BDA mental health group (2011). www.bda.uk.com/publications/statements/WeightManagementAdultsLearningDisabilities.pdf

- Delivering nutritional care through food and beverages services, produced by the Food Counts! Specialist group of the BDA

Occupational Therapists

by the British Assoc. of Occupational Therapists/ College of Occupational Therapists



College of
Occupational
Therapists

The occupational therapist's role in tackling the social determinants of health

Occupational therapists work with people of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties. They recognise the person's strengths as well as problems, and assist to identify and achieve goals which are important to that person. Such goals could be anything from being able to move around the home more safely to getting back to work. Techniques used may be rehabilitative (enabling a person to regain reduced abilities), educational (for example, managing pain, fatigue or anxiety), or adaptive (for example, finding new, easier ways of carrying out tasks, often using equipment or assistive technology). Occupational therapists contribute to the recommendations in the Marmot Review in the ways set out below.

Give every child the best start in life

Occupational therapists work with children who have physical, psychological, cognitive or social difficulties, in order to optimise their participation and give them the best start in life. Interventions may include helping the child develop basic self care and social skills, such as being able to eat independently or interact with others. Evidence shows that by working collaboratively with the child and the family, occupational therapists enable children with autistic spectrum disorder (ASD) to participate more fully in everyday life, reduce parental stress and increase feelings of confident parenting (179).

Enable all children, young people and adults to maximise their capabilities, and have control over their lives

Maintaining and increasing people's independence, function, quality of life and sense of control are key aims for occupational therapists, and will be a central rationale for their interventions. By providing rehabilitation and re-ablement programmes, occupational therapists ensure that health inequalities which might arise as the result of impairment are minimised. Regular occupational therapy sessions encouraging older people to carry out daily routines and activities can help maintain or improve their health and wellbeing (180).

Create fair employment and good work for all

Occupational therapists work in vocational rehabilitation services, to enable people with physical

or mental health conditions to return to work. Occupational therapy interventions will include retraining to learn new ways to carry out work tasks, capacity building, reasonable adjustments, disability awareness and return to work management (181-184). Occupational therapists enable people to remain in or return to the workplace, thereby enabling employment for people who might otherwise be excluded. An occupational therapy-led vocational rehabilitation intervention to support people with Multiple Sclerosis remain in work resulted in improvements in psychological and work status measures. A significant proportion of participants also benefited from a fatigue management programme (185).

Ensure a healthy standard of living for all

Occupational therapists work with groups of people who could be socially excluded, for example, people with learning disabilities, older people who live alone, homeless people, people from black and/or minority ethnic groups. For many people, living with a particular health condition can make them vulnerable to social isolation. By ensuring that occupational therapy services are accessible for all, occupational therapists help to promote a healthy standard of living for all. Additionally, occupational therapists view access to meaningful occupation as a basic requirement for good health and aim to facilitate meaningful occupation in all their interventions. Health flourishes when people have access to occupations that hold personal meaning, are publicly valued by the society in which they live, and lead to productive and satisfying lifestyles (186). By promoting meaningful occupation, occupational therapists help to ensure a healthy standard of living for all (187).

Create and develop healthy and sustainable places and communities

Occupational therapy interventions strive to ensure that physical, economic and social environments support community engagement in health-enhancing activity and occupation. Occupational therapy interventions will adapt the physical environment to ensure participation in community locations, for example, accessible 'Changing Places toilets' for the 2012 Olympics (188). They can also enable individuals to address social barriers, through development, for example, of assertiveness or anxiety management skills.

Strengthen the role and impact of ill health prevention

Occupational therapists contribute to all levels of ill health prevention, for example, providing interventions for at-risk groups to prevent health problems developing and targeting those with chronic disease to make the most improvements in health that are possible. Examples include contributing to 'Wellness' programmes for people who have been newly diagnosed with particular conditions or running falls-prevention programmes for the elderly. The development of falls-prevention services in the community can reduce the fall rate and improved the clinical outcome for older people who have previously fallen (189). Occupational therapists will also link with third sector organisations to promote health, for example linking with 'Walking the Way to Health' programmes to improve mental health in older people, or linking with 'Care and Repair' schemes to improve home safety.

Key actions occupational therapists can take to address the social determinants of health

Occupational therapists can:

- Develop the evidence base for the occupational therapy role in addressing the social determinants of health, focussing on evaluating the outcomes of interventions. A recent systematic review (190) identified relevant research evidence but concluded that more interventions need to be delivered systemically with robust evaluation processes
- Establish links with public health and health promotion colleagues, with a view to increasing joint or integrated working. Co-development and joint evaluation of these interventions will promote the growing evidence base that is required (190)
- Increase awareness of the occupational therapy contribution to reducing health inequalities among commissioners, the public and other health and social care professionals. Information can be disseminated through multi-professional training opportunities, user information material and service descriptions or specifications (191)
- Ensure that occupational therapy services are accessible to all in line with the College of Occupational Therapists Code of Ethics and Professional Conduct (192).

Case study

Shazir was a young man with mental health problems who was struggling to cope at home after his parents died. Shazir's occupational therapist initially worked with him to improve his ability to look after himself independently. The occupational therapy rehabilitation programme taught Shazir how to manage his laundry, budget, shop and cook for himself. The occupational therapist also worked with Shazir's brother so that he would manage any repairs that

needed doing around the house and help him get to appointments. At this point Shazir felt ready to do some voluntary work as he was keen to develop a work role and meet more people. Vocational rehabilitation delivered by the occupational therapist helped him find voluntary work in a local charity shop. After doing this for several months, the occupational therapist worked closely with Shazir so he could apply for and secure a part time job. Over a period of 18 months Shazir had changed from a young man who rarely left his home and to a man who was valued in his local community.

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Physiotherapists

by the Chartered Society of Physiotherapy



The physiotherapist's role in tackling the social determinants of health

The Marmot Review clearly articulates that action taken by the Department of Health and the NHS alone will not reduce health inequalities and that central and local government also need to take responsibility for the health and wellbeing of communities, through policies that fully address the social determinants of health.

Physiotherapy has an invaluable contribution to make, but needs to ensure that it evolves in line with the health and social care environment.

Physiotherapy enables people to move and function as well as they can, maximising quality of life, physical and mental health and wellbeing. With a focus on quality and productivity, it puts meeting patient and population needs, and optimising clinical outcomes and the patient experience, at the centre of all it does.

As an adaptable, engaged workforce, physiotherapists have the skills to address health care priorities, meet individual needs, and to develop and deliver services in clinically- and cost-effective ways.

Physiotherapists treat a wide range of conditions across the lifespan and as such, by promoting healthy lifestyles and provide education and counselling related to the risks associated with health and social inequalities, they are ideally placed to support health improvement across the range of policy objectives outlined in the Marmot Review:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention.

Physiotherapists support sustainable uptake of exercise and lifestyle strategies based on developing an understanding of the individual's needs, circumstances, attitudes, cultural and social preferences, and belief in their ability to change their behaviours.

The approaches employed may include advice, education, behavioural change activities, advising and teaching carers, parents, teachers and social care colleagues. By focussing on the social, as well as

biological and psychological determinants of health, and with strong links throughout the health, social care and third sectors, physiotherapists can work collaboratively, to promote a whole-system, coherent approach to prevent and manage poor health and maximise function, independence and wellbeing.

Actions physiotherapy staff should take

Examples of how physiotherapy practice can address public health improvement include:

- Making every contact count, by routinely providing clients with up-to-date lifestyle advice and signposting to local services as appropriate
- Providing primary or secondary prevention exercise classes, or tertiary prevention classes for individuals with established diseases or condition (e.g. cardiac rehabilitation, pulmonary rehabilitation)
- Working with local leisure centre and dieticians to develop programmes to promote maintenance of physical activity levels and healthy eating for people with mental health/learning disabilities
- Working within local organisations and companies to advise on how to improve the health and wellbeing of the workforce.

Case study

The Activate childhood obesity programme at Tower Hamlets was established by the physiotherapy team in 2008, when childhood obesity rates in the borough were significantly above the national average. Tower Hamlets is a densely populated area of East London with high levels of social deprivation and health inequalities.

The six-week programme is offered to children with obesity and co-morbidities and includes physiotherapy, dietetics, clinical psychology and physical activity. An antenatal and postnatal programme is also run for obese mothers, with specialist women's health physiotherapists.

The team also provides outreach support and education on the prevention of obesity within local mosques and to local health staff, schools and health visitors. The programme has a strong presence in the borough and good links with the local council.

In the second year of the scheme, rates of childhood obesity in the borough were falling, against a rising national trend.

Speech and Language Therapists by the Royal College of Speech and Language Therapists



The speech and language therapist's role in tackling the social determinants of health

Speech and language therapists assess, diagnose and manage disorders of speech, language, communication and swallowing in children and adults. They work with patients, families, teachers, health professionals and others to reduce the impact of these difficulties on people's wellbeing and their ability to participate in daily life. Their role includes the following:

Giving every child the best start in life

Communication and language are prime areas of learning and development and are recognised as a snapshot of children's health and wellbeing at age five. The Marmot Review identified communication skills as being necessary for school readiness.

Speech and language therapists (SLTs) take both a primary preventative and a more targeted approach to improve the communication and interaction skills of children with delayed or disordered speech or language, to give every child the best start in life.

Speech and language therapy helps to tackle health inequalities in relation to the health visiting service and the Healthy Child Programme. SLTs focus on tackling children's poor communication skills which are particularly high in areas of social deprivation. Many primary care trusts and local authorities have recognised the power of early language and communication development and have taken action to tackle the issue, aligning the work of speech and language therapists alongside the Healthy Child Programme and Sure Start Children's Centres.

SLTs work with health visitors in surveillance and identification of pre-school children which includes the early identification of problems and training them in language development.

SLTs support child development and school interaction by supporting whole class or school interventions on listening and narrative as well as more specific education to enable delivery of a personalised programme to meet need. Through this, SLTs improve children's access to education and reduce social exclusion.

SLTs raise the skills of the whole workforce and train the early-years workforce and schools to enable them to provide environments that protect and promote language development and optimise communication in the early years.

SLTs are well placed to support the primary prevention of ill health in the early years and support

child development. For example SLTs work with pregnant women who may themselves have speech, language and communication needs and would benefit from enhanced support in preparation for parenthood. SLTs offer parent–baby early communication classes and antenatal education on the development of good communication skills and support parents to understand speech, language and communication needs.

Enabling all children, young people and adults to maximise their capabilities and have control over their lives

SLTs support people with communication problems to have their voice heard. SLTs work with people with learning disability to take control over their own health and make informed decisions.

SLTs provide advice on extending the potential of older people with communication difficulties associated with dementia or stroke and work with staff to develop a communication-rich environment for patients.

Creating fair employment and good work for all

Dame Carol Black found that work is good for long-term health, wellbeing and self-esteem. Language is central to every job, from boardroom strategy meetings to manual tasks requiring fine measurements and specific instructions. SLTs enable people with long-term conditions and adults with learning disability to continue in work and support people to return to work after a brain injury or stroke. Speech and language therapy allows people with long-term communication problems a chance to retain their place in the work force, as well as their self-esteem, income, life plans and continued contribution to their community.

The government has recognised that teachers are more likely than other occupational groups to consult their doctors about voice disorders. SLTs work with professional voice users (such as teachers, call centre workers and clergy) to encourage good vocal health and to minimise and prevent voice disorders enabling them to remain in employment. This has included features on the radio to raise awareness of these issues.

Ensuring a healthy standard of living for all

To tackle health inequalities local authorities can provide services to improve communication skills where the purpose is to improve health and ensure a healthy standard of living for all.

Speech and language therapists promote activity to improve mental health, independence and quality of life among vulnerable adults. Speech and language therapists play a key role in the secondary prevention of ill health through supporting recovery, rehabilitation and re-engagement.

Strengthening the role and impact of ill-health prevention

SLTs ensure other health services are accessible to people with communication needs and help to promote health message take-up. SLTs work with other allied health professionals to promote health take-up to those with communication difficulties, for example promoting messages around healthy lifestyles, diet and exercise.

SLTs promote health and wellbeing of people with eating and swallowing difficulties associated with stroke, dementia or head and neck cancer. SLTs run training for staff residential and nursing homes in dysphagia management to support safe swallowing and to prevent further complications, including hospital admission, for patients.

Actions that the RCSLT and SLTs can take

RCSLT

- Produce a report into the link between communication needs and social disadvantage
- Produce guidance on how SLTs can help to tackle the social determinants of health
- Provide advice for members to encourage them to take action on health inequalities and social determinants of health.

SLTs

- Develop the evidence base for speech and language therapy intervention in addressing the social determinants of health and health tackling health inequalities
- Support integrated working across education, health, and public health
- Increase awareness of the role of SLTs in health promotion and public health
- Promote take-up of public health messages in people with speech, language and communication problems.

Case study: 'Stoke Speaks Out'

The national incidence of language difficulty is estimated to be around 10–12% of the population. However, in Stoke-on-Trent research indicated that almost 70% of children entering nursery had some form of language delay. This led to the development of a multi-agency initiative called Stoke Speaks Out to tackle the deficits in children's language abilities.

The *Stoke Speaks Out* team includes speech and language therapists, clinical psychologists, midwives and professionals from children and young people's services. Each agency contributes its expertise to help resolve the underlying issues causing language delay, and to promote secure parent-child

attachment, positive parenting, early opportunities for development through play, quality language and promoting environments.

Stoke Speaks Out developed a five-tier training framework to ensure that all the children's workforce, including health visitors and midwives, shared the same baseline knowledge. The training framework is open to any practitioner working with children and their families in Stoke on Trent and ensures that the practitioners receive quality assured training covering child development and speech, language and communication development.

As a result the percentage of children entering nursery with language delay fell from 64% in 2004 to 39.1% in 2010.

See the *Stoke Speaks Out* website for more information: www.stokespeaksout.org

Further reading

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- Healthy Lives, Healthy People: Towards a workforce strategy for the public health system (June 2012)
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Paramedics

by the College of Paramedics



The paramedic's role in tackling the social determinants of health

The clinical scope of operation for the UK Ambulance Services has changed radically and continues to evolve at an increasing pace, with greater emphasis on autonomous decision-making, treatment and more appropriate referral rather than the historical focus on transportation. This transition has followed the expansion of paramedic clinical capability and responsibility and has required a fundamental change in focus to one that is more heavily rooted in unscheduled and urgent care rather than in the life-threatening and critical emergency environment with which paramedics historically have been associated. There is now a much greater emphasis on clinical decision-making and a greater responsibility for appropriately assessing patients to enable effective evidence-based decisions on where patients are best managed within the health care system.

To varying extents, some NHS ambulance services across the UK have adopted specialist paramedic positions and the range of post-registration specialist roles is broadening, with the expanding role of paramedics working in primary care being the predominant area of expansion and with acute patient care needs met with other developments such as the critical care paramedic. More recent initiatives have included paramedic practitioners in 'hear and treat' roles, where they provide clinical supervision and operate complex triage systems usually from an ambulance services communications centre.

More roles are likely to emerge in the next few years as paramedics become ever more ubiquitous in the health care system, supported and enhanced with greater post-registration knowledge and skills and enabled by academic graduate qualifications. Paramedics are now found in the majority of countries in the developed world and the UK can be rightly proud of being at the forefront of the development of paramedics as an allied health profession whose registrants play an increasingly important part in the delivery of integrated health care in the 21st century.

As first-contact practitioners, paramedics need to have the underpinning knowledge, competencies and clinical practice experience to undertake assessments, treatment and to implement appropriate management plans for their patients. The most effective and appropriate patient management plans are developed through a partnership approach with

other professions in an integrated health care system. This frequently means departing from the historical role associated with ambulance personnel and paramedics and may result in alternative pathways to complete an episode of patient care without the patient being conveyed to the hospital emergency department as was often the way in the past.

As is the case for other allied health professionals, paramedics are now more likely to see an increase in the incidence of chronic illnesses in the patients they attend. The workload of paramedics is predominantly of urgent and emergency undifferentiated health care requests, ranging from a small proportion that are life-threatening to a high proportion of low-acuity cases.

Paramedics do not usually select their case-loads; instead through patient demand and a degree of chance (based on the locations of crew in relation to an incident), paramedics can see patients from a wide demographic and socio-economic spread within a shift. Paramedics are renowned for their excellent abilities to communicate with all members of society, whether it is those with learning disabilities, the landed gentry, travellers or immigrants. For members of society, from whichever background, who are suffering times of hardship of immense physical, mental or social challenges, often paramedics are their only access to health care. Many patients with long-term conditions, for example diabetes, may also be alcoholic and access much of their health care by default from paramedics. Other groups in society, such as gypsies and travellers, who may not usually access primary health care, contact paramedics in times of crisis, allowing this group of clinicians into their homes and environments where other health and social care professions may not be permitted.

Paramedics are also emergency service workers and have a close working relationship with the police and fire services; however this relationship may sometimes have the potential to come into conflict with professional issues pertaining to patient need. For example, paramedics have a barrier-free, judgement-free access for drug addicts, especially those who overdose on class-A drugs. In order to ensure patient safety, through continued access to health care, paramedics witness illegal practices but cannot report them; but simultaneously rely on the police for their protection and safety.

The College of Paramedics supports comprehensive skills and knowledge for paramedics, which includes the ability to assess, treat and refer patients



to the most appropriate point of health care. It is also supportive of opportunities to develop extended scopes of practice. As a result of the 'no-barrier' access historically afforded by the 999 service, combined with the continued developing abilities of the paramedic profession, ambulance clinicians are now firmly delivering within the unscheduled and urgent care arena, particularly to those groups who may not otherwise access health care through traditional pathways. Further, ambulance clinicians are afforded privileged, unbiased access to all groups in society, as a result of:

- A free access number – 999
- 24/7 high quality care
- High clinician to patient ratio
- Barrier-free access
- Access to a professional group who are respected throughout society
- Perceived holistic home-based care
- Perceived direct, fast-access to hospital pathways.

Evidence suggests that in many areas, there is a social gradient to ambulance call-outs (193-195), supporting the anecdotal perspective therefore that paramedics are more likely to treat those from a lower socio-economic background. They see the effects of social and economic deprivation on the health of their patients, to many of which they have unique and privileged access, and there are actions that they can take to mitigate this effect.

Actions paramedic staff should take

- Be aware of the ways in which social and economic circumstances impact on the health of the patients they treat
- Document and pass on information about their patients, for example where, how and why an accident or injury has occurred. This information is beneficial to creating a holistic and complete view of the patient and their circumstances
- Develop highly efficient skills in assessing and treating patients before admission to acute care, using referral to other services (e.g. primary care) or discharge into the community
- Be aware of the value of referral to a range of other practitioners and services, both within and outside the health sector. For example, paramedics increasingly refer their patients to social services in order to tackle the social factors that may be affecting their health
- Continue to play a key role in safeguarding issues, both relating to the patients, but also other parties, including children
- Give health information and advice to patients and therefore increase the prevention aspect of their role. This can include running health screening and promotion or injury prevention programmes (such programmes may include blood pressure and cardiac arrhythmia screening); to increasing awareness among young people about the effects of alcohol, and providing

individual advice to patients. There is more information about this in the Ambulance Service Network's document: *A vision for emergency and urgent care: The role of ambulance services* (196).

- Give advice, information and referrals to other, non-health services, such as Citizens Advice Bureaux, home insulation, and fire services as part of a holistic programme of care and support or self-care.
- Paramedics can also contribute to activities within the ambulance service as a whole that would help to reduce inequalities, such as:
 - Contributing aggregate information (health informatics data) to other health workers, the police, local authority etc. in order to identify geographical areas of concern, or an increase in particular health problems
 - Contributing to Joint Strategic Needs Assessments, local strategic partnerships and local area agreements.

Case Study

East Midlands Ambulance Service (195) developed a programme which mapped ambulance responses by pick-up postcode. This was then compared to deprivation level, showing a clear socio-economic gradient (the areas of highest deprivation had a rate over four times higher than the areas of less deprivation). Building on these results, they developed a collaborative project with Government Office East Midlands and East Midlands Public Health Observatory which aimed to reduce crime and disorder. This estimated which ambulance responses were related to alcohol misuse or violent crime, mapped the results for priority areas, then shared the results with Crime and Disorder Reduction Partnerships. The NHS Confederation Ambulance Network supports this, suggesting that ambulance services and paramedics can work with local authorities, the police and the wider NHS to inform and support the development of strategies to reduce alcohol consumption, including providing data to map geographical areas of concern or groups of patients (196).

Radiographers

by the Society and College of Radiographers



The radiographer's role in addressing the social determinants of health

Diagnostic radiographers

A very large proportion of health interventions involve diagnostic imaging. This means that diagnostic radiographers come into contact with the large majority of individuals that use the NHS. It has been recognised that this provides considerable potential for the profession to play a useful role in addressing aspects of health inequality and health promotional activities.

Therapeutic radiographers

The nature of therapeutic radiography is that there will be repeated contact with individuals receiving radiotherapy and their carers, often over several weeks. Therapeutic radiographers are consequently able to develop strong relationships and have a key role in advising and supporting patients from diagnosis to follow-up, in adapting information and support to suit the needs of the individual in line with cultural, familial and social requirements. Therapeutic radiographers may receive particular insights relating to health and social circumstances of their patients and their carers. The ability to recognise issues, give general advice and/or to liaise appropriately to escalate specific concerns is a key skill for radiographers. Advice given and referral should go beyond healthy behaviours and also address the social determinants of health, referring patients to wider services.

Some activities that diagnostic and therapeutic radiographers can engage in

Recognition of social determinants of health factors on patient health

Radiographers are often in a position to understand social, environmental and economic influences on patient health:

- Diagnostic radiographers will often be among the first health professionals that see a child following injury. Where examination reveals evidence of potential abuse, malnutrition, neglect or the negative influence of other social or economic conditions, radiographers can raise concerns appropriately
- The accuracy of delivery of radiotherapy depends heavily on a high degree of cooperation and compliance from the individual being

treated. As well as working to achieve equity of access and treatment, therapeutic radiographers exercise a great deal of skill and will engage with other professionals appropriately to ensure people receive support from appropriate agencies and other professionals (e.g. social care) to help reduce the impact of social determinants of health.

Working in partnership and referring patients to other services

Radiographers can and often do work in partnership with clinical and social care colleagues in order to provide the best care for patients and tackle the root causes of ill health. In order to tackle the social determinants of health, it is also important to refer patients to other services. Some examples are:

- In specialist paediatric units and particularly at advanced and consultant practitioner level, diagnostic radiographers may take a lead role in diagnosis, assessment of injury or disease mechanism. In this role, liaison with other professionals to ensure the appropriate outcomes for the child are achieved is essential
- At advanced and consultant practitioner level, diagnostic radiographers are likely to take the lead in giving first line advice and support to individuals and in liaising within multidisciplinary teams to ensure that health inequalities are tackled
- As with diagnostic radiographers, the close relationship that is built between therapeutic radiographers and their patients can create circumstances where the radiographer is party to information about individual circumstances where onward referral to appropriate health or social care agencies is required to ensure that needs are dealt with
- Effective, timely screening within the established national programmes is a key area where diagnostic radiographers are involved in preventing ill health through early detection. These contexts also provide opportunity for onward referral to other services.

Dissemination of public health messages and prevention work

As well as detecting the effect of social determinants of health and referring for further support, radiographers can take steps to improve health and reduce inequalities through prevention work and disseminating public health messages.

- The potential for diagnostic radiographers to take part in dissemination of health promotion advice and information is increased in situations where the service is dealing with specific health and some social issues
- In the NHS Breast Screening and other screening services, diagnostic radiographers frequently work to increase uptake rates and consequently early disease detection among differing ethnic and social groups
- Cancers and other disease processes may have reached a more advanced stage prior to the individual attending for examination than is the case in the wider population. The diagnostic radiographer may be the first clinician in whom the individual feels able to confide concerning health concerns, abuse or other issues
- The re-emergence of chest x-ray screening and monitoring of tuberculosis among some deprived and immigrant populations places diagnostic radiographers in a strong position to advise and support improved health
- Diagnostic radiographers involved in obstetric ultrasound services and specifically in the Foetal Anomaly Screening Programme are in an excellent position to provide health advice in pregnancy, thereby improving the health of the mother and their child
- At advanced and consultant practitioner level, therapeutic radiographers may be in longer-term contact with individuals following treatment, providing review and follow-up advice and support to ensure that all patients are best able to achieve and maintain good health. This will involve detailed information and guidance on ensuring the effects of radiotherapy do not lead to avoidable further disease processes as part of the multi-disciplinary approach to their care.

Conclusion

Members of the imaging and radiotherapy workforces are often well placed to understand the effects of social determinants of health on their patients, engage in prevention and health promotion work, and work in partnership with other services, referring patients where necessary. The Society and College of Radiographers (SCoR) publishes guidance on influencing the choices made by their patients and users with regard to health and well-being and advises and supports the radiography workforce in this important role.

The Society and College of Radiographers

The professional body defines the career framework for the radiographic workforce. The following statements are provided within the expected outcomes for all autonomous practitioners in both disciplines (197):

- Meet the care needs of individuals and their significant others sensitively and respectfully, having regard to the impact of illness and trauma and to socio-cultural differences
- Have due regard to patients' health status and co-morbidities; promoting healthy living.

The professional body also publishes guidance documents covering aspects of practice. These include *Health Promotion: guidance and advice for the radiography workforce* (198).

Medical students by Medsin



The role of students in tackling the social determinants of health

As the next generation of health professionals, students are uniquely placed to challenge current models and understanding of health and disease and to take serious action on the social determinants of health. True action requires a meaningful change in health culture. Students can be the drivers of such a cultural change if they are equipped and engendered with a proper appreciation of the fundamental roles of living and working conditions in shaping health outcomes, thus increasing understanding of the communities in which we serve and reducing a victim-blaming attitude towards disadvantaged individuals and communities.

Education

Medical students are fundamental, yet often under-represented, stakeholders in the design and implementation of medical curricula, both within their own medical schools and more widely in national and international education policy. Students have the potential to be the drivers for greater inclusion of the social determinants of health in developing medical curricula. This could be achieved through an emphasis on placements that expose students to the reality of health inequity outside of the narrow biomedical sphere and the development of compulsory ‘community immersion activities’ as part of medical training. Education that also encompasses advocacy skills will equip students to tackle the social determinants of health.

Advocacy

While students may not be experienced clinicians, they do have passion for change and powerful voices to call for such change. Thus students can be engaged in effective and strategic advocacy at many different levels, ranging from advocating for the rights of their individual patients, to campaigning for changes in local communities, to population-level political change to challenge the damaging social determinants of ill health. They are particularly well placed to use these advocacy skills to effect changes in health workforce training.

Action

Like advocacy, action against the social determinants of ill health does not require high levels of clinical skill. Through carefully-planned community action projects targeted at vulnerable and underprivileged

populations, students have the potential to bring about a direct positive impact on individuals and groups, but also to learn from their experiences and gain greater understanding of the factors which constrain them. This active learning process will provide students with an increased understanding of the changes that are needed to enable individuals ‘to maximise their capabilities and have control over their lives.

Practical actions students can take now

- Educate themselves about the social determinants of health by reading or attending an educational event
- Educate others by raising issues of the underlying determinants of health in university classes and discussions
- Campaign to change the curriculum at their medical school to include appropriate education about social determinants of health and training in how to combat them
- Add their voice to existing campaigns, for example by signing a petition calling for action on social determinants of health on a local, national or global level
- Set up a new campaign to call for better support for a deprived or vulnerable group in their area
- Add their support to existing community programmes working with vulnerable populations
- Set up a new community programme to support a deprived group nearby
- Proactively seek out opportunities during their medical course to see and learn from examples of programmes to support health equity and vulnerable patients
- Encourage other health professionals they work with to partake in this agenda by engaging them in discussion about social determinants of health and sharing information about opportunities to get involved further
- Get involved with organisations working on this agenda. For example, they could engage with Medsin-UK’s work in tackling health inequity and the social determinants of health at a local, national or international level through education, advocacy and action, by contacting the Medsin branch at their local medical school; and through Medsin-UK, get involved with the International Federation of Medical Students’ Associations, an umbrella organisation

representing 1.2 million medical students from over 100 countries also engaged in tackling the social determinants of health (199).

Case studies

Case study 1: Student-led educational provision on the social determinants of health

Many students appreciate the importance of learning about these issues and are trying to provide education through student-led educational events, collation of educational resources, and lobbying medical schools to provide increased teaching on these areas.

At a local level

Thirty local student groups around the UK are holding regular educational events for their peers, many of which tackle issues of health equity and the social determinants of health. Similar groups exist in many other countries such as the Netherlands (200). Students are also encouraging their universities to provide more teaching on these key topics. A group of UCL students approached their Dean in 1999 to ask for more teaching on the social determinants of health and their impact at a global level, and since UCL's intercalated BSc in 2001, similar advocacy by students across the country has increased the number of iBScs (201).

At a national level

Students from many countries are trying to produce and collate educational resources for students on this topic. For example, the Australian Medical Students Organisation (AMSA-Australia), has produced an impressive set of podcasts on 21st century medical professionalism, encompassing health equity issues (202).

At an international level

The International Federation of Medical Student Associations (IFMSA) held a five-day conference on 'Youth and the social determinants of health' in Ghana in March 2012. This event drew together over 800 students from more than 90 different countries, and considered a range of topics such as the generation of sustainable cities, the impact of climate change, and cross-border health issues through a mixture of speakers, workshops and debates (203). The IFMSA also co-hosted a side event on the social determinants of health at the 65th World Health Assembly. This incredibly popular event drew approximately 200 official government delegates and representatives of civil society to be educated about the importance of social determinants of health and the role students are playing worldwide in tackling them (204).

Case study 2: Student-led advocacy on the health benefits of an environmentally sustainable future

'Creating a sustainable future is entirely compatible with action to reduce health inequalities: sustainable local communities, active transport, sustainable food production, and zero-carbon houses will have health benefits across society.' The Marmot Review

Healthy Planet UK is a student group dedicated to education, action and advocacy around climate change and health within the UK and several other countries in the IFMSA network.

At a local level

Students run peer-to-peer workshops, advocate for incorporation of more teaching on climate change and health, and work towards the implementation of environmentally-friendly policies within their universities and hospitals.

At a national level

Students work with groups such as the Stop Climate Chaos Coalition to influence UK climate policy, and the Centre for Sustainable Healthcare and NHS Sustainable Development Unit on issues related to health care sustainability and the role of students within it. They also engage with the media to call for action to promote and protect health in the face of climate change (205).

At an international level

Both Healthy Planet UK and the IFMSA have sent delegations to summits producing health policy in this area including Rio+20, COP 17 and COP 18 and worked together with other youth groups as part of 'YOUNGO', a group of all the youth-NGOs working on climate change. With these groups they have made interventions, engaged with national and international media, and taken part in advocacy stunts including making a human red ribbon for World Aids Day, dressing up as doctors and taking the temperature of the planet and producing a video about the Kyoto Protocol which has now been watched by more than 3,500 people on YouTube (206). Students involved in Healthy Planet UK were also instrumental in creating the Doha Declaration on Climate Health and Wellbeing, which has the signatures of over 80 medical institutions and more than 1,300 individuals.

Case study 3: Student-led action on working towards health equity for refugees, asylum seekers and undocumented migrants

Crossing Borders was first established in 2004 by concerned students with the aim of removing barriers to health care for refugees, asylum seekers and undocumented migrants in the UK. Today, it is an international network of students who continue to strive to fulfil this goal, which is as relevant now as it was then.

At a local level

Students have worked on projects such as the creation of a leaflet to educate newly-arrived migrants to their areas on how to access health care and befriending schemes. Other successes include clothes drives, collaborating with GP practices and campaigning for signatures towards various related petitions.

At a national level

UK students have drafted policy on access to health care for these groups. Students in Glasgow are organising a weekend conference in March 2013 which will draw together over 300 students from across the country. It aims to raise awareness of the health needs of this group, to provide tangible methods of engaging with agenda, and to facilitate sharing of best practice for local community-led student action projects (207).

At an international level

Students from a range of different countries including the UK, Australia, Canada, Quebec, Denmark and Norway have shared ideas about how students can support the right of refugees and asylum seekers to health care and worked together to propose (and pass) IFMSA policy on this issue at the March Meeting in Ghana. This agenda will be taken forward during the Pre-General Assembly 'Advocacy Workshop' at the next IFMSA meeting, 'Advocacy and the Physician in Training', held by the American Medical Students Association (208).

Clinical Commissioning Groups by the Royal College of GPs



The role of CCGs in tackling the social determinants of health

As stated in Part A of this report, commissioning is a powerful tool for addressing the social determinants of health, and these social determinants should be at the core of commissioning.

The Health and Social Care Act (April 2012) requires CCGs in England to:

- Act with a view to securing continuous improvement in quality of services and in outcomes
- Have regard to the need to reduce inequalities between patients in access to and outcomes from health services
- Promote the involvement of patients, their carers and representatives in decisions about the provision of health services to them
- Promote innovation in the provision of health services
- Act with a view to securing integration in the provision of health services, and the provision of health and social care services where the CCG considers that this would improve the quality of the services or reduce inequalities between patients in outcomes and access to services.

In addition, the Equality Act 2010 “requires commissioners of services to take account of inequalities stemming from socio-economic disadvantage and to actively try and address them”.

CCGs are also obliged to work with local authorities to prepare a Joint Strategic Needs Assessment (JSNA), a duty which is discharged through the local health and wellbeing board. The aim is to join up commissioning across health and social care, and to use the JSNA to produce a joint health and wellbeing strategy, for implementation across health and social care, which CCGs must use to inform their commissioning plans. The JSNA and joint health and wellbeing strategy are key to understanding inequalities in the local area and factors which influence them such as poor housing, unemployment and poor educational attainment. This gives the opportunity through the health and wellbeing strategy and CCG commissioning plans to potentially align commissioning of services related to wider health determinants such as housing, education or lifestyle behaviours with integrated commissioning of health and social care services – hence the description of commissioning as a powerful tool.

Actions CCGs should take

- Assess need and develop a health and wellbeing strategy
- Identify a GP among the CCG Executive team who leads on health strategy and tackling inequalities (this is likely to be the Health and Wellbeing Board representative) and ensure effective representation of the CCG and input to the local Health and Wellbeing Board
- Ensure direct public health representation on the CCG’s Governing Body and on commissioning sub-groups
- Help to develop a ‘user-friendly’ new-style JSNA which uses a cradle-to-grave approach, has clear priorities and can be clearly aligned with the CCG’s commissioning plans
- Develop a local Health and Wellbeing Strategy which maps to the identified priorities and is also aligned with CCG commissioning plans.

Commissioning

- Aim to plan and commission services in an integrated way across health and social care so that health and social care services better meet everyone’s needs within the local community, including people in the most vulnerable circumstances and the groups with the worst health outcomes
- Ensure a focus on vulnerable groups at every stage of the commissioning cycle – from JSNA to contract negotiation rounds – to include those unregistered with general practice, children, consideration of access and safeguarding issues for people with learning disabilities, severe and enduring mental health problems, co-morbidity, and minority groups for all service commissioning, and in particular with potential service reconfiguration. The legal requirement to assess services in an Equality framework will help this process
- Make use of incentives with providers – this would include promoting good practice for providers as employers and managers through the contractual framework. Contract negotiation can include use of the quality incentive mechanisms (CQUIN) to target lifestyle factors in health such as breastfeeding promotion, smoking cessation and so on, and key performance indicators (KPIs) with health inequality-based outcomes relating to specific provider contracts
- Work with Healthwatch, the voluntary sector

and with effective local public engagement to redress health inequalities within the CCG population, for example with regard to primary care development and community services provision, with district or borough councils to map these to the local regeneration strategy, and with the Local Strategic Partnership of local employers and businesses

- Address health inequalities within primary care: CCGs are responsible for driving up quality in primary care and are well-placed to assess and tackle variations in primary care performance, where these may exacerbate health inequalities. The approach taken by Professor Chris Bentley and the former Health Inequalities National Support Team uses benchmarking of practices within a CCG area to identify areas of unacceptable variation, for example by comparing practice-level expected versus actual prevalence in QOF disease areas using data which is available on Public Health Observatory websites
- Provide, as part of the commissioning cycle, ongoing monitoring of health outcomes including primary care performance indicators, the equality impact assessment, provider CQUINs and KPIs with a health inequalities perspective, and, in collaboration with local authority colleagues, monitoring of the broader health outcomes likely to be affected by social determinants of health.

Case study

Warwickshire JSNA is published as an interactive website (209) which identifies key themes, loosely structured to follow a life-course approach. The key themes are laid out with the background needs assessment data, a list of outcomes sought, and who needs to take action. The headings for the key themes are: Children and young people (including educational attainment and looked-after children); Lifestyle factors affecting health and wellbeing; Ill-health (including long-term conditions and mental wellbeing); Vulnerable communities (including reducing health inequalities specifically, disability and safeguarding) and Old age (including dementia, ageing and frailty). This approach, taken with the Warwickshire Health and Wellbeing Strategy, which also highlights priorities for housing, education, and healthy and sustainable communities, will form the basis of the three constituent CCGs' commissioning plans, and will enable a coordinated countywide approach to action on the social determinants of health and tackling health inequalities.

For example, Rugby CCG has over the past year used this approach to work towards integrated health and social care commissioning for people with learning disability, developed plans to target services for people with alcohol and substance problems and mental health co-morbidity, and worked with local authority colleagues to highlight issues around adult safeguarding in primary care and care homes.

Clinically-led commissioning, through clinical

commissioning groups and the accompanying statutory framework, provides a real opportunity for action on the social determinants of health. CCGs are membership organisations, and all GPs and practices have a shared responsibility to work in this way. Direct accountability for doing so sits with the Health and Wellbeing Board in each area, and with the National Commissioning Board. The opportunity for CCGs to effect real change in the health of their population through commissioning must not be missed.

Further reading

- Department of Health (2012) JSNAs and joint health and wellbeing strategies – draft guidance, January
- NHS Confederation (2011) Operating Principles for health and wellbeing boards
- The King's Fund (2011) Transforming our health care system – ten priorities for commissioners

Dentists and oral health teams

by David Williams, Aubrey Sheiham & Richard Watt



On behalf of: Faculty of Dental Surgery, Royal College of Surgeons of England; Dental Faculty, Royal College of Surgeons of Edinburgh; Dental Faculty, Royal College of Physicians and Surgeons of Glasgow; Faculty of General Dental Practice, Royal College of Surgeons of England; The Dental Schools Council; British Association for the Study of Community Dentistry

The role of dentists and oral health teams in addressing the social determinants of health

Oral health is associated with socio-economic status, which links to family income, educational attainment, employment, housing, risk of accidents, physical health, and mental health. Indicators of the health of children and young people show that low birth weight, measles, whooping cough, road traffic accident casualties, dental health, teenage conceptions, childhood obesity and reported health status are all related to levels of socio-economic deprivation. Children and young people in poorer areas have a worse health status than those in the more affluent (2).

Given the close links between oral health and other indicators such as family income and educational attainment of children and parents, a whole-systems approach to improving oral health in the context of general health is required. Some of the principles that must underpin action include:

- Tailoring the response to the level of oral and general health need
- Building on community assets and strengthening family competence to self-manage health, including oral health
- Placing an emphasis on early years and early intervention
- Taking a family focus
- Taking a personalised approach to delivering services.

All primary health care professionals should tackle the needs of families in the context of their environment and experience. There is a fundamental need to integrate initiatives to improve oral health with more general interventions to support good physical

and mental health. Primary care is the first point of contact with the health service and is the setting in which most care – both general and oral – is provided. Oral health teams, collaborating with primary care teams, have the largely unexploited potential to be important advocates, enablers and mediators for oral health. Because the risk factors for oral and general health are the same, such activities will also promote good general health.

Primary medical care is increasingly appreciating the pivotal importance of social determinants in influencing health status and health outcomes. If oral health care is to be properly integrated with health care in general, it is essential that all members of oral health teams understand the importance of the social determinants of oral health and integrate their activities with other groups.

Actions oral health teams should take

- All members of oral health teams should acquire a thorough understanding of the importance that social determinants play in oral as well as general health. They should have a thorough understanding of how the conditions in which people are born, live, work and age can affect their health, and how they can act to tackle these.
- Dentists and oral health teams should engage in partnership with communities to help them better understand and tackle the social, economic and environmental factors that determine oral health and increase inequalities.
- Dentists and oral health teams should engage with colleagues such as primary health care professionals in the development of cross-sectoral partnerships, so that oral health promotion strategies become incorporated into all strategies for health
- Dentists should become advocates for health, particularly oral health, with their patients and the wider community. This should include an emphasis on acting as enablers, helping to make healthy choices the easier choices and empowering people to take control of their own lives and health.

Case study

Working with the Primary Health Care Team to promote the oral health of children by school nurses in Tameside, Greater Manchester, UK

School nurses and school nurse assistants deliver health programmes in schools including health and sex education, developmental screening, health interviews, and immunisation programmes. A group of these nurses approached Greater Manchester's oral health team to request a 'teaching resource' that they could use to engage with Reception/Year 1 children and their families (210–212). They wanted a resource that was child-friendly, and would enable the named school nurse to begin to build a relationship with the children. This would introduce the children to the nurse and facilitate the other screening initiatives that the school nurse would carry out, such as developmental checks. A fun pack was developed by the oral health team in collaboration with the school nurse assistants and was designed to involve parents and carers. Post-evaluation questionnaires were then sent home at the end of the topic. School nurses and their teams are also offered annual training and update sessions on oral health.

Benefits and principles of the scheme

- Oral health is not seen as a 'standalone' topic
- The pack gives the school nurse teams an opportunity to introduce themselves to the parents
- This is a good joint working initiative between the school nursing service and the oral health team.

Impacts of the scheme

- Embedding oral health into other care pathways
- Increased knowledge around cause and prevention of oral disease
- Increased knowledge in accessing NHS dental services
- Increased awareness of impacts of oral health and the Common Risk Factor Approach
- Cost-effective, because resources are shared
- Continuing Professional Development for recipients.

Intermediate impacts on oral health

- Increased availability and access to evidenced, informed oral health advice and information
- Increased NHS dental attendance
- Increased access to appropriate services for vulnerable groups.

Key message

Oral health teams should work closely with other health professionals working to reduce risk factors and support families to achieve health and wellbeing.

General practitioners by the Royal College of GPs



The role of general practitioners in tackling the social determinants of health

General practitioners (GPs) aim to provide “high quality, evidence-informed holistic care to their patients and to families in their communities, responsive to their needs” (213). In *Fair Society Healthy Lives*, Marmot *et al* demonstrated that need is not evenly distributed between patients, and recommended an approach based on ‘proportionate universalism’ (2). Providing care “with a scale and intensity that is proportionate to the level of disadvantage” (2) is a familiar philosophy to general practitioners who aspire to provide ‘person-centred’ (214) care.

This report from the UCL Institute of Health Equity builds on the recommendations made in *Fair Society Healthy Lives*. It serves as a welcome summary of the challenges we face in dividing time and resources between patients according to need, and suggests ways in which all health care professionals can take action on the social determinants of health.

Three areas for action are identified: ‘Practice’, ‘Education’ and ‘Incentives, Monitoring and Directives’. All GPs are involved in at least one of these areas, and increasingly more than one, as CCGs take on responsibility for commissioning. Below we suggest a number of questions General Practitioners can consider to ensure that their day-to-day practice improves the health of those at risk from the social determinants of health. A further section follows, considering the vital role of commissioning in tackling health inequalities.

Action on the social determinants of health in practice

There is good evidence that good quality general practice reduces inequalities in health and attenuates the detrimental effects of social disadvantage (215). Poor practice, or lack of access to a GP, broadens health inequality. But what is ‘good practice’?

Modern medical generalism — seeing the whole and knowing the community

Good practice requires clinicians to understand their patients’ needs. There may be many ways to understand needs and to respond to them, from ensuring adequate time to listen in an individual consultation, to identifying groups of patients within a practice who are most vulnerable. Offering anticipatory care in a person-specific way requires an understanding

of the community, culture and environment from which patients come.

Creation of a therapeutic relationship

Seeing a known and trusted doctor is central to what general practice aims to offer to all patients. Relationship continuity has demonstrable benefits for health across the board (216) but may be more difficult to establish with those living chaotic lives. Flexible appointment types and systems may be vital for enabling people to take control and get the help they need.

Coordination and collaboration across professional and organisational boundaries

Multidisciplinary communication and timely liaison with professional colleagues is essential to providing holistic care. Most patients who are vulnerable will benefit from input from more than one type of profession. There are great benefits to knowing the wide range of services available locally to an individual practice and coordinating and collaborating well with local organisations and professionals.

Questions to ask in practice

What vulnerable groups are registered with your practice and what can be done to improve care for them?

For example: How many patients with mental health problems miss their annual review? How many patients do you have with learning disability? How many people miss screening opportunities? Do you discuss this opportunistically in consultations? How best can you identify and support carers? Are your patients at higher risk of any particular illnesses than the national population? How can you address this locally?

Does your practice have any barriers to patient access? How can you change things to make it easier for vulnerable patients?

For example: Are there any obstacles to patients being able to book appointments? How do you communicate with patients who have no telephone? Do your reception and management teams know how to register a patient who is homeless? How does the team help people with poor literacy skills?

What challenges to communication do you encounter?

For example: Are language advocates booked routinely when required? Do you have enough time

with vulnerable patients? How does your practice encourage continuity of practitioner? How do you communicate with other professionals? Does the practice have a lead for safeguarding vulnerable children and adults? Do you have regular multidisciplinary meetings? How do you promote the creation of a therapeutic relationship?

Are there any extra services you could be offering?

For example: What kinds of social prescribing can you offer? What help do you offer those with alcohol or substance dependence? What mechanism does your practice have for protecting health professionals from stress? What educational opportunities do you offer staff? What is the practice policy about advocacy letters? Is there a charge for this service?

Further reading

There is now a wealth of resources available to support practitioners in providing what is considered good quality general practice. Below is a list of publications which individual doctors or practices may find helpful in considering how to improve the care that they offer those at risk from the social determinants of health. Further resources including a wide range of e-learning possibilities can be found at www.rcgp.org.uk

General practice & health inequalities (overviews)

- Ali A, Wright N and Rae M (ed.) (2008) *Addressing Health Inequalities: A guide for General Practitioners*. London: Royal College of General Practitioners
- Hutt P and Gilmour S (2010) *Tackling inequalities in general practice: An Inquiry into the Quality of General Practice in England*. London: King's Fund
- Royal College General Practice and the Health Foundation (2011) *Guiding Patients through Complexity: Modern Medical Generalism*, Royal College General Practice and the Health Foundation; RCGP, October.
- Royal College of General Practice 2009 Strategic Review of Health Inequalities in England Post 2010 (Marmot Review) (2010): An RCGP paper on the role of primary care in the reduction of health inequalities.

Practice access

- Royal College of General Practitioners (Scotland), the Scottish Government Health Department, the Glasgow Centre for Population Health, and the Section of General Practice & Primary Care at the University of Glasgow (2011) *Deep End reports 13 GPs at the Deep End*. www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/

Vulnerable Groups (examples only)

- Houghton M and RCGP Learning Disabilities Group (2010) *A step by step guide for GP Practices: Annual Health Checks for People with a Learning Disability* RCGP 2010.
- Royal College of General Practitioners and The Princess Royal Trust for Carers (2011) *Supporting carers: An action guide for general practitioners and their teams* (2nd edition).
- Royal College of General Practitioners (2004) *A toolkit for General Practitioners and Primary Care Organisations: Criteria, Standards and Evidence required for Practitioners working with Drug Users*.
- Royal College of General Practitioners Primary Care Mental Health Forum produce a number of factsheets about different mental health problems. www.rcgp.org.uk/clinical-and-research/clinical-resources/primary-care-mental-health-forum.aspx

Social prescribing

- Royal College of General Practitioners (Scotland), the Scottish Government Health Department, the Glasgow Centre for Population Health, and the Section of General Practice and Primary Care at the University of Glasgow (2011) *Deep End report 8. GPs at the Deep End*.

Health and work

- Royal College of General Practice, Faculty of Occupational Medicine, and Society of Occupational Medicine supported by the Department for Work and Pensions (2006) *The Health and Work Handbook. Patient care and occupational health: a partnership guide for primary care and occupational health teams*. www.rcgp.org.uk/pdf/healthandworkhdbk.pdf

Screening

- Davey C, Austoker A, Macleod U (1999) *Reducing inequalities in breast cancer: a guide for primary care*. London: CRC
- National Institute for Health and Clinical Excellence (2009) *Reducing differences in the uptake of immunisations (including targeted vaccines) among children and young people aged under 19 years*. Public Health Guidance 21. London: NICE. www.nice.org.uk/nicemedia/pdf/PH21Guidance.pdf

Continuity of care

- Hill A and Freeman G (2011) *Promoting Continuity of Care in General Practice* RCGP Policy Paper: Royal College of General Practitioners, March

Hospital doctors

by the Royal College of Physicians



The role of hospital doctors in tackling the social determinants of health

Doctors are the most trusted and respected professionals in society, and this goodwill needs to be channelled into programmes tackling health inequalities. Members of the entire profession can use their powerful voices, on a personal, community, national or global level, to promote action on the social determinants of health.

An increased interaction between clinicians, public health teams and researchers, social care services and local government, and a better flow of information between these groups, will help to establish which health promotion initiatives are most effective, or which population groups are under-using various health care services.

Doctors also have an important role as managers to ensure that their staff are well supported and able to lead successful, productive working lives – which will mean better health for them and their families. Management practice has a large influence on whether people are present or absent from work, and in supporting staff members who have been on long-term absence to return to appropriate work successfully.

Actions hospital doctors could take

As clinicians

- Ensure access to high quality health care is available to vulnerable groups by working in flexible ways, for example by working:
 - outside the hospital setting or providing out-of-hours clinics, or
 - with voluntary organisations to raise the profile of health services and health need to disadvantaged groups
- Develop bilateral referral pathways with local service providers and use clinical consultations as an opportunity to refer patients to appropriate support services such as housing and debt advice services
- Work with hospital managers to collect data on admissions relating to the social determinants of health. These could be published to highlight “inequality attributable admissions” and inform trust and national level initiatives.

As advocates

- Work with public health specialist teams and other sectors (for example housing, education, employment and environment) in advocating and developing services and programmes to encourage better outcomes for health, such as conducting health equity audits
- Sit on Health and Wellbeing Boards and/or actively contribute to the Joint Strategic Needs Assessment (JSNA), to address the fact that some people may not access primary care and thus their needs are not identified.

As managers and clinical leads

- Work with hospital trust leaders to ensure that their trust is a model employer and that all staff are well supported as employees, including developing appropriate working patterns, clear job roles and high quality appraisals
- Undertake training on how to manage staff returning from long-term sickness absence, and apply what they have learnt to support staff returning to work.

As educators

- Ensure medical students and trainees have exposure to community placements that tackle broader social determinants and are guided to investigate the social factors contributing to the ill health of patients when they present to acute services.

Examples

Contribute to the local Health and Wellbeing Board Health and Wellbeing Boards (HWBBs) are currently being established in every local authority in England. HWBBs will work with local authorities and Clinical Commissioning Groups to draft an annual Health and Wellbeing Strategy for the area, based on the JSNA (a measure of health and wellbeing people in the area).

Hospital clinicians bring significant knowledge at the sharp end of the health problems of the population and can provide analysis of major disease trends in the community. Doctors can also help ensure that the Health and Wellbeing Strategy includes integrated services that take into account a range of social, economic and environmental factors to improve the health of the local population.

Use the local health profile to support patients and staff

Health profiles have been developed by public health teams based within several trusts, in collaboration with other partners. They include indicators for a number of measures that would impact on inequalities and access to health care, such as smoking, obesity and physical activity levels, communicable diseases, vaccinations, GP registration status, employment and housing. These profiles are then informing how trusts engage with their patients and how they support the health and wellbeing of their staff.

Case studies

Find and Treat

A mobile tuberculosis (TB) service visits 210 locations in London where people at high risk of TB can be found such as drug treatment centres, hostels, and day centres for the homeless. Staffed by a registrar, nurse, radiographer, with administration support, the service provides X-ray screening for TB on a voluntary basis as well as awareness-raising, treatment support, peer support for treatment completion and follow-up for patients who are non-adherent to treatment or lost to follow-up from other London TB services. The service identifies an infectious disease in a usually 'hard-to-reach' population and provides support for the duration of treatment, reducing the risk of relapse or development of resistant TB.

The service has been shown to be cost-effective and popular with patients and health care staff.

This is an important example of improving access to services for patients who may otherwise miss out on primary or secondary care and thus improving their health and the health of the population by reducing the spread of TB.

Further reading

- Royal College of Physicians (2010) How doctors can close the gap: tackling the social determinants of health through culture change, advocacy and education. London: RCP. www.rcplondon.ac.uk/resources/how-doctors-can-close-gap
- Royal College of Physicians (2010) Future physician: changing doctors in changing times – report of a working party. London: RC. <http://bookshop.rcplondon.ac.uk/details.aspx?e=314>
- Royal College of Physicians and Faculty of Occupational Medicine (2012) Implementing NICE public health guidance for the workplace: Overcoming barriers and sharing success. London: RCP. www.rcplondon.ac.uk/projects/staff-health-improvement-project

Midwives

by the Royal College of Midwives



The midwife's role in tackling the social determinants of health

As the main professional carer of women during pregnancy, birth and the postnatal period, midwives are the best placed of all health care workers to ensure that children get the best start in life. As midwives build relationships with the women they care for, they have the opportunity to see and understand the social conditions in which they live. Midwives build up a good understanding of each woman's needs, can tailor care and advice to meet those needs and can be highly influential on lifestyles.

While midwives have opportunities to affect the social conditions in which women give birth and raise families, their primary responsibilities remain as giving health care and encouraging lifestyle changes that have an immediate impact on health. Midwives' ability to address the social determinants of health depends on being adequately mandated, trained and supported to do so. One of the biggest barriers to midwives addressing the social determinants of health is a lack of time.

Actions midwives could take

This section outlines practical things that midwives can do to help tackle the social determinants of health.

Gathering information

- During antenatal care, midwives can ask each woman about her and her family's employment, financial and housing situation. This could form part of a broader social assessment and part of discussion to determine if a woman is eligible for access to the Healthy Start scheme
- When visiting a woman's home, midwives can take note of the conditions in which she lives. Midwives can look out for signs that the woman and her family might be struggling financially or otherwise to create a positive environment in which to raise a baby. Signs could include temporary accommodation, inadequate heating, or social isolation.

Acting (these actions are based on existing NICE guidance)

- Where resources allow, midwives should spend more time with a woman if she is in difficult social circumstances or is leading an unhealthy

lifestyle. Midwives can use this time to provide additional information and advice on available support services. Midwives should also aim to provide more flexibility in length and frequency of antenatal and postnatal appointments

- Midwives can work closely with other agencies, and initiate a coordinated care plan where appropriate. Midwives should explain to women why and when information may be shared with other agencies, and discuss fears sensitively and respect confidentiality. Where appropriate, women with complex social needs should have access to an out-of-hours contact number
- Midwives should ensure a one-to-one consultation with each woman, without partner, family or legal guardian on at least one occasion
- Midwives can offer extra support to help women attend appointments, including reminders and transport assistance
- Midwives should ensure an effective handover process, particularly to health visitors, at the end of the postnatal period.

Providing information

- Midwives should ensure that women fully understand the importance of, and their entitlement to receive, maternity care and other NHS services. They should ensure that all women have telephone access to a midwife
- Midwives can provide information about non-NHS services, and make referrals where appropriate. This should be done according to an up-to-date protocol that specifies what local services are available. Relevant services might include housing, welfare and other local government services
- Midwives can provide advice and information about the Healthy Start scheme
- Midwives should discuss healthy and realistic diet options, including Vitamin D supplementation and the impact of healthy eating on the unborn baby.

System feedback

- Midwives can speak to staff of non-NHS services about the quality of local services that address the social determinants of health. This might be about the quality of services provided to an individual woman (where confidentiality allows) or about the quality of services in general
- Midwives can speak to their managers about having the necessary support for working with

socially disadvantaged women. This might include having adequate time for booking appointments, receiving appropriate training, and having local referral protocols in place.

Case studies

Plymouth Hospitals NHS Trust

A safeguarding midwifery team identifies vulnerable families using a broad assessment framework including social determinant aspects such as employment, housing and social integration. Potentially vulnerable families are then referred to appropriate services through close multi-agency cooperation and clearly defined pathways. Early engagement with relevant services and a broader focus on family support enables better outcomes. Since the approach was implemented, communication has improved between agencies, vulnerable families are referred to appropriate services sooner, and both midwifery staff and families are more engaged with the assessment and referral process.

Queen Elizabeth Hospital NHS Trust, Woolwich

The Best Beginnings team tailors care to meet the particular needs of individual families. By working with partners in this London community, the team are able to address health and social inequality risk factors associated with infant and maternal mortality. Families experiencing social deprivation and exclusion are also supported to develop healthier lifestyles.

Further reading

- NICE guidance
 - Antenatal care: routine care for the healthy pregnant woman. www.nice.org.uk/CG062
 - Routine postnatal care of women and their babies. www.nice.org.uk/CG037
 - Pregnancy and complex social factors. www.nice.org.uk/guidance/CG110
 - Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households. www.nice.org.uk/PH011
 - Behaviour change at population, community and individual levels. www.nice.org.uk/PH006
- RCM Position Statement on women centred care. www.rcm.org.uk/college/policy-practice/guidelines/rcm-position-statements/position-statements/
- Midwifery 2020 Public Health Workstream Final Report. www.midwifery2020.org/PublicHealth/

Nurses

by the Royal College of Nursing



The role of nursing in tackling the social determinants of health and actions nursing staff can take

If we are to close the gap in health inequalities and the burden of avoidable ill health, then we must harness the full potential of the nursing workforce. It is crucial that public health nursing expertise and experience is fully recognised, is appropriately funded and is supported and utilised.

The RCN believes that the delivery of public health is of necessity on a continuum and therefore every nurse has a contribution to make, in whatever role they play, to improve the health of individuals and the communities they interact with. Together with specialists in public health nursing all nurses can navigate care 'upstream'. Upstream approaches seek the causes of disease and preventable disability in order to address problems through prevention, rather than treatment, initiating care to prevent people from becoming ill in the first place. Nurses also have a key role in minimising the impact of illness, promoting health and function (capabilities), and helping people maintain their roles at home, at work, at leisure and in their communities.

In *Going Upstream: Nursing's contribution to public health* (see below) the RCN offered nurses working in all four nations of the UK a framework to engage actively in upstream public health. The RCN believes a set of core ingredients and principles will help underpin the work of nursing. The principles include:

- All nurses, regardless of their work environment, knowing and understanding the health needs of their local population
- Nurses identifying defined populations to enable health care teams to target individuals who would most benefit from preventive approaches
- Nurses working in partnership with other members of health and social care organisations, to influence the work on tackling the wider determinants of health
- Nurses engaging local people and groups, including those who are not in work, in public health awareness and action
- Nurses making it their business to be informed, aware and responsive to disease outbreaks and other threats to health
- Nurses utilising public health evidence in everyday practice, not just evidence for treating illness
- Nurses working to a public health knowledge and skills framework based on the 'novice to expert' criteria.

Nurses, health care assistants, midwives and health visitors are in a unique position to contribute to the lifespan approach to health protection and health improvement. They may work in public health departments as a public health consultant or director of public health; they may support early-years development as midwives, nurses and health visitors through targeted interventions (for example, through the Family Nurse Partnership programme); they may be specialist nurses who provide care and early intervention at specific times of need.

Case studies

Targeting screening for vulnerable patients

Inclusion Healthcare is a social enterprise jointly run by a nurse and a doctor. The focus of their work is to deliver a quality service to homeless and other socially excluded people. The enterprise has employed nurses to work in partnership with other agencies (health and non-health) to improve patient pathways for homeless people who become ill, thus avoiding unnecessary hospital admissions for this group of patients.

In December 2010 they commenced the delivery of a full range of primary health care services, including health education, promotion and screening, to a highly vulnerable group of adults with moderate and severe learning disabilities. This is particularly important because the team has identified that people with learning disabilities may die from manageable long-term conditions. The team's aim is to improve health outcomes for this group of patients by ensuring timely interventions and proactive care.

Protection from abuse and domestic violence

Lucy is a domestic violence risk liaison nurse who acts as a coordinator between the Multi-Agency Risk Assessment Conference (MARAC) in Bristol and local health care providers. Her role includes highlighting to clinicians those patients receiving support through the MARAC, so that patients who are considered at risk receive an appropriate and sensitive service. The service has been established in recognition of the significant amount of domestic violence experienced by women and the escalating annual domestic violence cost and the significant percentage of children (75 per cent) subject to child protection plans who live in households where domestic violence occurs. The service is aimed at GPs, health visitors and community health



professionals who are taught to use recognised risk identification tools to assess clients who may be at a high risk of abuse. Nationally, MARACs have been shown to reduce repeat victimisation from 32 per cent to 10 per cent (217).

Safe discharge to warm homes

The RCN has been involved in the production of, and has co-badged, the Hospital 2 Home discharge pack to support care of older people (218). The discharge pack is designed to make it easier for health and social care professionals involved in hospital discharge to support older patients in returning home safely after a hospital stay and reduce the risk of readmission to hospital. The production of this discharge pack was supported by the Department of Health and the Department for Communities & Local Government.

The checklist asks several questions to assess the suitability of the patient's housing such as, 'Is their home warm enough? Is the heating working adequately?' The factsheet *Services to support older people returning home from hospital* then signposts to home improvement agencies (HIAs) which assist vulnerable homeowners or private sector tenants who are older, disabled or on low income to repair, improve, maintain or adapt their home, to improve energy-efficiency, for example. Using this discharge pack appropriately is one way in which health and social care professionals can be aware that social determinants that affect environment can have an impact on health inequalities, and therefore steps can be taken to address these environmental factors.

Further reading

- RCN (2012) Going upstream: nursing's contribution to public health. RCN guidance for nurses – Prevent, promote and protect.
- RCN (2012) Health inequalities and the social determinants of health. RCN Policy Briefing.
- RCN (2012) Human Rights and Nursing. RCN position statement.
- RCN (2012) The RCN's UK position on School Nursing.
- RCN (2011) The RCN's UK position on health visiting and the early years.
- RCN (2011) RCN response to the Public Health White Paper, *Healthy lives, healthy people: our strategy for public health in England*.
- RCN (2010) Pillars of the Community. The RCN's position of the registered nursing workforce in the community.

Obstetricians and gynaecologists by the Royal College of Obstetricians and Gynaecologists



Royal College of
Obstetricians and Gynaecologists
Bringing to life the best in women's health care

The role of obstetricians and gynaecologists in tackling the social determinants of health

Women have more predictable long-term reproductive health care needs than men and more frequent interactions with health services. Most women will have some contact with an obstetrician or gynaecologist at some point during their lives and doctors in the speciality need to recognise how their contribution, as part of the multi-disciplinary team, can affect the overall health and wellbeing of women and their children.

The antenatal period represents a window of opportunity for health care providers to identify clinical, social and behavioural risk factors, and to provide appropriate interventions where necessary. The sustained contact with the health service during the postnatal period also provides continued opportunities for the health care team to provide input into the woman and her family's needs. The majority of women are discharged from hospital within hours of giving birth and community-based resources are provided by midwives. However, the links to obstetric expertise are still available as required.

Once a woman completes her reproductive years the opportunity for education and health promotion can diminish, and many women may not seek help for their gynaecological symptoms as readily as they may have done for their pregnancy. A life-course approach to women's health care, by obstetricians and gynaecologists, recognising all opportunities for interventions that can address the effects of the social determinants of health, is key to reducing the impact of these determinants on women and their children.

Initial analysis of maternity data by the RCOG (currently unpublished), has shown wide variation in the obstetric outcomes experienced by women of different socio-economic status. In the most deprived areas of the country, the likelihood of a woman having a premature or growth-restricted baby is 1.4 and 1.9 times higher, respectively, than for a woman of the same age and ethnicity living in a more affluent area.

More work needs to be done to understand why these variations occur and, consequently, how they may be reduced in the future. Improved data collection and analysis of clinical outcomes, and the association with the social deprivation, could be one solution. In addition, bringing existing databases together in clinically meaningful ways could enable richer and more robust analysis of the data on the social determinants of women's health.

As it stands, there is not a great deal of emphasis on understanding the social determinants of health and how they can be addressed in undergraduate and postgraduate training programmes for all health care professionals, and opportunities for joint training programmes, joint posts and secondments with public health could be explored.

Use of clinical networks and improved linkage with other specialties (diabetes, hypertension and so on), could serve to reverse the current situation where there is a tendency to focus on disease or episodic events within networks. For example, a Women's Health Network could encompass all aspects of maternity and new-born care but also broader aspects of women's ill health in later life, often related to pregnancy and influenced by social determinants. Examples would include the influence of nutrition/diet and smoking on pregnancy and foetal growth, and their subsequent importance in the non-pregnant state later in life.

Actions obstetricians and gynaecologists should take

- Use the maternity episode as an opportunity to improve health education beyond the postnatal period
- Use the maternity episode as an opportunity to work with other professionals (e.g. social services, local authorities, schools, police, voluntary organisations and charities), in order to engage with seldom heard/hard-to-reach women
- Foster and develop links with other specialists such as diabetes, hypertension and mental health experts
- Influence colleagues and their teams to improve the quality and quantity of data collection for analysis
- Work with commissioners to understand the population and their requirements, so that health care services can be organised to be responsive to women's needs (more care delivered in community settings)
- Seek opportunities for health education
- Link with other specialties (such as Community Sexual and Reproductive Health Care)
- Work with the RCOG and women's groups to ensure that the curriculum and training programmes train doctors in the specific issues relating to the care of disadvantaged women.

Case studies

The Tomorrow's Specialist Working Party undertook to collect evidence from a wide range of sources, which included Health Link (219), an independent patient interest group that works on new ways of linking up communities and the NHS, drawing in the views of 'marginalised' groups to give them influence, and National Voices(220), the national coalition of charities that is seeking to narrow the gap between the policy theories and the reality of the health services. The Directors, Elizabeth Manero and Jeremy Taylor, respectively, helped shape the Working Party's thoughts on what should be done to improve the care and access to services of disadvantaged women. Please see the extract from the *Tomorrow's Specialist* report in Appendix 1.

Further reading

- RCOG (2011) *High Quality Women's health Care: a proposal for change*
- RCOG (2011) *Why Should We Consider a Life Course Approach to Women's Health Care (SAC Opinion Paper 27)*
- RCOG (2012) *Endometrial Cancer in Obese Women (Scientific Impact Paper No 32)*
- RCOG (2012) *Tomorrow's Specialist*

Appendix 1: Extract from the Tomorrow's Specialist Working Party report (221)

Caring for disadvantaged women

There is a risk that some groups of women will be disadvantaged as different health models emerge. This is particularly true for poorly educated women with low socio-economic status. Access to care for women who are older, homeless, have mental health problems, are refugees, have a disability or are otherwise isolated from society needs to be innovative and imaginative.

The impact on long-term health for individual women is unfavourable if their needs are not met adequately and these poor health outcomes are likely to continue in their children.

Women, their partners and their families are concerned with 'quality of life' matters, and health care provision that takes into account the overall physical, mental and spiritual needs of women is increasingly important. Knowledge of 'wellness' and preventive health is important for individuals as well as being of increasing importance to public health. Many of the underlying factors for poor health and poorer health outcomes (for example, obesity) cannot be managed by purely concentrating on the physical aspects of health.

Engaging disadvantaged and 'seldom heard' women can be facilitated by moving care into the community, providing that all clinicians are ready to collaborate with other professionals: social services, local authorities, schools, police, voluntary organisations and charities. Accessing intelligence on the

local population can provide information on how to make contact with and communicate health care messages to all women.

Disadvantaged women may be less able to make the best health care choices for themselves, owing to difficulties in accessing information, but they can be enabled and empowered with the right approach and the right resources (such as interpreters and visual materials). During pregnancy, women's motivation to take care of themselves and their family can and should be harnessed to communicate fundamental messages and instil lifestyle changes that can be maintained after the birth of their babies (222).

The specific needs of women with mental health problems are a particularly neglected area of practice for the majority of specialists in obstetrics and gynaecology. The stressful nature of many women's health problems, particularly during pregnancy, means that developing an integrated service, and improving the understanding of the psychiatric, psychological and social issues facing these women, is vital if their outcomes are to be improved and their future engagement with health services is to be assured.

Doctors caring for women need to work with other health care professionals and social care providers to understand the wider health needs. Doctors with expertise in obstetrics and gynaecology, and women themselves, should be the foremost advocates for women's health.

The full recommendations are available in the Tomorrow's Specialist (223).

Paediatricians

by the Royal College of Paediatrics and Child Health



The paediatrician's role in tackling the social determinants of health

Paediatricians take on a special dual-role of agent as the doctor is both the agent for the patient and for the parent or carer who has prime responsibility for the child. The doctor is thus an advocate for the child and in child protection issues is fully aware that 'interests of the child are paramount'. Paediatricians should be well-equipped not only to recognise problems that indicate child poverty and health inequalities, but also to intervene and treat these problems as early as possible to prevent long-term consequences to health.

It is clear, then, that paediatricians have three general roles in reducing health inequalities: in improving their own awareness of the issue, in working to create public awareness and knowledgeable patients in regards to health inequalities, and in promoting changes within both the health profession and the government; many actions are overarching and fall within more than one of these categories. All of these actions will contribute to decreasing the number of premature deaths as well as providing economic benefits in terms of saved health care costs. Most importantly, tackling these inequalities will help to give children the best possible start in life and the ability to maximise their capabilities.

Actions that paediatricians should take

Awareness, training and development within the health profession

Paediatricians should:

- Adopt a holistic, multidimensional approach to the process of diagnostic assessment and intervention, recognising all the biological, social and environmental influences on the evolution of the health and development of a child
- Be aware of the concept of 'readiness for school', the ability of the child to develop to his/her full potential and perhaps break out of an intergenerational cycle of poor achievement and socio-economic deprivation, as well as the early years' factors that influence this and how to promote good practices and available evidence-based interventions with individual families
- Also be aware of the 'millennial' morbidities of childhood, which are reflected in the current RCPCH policy objectives to tackle obesity and

child mental health problems, with their strong life-course influences

- Be trained about the factors that affect access to services – not just geographical, financial and cultural, but also the attitude, educational level and physical and mental health of parents and other family members. They should be encouraged to use the social determinants of health model when evaluating a child's health, not only focusing on physical health and overall wellbeing, but also recognising protective and adverse risk factors within the family and external environment
- Be aware of how systems within their own influence might be altered and be able to develop procedures, for example for non-attendance of children, fast-tracking highly mobile populations such as migrants or traveller families, ensuring all patients seen in secondary care have been registered with primary care providers, making appropriate use of liaison health visitor services at the interface with A&E
- Partake in regular study days both at the College and locally. Exam questions should be required to assess paediatricians' basic knowledge of health inequalities. They should also be given new inductions (either by a consultant, health visitor or social worker) upon arrival to each new trust in order to learn about services and demographics of the local area served by the unit
- Work across the health professions, especially with obstetrics, as antenatal care, nutrition and parenting are also important aspects of health
- Become aware of local projects and services, such as the Child Poverty Intervention Project pilot or Teenage Parents Supported Housing pilot and local authority child poverty projects, by keeping up-to-date information
- Recognise the child's right to be heard and encourage the patient's increasing involvement in decision-making throughout maturity and growth
- Take up opportunities for training in motivational interviewing and behavioural change as well as in advocacy skills for influencing local and wider political structures.

Public and patient awareness

Paediatricians should:

- Take every opportunity to explain in a non-judgemental way the effects of parental behaviour on children's health. This includes negative

socio-emotional parenting, passive smoking, addiction, domestic violence and unregulated, constant television viewing

- Adopt a positive, strengths-based approach in order to promote those protective factors which mitigate against the effects of poverty in a particular family
- Encourage parents to remain in contact with health visitors and key workers, as well as encourage regular health visitor follow-ups for weight measurements and advice and regular immunisation
- Inform patients of services such as Sure Start Children's Centres and maternity grants, local children's centres that provide free activities and courses, library services (including toy libraries, storytime and rhymetime), FareShare (for food access), school breakfast clubs and after-school study clubs, as well as disability living and carers allowances
- Contact social services, health visitors and GPs to make sure they are aware of the child and family. They should work to increase the public knowledge of the availability of these services
- Make better use of the personal child health record (PCHR or 'red book') and information sheets given to parents of newborn children, in order to provide guidelines and advice on topics such as developmental support, nutrition, dental hygiene and immunisation
- If caring for children with long-term conditions and disabilities, promote key worker schemes and parent support groups and provide easily accessible information, as well as give individual encouragement to parents, with the aim that they learn to become good advocates for their children.

Promotion and advocacy

Paediatricians should:

- Promote with policy makers the fact that children have their lifestyle choices made for them initially, and then adopt those they have grown up with, making the potential to change more difficult when fully independent
- Write to and engage with MPs to encourage a culture of integration of services for children, involving health, education and social services, especially in times when structural changes brought about by the Health and Social Care Act may mitigate against this
- Use as an example the presentation of data on the cost to the NHS of treating accidental injury in children, to develop with others injury prevention schemes, and encourage lobbying – both individually and with organisations – for changes to the environment
- Advocate for educational and environmental measures to improve access to healthy exercise, knowledge of healthy diets and the adverse influence of advertising and marketing
- Push for improvements within the health profession such as further enhancement of the PCHR. Paediatricians should become familiar with local

services and use their knowledge to signpost to such services and projects

- Canvass for change by promoting and taking part in hospital audits, which could be used to highlight health discrepancies and also as a measure to highlight issues with MPs and government.

Case studies

'No Death is Best' – an infant mortality reduction campaign in Harrow, London

In 2005, the Director of Public Health in Harrow became concerned about an unusual increase in the number of infant deaths (the infant mortality rate in 2003 was more than 7 per 1000). Chaired by Professor Mitch Blair, an interdisciplinary multi-professional group was set up to look at how Harrow might be able to tackle the issue. From comparison with neighbouring areas, it was clear that Harrow had very disparate rates of infant mortality ranging from 2 per thousand to 17 per thousand within a very small geographical area. Prof Blair's group used guidance produced by the Department of Health on reducing the disparity of infant mortality rates between the richest and poorest as the basis for their action plan and worked closely with health visitors, midwives, public health analysts and specialists in smoking cessation and teenage pregnancy. They produced a campaign to try to raise awareness among all health professionals and the public about the key determinants to minimise infant death risk and optimise infant health. The campaign, 'No Death is Best', was a mnemonic for the key actions required (see box below).

Harrow's infant mortality is now 4.8 per 1000 (2011) and is similar to the England average. The group has been able to measure progress against a scorecard which was incorporated in the Children and Young People's Strategic Partnership Plan for Harrow, and the programme was overseen by the borough's Scrutiny Committee. They have maintained a focus on infant mortality and regularly meet as a group known as the Harrow Infant Health Group.

Nutrition – prevention of Obesity, ensure adequate intake of folate, iron, vitamin D and Ca

Immunisation uptake in first year – keep above 95%

Smoking cessation – increase access and quit rates

Breast feeding initiation – increase

Early antenatal booking – increase proportion of all pregnancies booked before 12 weeks

SIDS prevention – Back to Sleep – housing awareness-raising, re. overcrowding

Teenage pregnancy prevention/support

Service remodelling in Derbyshire – Centre for Excellence and Outcomes in Children and Young People's Services (224)

The Derbyshire community paediatric service underwent a complete remodelling to ensure that children and young people living in deprived

circumstances, particularly those in the poorest and most vulnerable categories, received equitable access to care. Derby targeted children with special educational needs, those in need of safeguarding or in care, travellers, asylum seekers and refugees, and young offenders. Care was offered in places close to home and school, using a multi-agency approach and open referral system (mostly from health visitors and school nurses). Following the remodelling, more than two-thirds of patient contacts are with children in the most deprived two-fifths of the population, a group that represents over half of the local child population and the traditionally hard-to-reach children.

Psychiatrists

by the Royal College of Psychiatrists



The psychiatrist's role in tackling the social determinants of health

Mental disorders account for the largest burden of disease in the UK (225) and result in a range of health risk behaviours, physical illness and inequalities. Since the majority of mental disorder, with the exception of dementia, has already arisen by early adulthood (226; 227), inequalities which result in and from mental disorder have disproportionate effects.

Inequalities are associated with an increased risk of mental disorder (228). For example, comparing adults from English households in the bottom 20% income bracket with those in households in the highest 20% income bracket (229) shows:

- Common mental disorder is 2.7 times more common in men and 1.4 times more common in women
- Self-harm is 3.2 times more common in men and 2.5 times more common in women
- Suicide attempts are 5.0 times more common in men and 3.2 times more common in women
- Psychotic disorder is nine times more common in adults
- Dependence on any drug is 4.6 times more common for men and 33 times more common for women.

Mental disorder then results in a range of further inequalities (228).

These effects are perpetuated by only a minority of those with mental disorder, other than people with psychosis, receiving treatment for mental disorder, associated health risk behaviour and physical illness. Furthermore, there is almost no investment in prevention of mental disorder despite good evidence and a strong national policy narrative. Psychiatrists have a key role in highlighting the importance of both addressing inequalities to reduce risk of mental disorder and mitigating the associated inequalities which impact on recovery.

The overarching question is why only a minority of people with mental disorder receive any intervention (229; 230) and why almost nothing is spent on prevention of mental disorder or promotion of mental health (231), despite:

- Mental disorder being the largest cause of burden of disease in the UK (225)
- There being a strong evidence base for effective interventions both to treat mental disorder,

prevent mental disorder and promote mental health (232-234)

- There being a strong evidence base for economic returns of such interventions even in the short term (235)
- A clear case for action being made in both in mental health and public health government policy (75; 236).

An important reason for the lack of interventions and spending is institutional discrimination. Psychiatrists have an important role in addressing such discrimination, championing these issues, ensuring that these key facts are prominently in the public domain and supporting local investment in mental health. Public mental health commissioning guidance can support commissioners and local government to implement government policy (228). However, this requires an appropriate level of sustained resourcing.

Actions psychiatrists should take

Highlight local-level inequalities in access to services for treatment of mental disorder

Both treatment and prevention of mental disorder reduce further inequalities resulting from mental disorder (237). However, only a minority of people with mental disorder receive any intervention, other than people with psychosis. This would not be acceptable for other illness and indeed, almost all people with a disease such as cancer receive intervention. Furthermore, since half of all lifetime mental illness has arisen by age 14 (227) and three quarters by the mid-twenties (226), with the exception of dementia, early intervention is required during teenage years and the early twenties, with a proportionate universalism approach ensuring greater access for higher risk groups.

Psychiatrists should therefore be engaged in the commissioning process and, with their public health colleagues, provide information on the local expected numbers with different mental disorder, the proportion receiving intervention and the levels of unmet need, including from higher risk groups (234). Such information is an important part of a Joint Strategic Needs Assessment (JSNA) which is an important process for informing local commissioning decisions (228).

Highlight local-level inequalities regarding access to services for treatment and prevention of associated physical illness

People with mental disorder are less likely to receive interventions to address health risk behaviour and physical illness despite being at much greater risk.

Therefore, psychiatrists should ensure that the following information is readily available (228):

- Information on the levels of different health risk behaviour in people with mental disorder
- Information on the proportion of people with mental disorder receiving interventions to address health risk behaviour
- Information on the proportion of people with mental disorder and physical illness
- Information on the proportion of people with mental disorder and physical illness receiving appropriate treatment.

Psychiatrists caring for particular groups such as those with intellectual disability at higher risk of physical illness also need to report this information.

The RCPsych parity report (238) highlights that since increased levels of smoking are responsible for the largest proportion of health inequality among people with mental disorders, supporting people with mental disorders to stop smoking will have an even larger impact on health outcomes and directly reduce health inequalities. However, health inequality experienced by people with mental disorder will widen if investment in smoking cessation services for this group is not greater than for the general population (239). Furthermore, since mental disorder is associated with subsequent several-fold increased risk rates of smoking and other health risk behaviour, interventions to prevent mental disorder can also prevent such health risk behaviour (228).

Highlight local-level risk factors for mental disorder including inequalities

A range of risk factors and inequalities is associated with increased rates of mental disorder, particularly for higher risk groups. The cross-government mental health strategy *No health without mental health* (236) states that it is necessary to challenge health inequalities in order to build a healthier, more productive and fairer society (236). Social inequality of all kinds contributes to the risk of mental disorder. In turn, mental disorder can result in further inequality – for example, worse outcomes in employment and housing for people with disorder (236). Mental health, individual resilience and social exclusion are all influenced by a range and interaction of different factors across the life course such as social position, education, housing, employment and exposure to violence.

Addressing such factors at the level of the individual, family, local community and wider society can prevent a significant proportion of mental disorder and associated inequalities (232). While many psychiatrists already adopt a public mental health approach in their work and influence national and local strategy (234), they have an important role in highlighting the relationship between inequality

and the risk of mental disorder which then results in a range of further inequalities. This should facilitate partnership working with public health colleagues, including documentation and incorporation of such factors into JSNA, which in turn informs strategic priorities as well as the commissioning of interventions.

Highlight local-level inequalities regarding access to services for prevention of mental disorder and promotion of mental health

The equivalent of less than 0.001% of the annual mental health budget is spent on prevention or promotion (231), which means that very few people receive such interventions, despite there being a good evidence base for their value (232; 234; 236). Since mental disorder is associated with a wide range of inequalities, many of these can be prevented by such interventions. Such interventions also result in significant economic savings (235). A proportionate universalism approach ensures greater coverage for those at higher risk who require more targeted approaches.

Doctors are important leaders in facilitating local and national implementation of public mental health strategies (234).

Support the commissioning of interventions to reduce inequalities

Section 1 above highlights the impact of inequalities on the risk of developing mental disorder. Since treatment of mental disorder can only prevent a proportion of the burden of disease, the prevention of mental disorder through the reduction of inequalities is important for sustainably reducing the burden of mental disorder. Such interventions are outlined in the Marmot review *Fair Society Healthy Lives* (2) and should be familiar to psychiatrists who can highlight their importance, including in the JSNA.

Training and education

Integrated pathways of care and treatment need to be tailored to take account of the social determinants of mental disorder. Training about the determinants of mental disorder and wellbeing, as well as associated opportunities for prevention and promotion, should be an important part of undergraduate and post-graduate levels of education. This would highlight both the underlying determinants of mental disorder and the broad range of inequalities resulting from mental disorder, which is the single cause of burden of disease in the UK. Psychiatrists should be familiar with interventions which reduce inequalities, since these are important to sustainably reduce the burden of mental disorder. Similarly, they should be aware of interventions to reduce the impact of inequalities on people who have already developed mental disorder.

Case study

A 20-year-old man with severe intellectual disability (ID) and no spoken language, lives with his mother, and takes medication for epilepsy and for attention

deficit-hyperactivity disorder (ADHD). Until two years ago, he was supported to have physical health checks, including blood tests as part of monitoring of medication by attending the day hospital service under the care of the paediatrician. He has not had blood tests for two years, since he assaulted the phlebotomist in the general practice surgery; the phlebotomist was under pressure and did not have time to read his communication guidelines. The GP decided to discontinue the ADHD medication as it was difficult to monitor the young man's blood pressure.

The young man's mother later contacted adult social care for support for her son as there had been a change in her son's behaviour; he was unsettled and constantly on the go; he was not sleeping; and he was no longer complying with taking his epilepsy medication. The social care team that caters for people with intellectual disability is integrated with the health professionals, including ID psychiatry and psychology. After assessment, he was restarted on ADHD medication and a programme of desensitisation helped him to tolerate having his blood pressure monitored. He was underweight, but unfortunately the team does not include a dietician, and initial referral to a community dietician was rejected as they did not feel able to cater for people with ID. However, the NHS trust that employs the dietician also employs an ID liaison nurse, who was able to facilitate an assessment. The young man gradually reached a healthier weight. It continued to be difficult to facilitate blood tests, but when the young man later required dental work under sedation, the dentist was shown the young man's health passport which suggests taking bloods when an opportunity arises.

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Social workers and social care

by the Social Work and Health Inequalities Network



The role of social workers and social care in tackling the social determinants of health

Every year more than five million children and adults have contact with social care practitioners in England. Social care and social work staff work with many of the most socially vulnerable people in society, from before birth to death. Most social care service users are living with poor physical and/or mental health. Frequently this is central to the reason for the social care contact; for example, this is invariably the case for older people. In addition, most service users' current and future health is threatened by the disadvantaged circumstances in which they live. For example, the vast majority of children in contact with social services are living in poverty, in many cases compounded by living in families where other health-threatening conditions also exist, such as poor housing, parental drug use, domestic violence or poor parental mental health. Social care service users exemplify those who are most likely to be towards the bottom of the health inequalities gradient, living shorter than average lives with higher levels of illness because of adverse social circumstances, often extending over long periods.

Social work and social care staff make a significant contribution to reducing health inequalities (241). Firstly, this is through the direct practice of staff on the front line with public, not for profit and commercial services employing around two million people, many of whom are front line carers working for relatively low pay. Secondly, senior managers in social care and elected politicians with social service responsibilities have the potential to address the social determinants of health for large numbers of people in a variety of ways.

Actions managers can take

- As leaders holding substantial budgets, managers can influence organisational priorities towards redressing the social causes and consequences of health inequalities
- As employers, managers can influence the health and wellbeing of their workers, and their workers' families, through good employment practices, including occupational health policies
- As strategic partners of health, housing, education, welfare, leisure, environmental and other services in and outside local government, managers can influence the construction and

application of multi-agency policies, for example, by ensuring that local strategies such as the JSNA, Joint Health and Wellbeing and Child Poverty strategies identify the role of social work and social care in tackling health inequalities

- As commissioners and regulators of services for service users, managers can influence the quality and nature of service provision and the employment practices of their contractual or regulatory partners. For example, the transfer of responsibility of public health and other functions to local authorities has the potential for strengthened collaborative relationships between health care in the NHS and health and social care in local authorities
- As providers of training and staff development, managers can work to ensure that all staff are aware of the importance of the social determinants of health in the lives of service users and know how to work to minimise health inequalities; for example, how integrated health and social care services can help to maintain quality of life and independent living for as long as possible
- As data gatherers, analysts and publishers, managers can provide intelligence about the social determinants of health and their consequences
- As leaders, their roles are similar to those of health service managers, outlined elsewhere in this report, so the remainder of this annex focuses on the roles of practitioners. However, the roles of managers, just because of their overarching responsibilities, are arguably more far reaching.

Actions practitioners can take

The breadth of the potential for social work and social care staff to influence service users' and carers' health is reflected in NICE guidance. Many NICE guidance statements include references to the roles of social care professionals and some have been jointly prepared with the Social Care Institute for Excellence. Examples of relevant documents include:

- PH28 Promoting the quality of life of looked after children and young people
- CG89 When to suspect child maltreatment
- TA102 Conduct Disorder in Children – parent-training/education programmes
- QS11, CG115 Alcohol use

- PH16 Mental wellbeing and older people
- CG24 Dementia
- QS13 End of life care for adults

The range of involvement of social care staff – with babies, children, young people and parents, with adults with learning disabilities, disabled adults and adults using mental health services, and with older people – means that this annex cannot spell out the detail of roles in relation to each of many service user groups. Instead we will focus on key issues which cut across user groups: primary, secondary and tertiary interventions.

Primary intervention

Examples of primary interventions and health promotion include:

- Working to ensure children in need can have a healthy start in life by providing tailored support for families in the context of universal services in Children’s Centres
- Preventing loneliness and social isolation among older people (242)
- Supporting people in mental distress to access meaningful work (243)
- Assisting adults with learning disabilities to live independently (244).

Secondary intervention

Examples of social work involvement of secondary prevention include:

- Supporting adults with learning disabilities to access health screening programmes (245)
- Increasing access to public health services by ethnic minority women (246)
- Improving psychosocial care for cancer patients (247)
- Taking action to reduce cancer inequalities among lesbian, gay, bisexual and transgender people (248).

Tertiary intervention

Examples of tertiary interventions include:

- Reducing inequalities between young women leaving the care system and other young adults making the transition to adult life by providing support on sexual health issues
- Supporting adults with severe learning disabilities lacking supportive family networks to maximise their social care services
- Ensuring that older people discharged from hospital have adequate social, economic, and environmental resources to maximise their recovery.

Case studies

Case study 1: primary intervention

The use of Social Impact Bonds (an investment fund, raised from socially-motivated individuals and organisations) in Wales is designed to support the re-engineering of services to help families to remain together and to reduce the rising numbers

of children being taken into care. This is in response to the evidence that children who are looked after are overwhelmingly drawn from the poorest families and that their education and health outcomes are likely to be further disadvantaged by the care. If it works as intended, however, they will provide an example of direct work which addresses both social and health inequalities in the lives of families and young people in some of the most difficult and deprived circumstances.

Case study 2: tertiary intervention

A hospital aftercare project funded by Age England provided short-term advocacy, information and support to facilitate older service users’ re-engagement in social networks following discharge (249). Service user feedback indicated that friendship, recreational and family groups, health care treatment and locality-based organisations and contacts were accessed, contributing to restoring and sustaining service users’ physical health and psychological wellbeing.

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On behalf of the Social Work and Health Inequalities Network (240)

Abbreviations

ACEVO	Association of Chief Executives of Voluntary Organisations	RCPCH	Royal College of Paediatrics and Child Health
AoMRC	Academy of Medical Royal Colleges	RCPsych	Royal College of Psychiatrists
AHPF	Allied Health Professionals Federation	RCSLT	Royal College of Speech and Language Therapy
BAOT	British Association of Occupational Therapists	SDH	social determinants of health
BMA	British Medical Association	SoS	Secretary of State
BDA	British Dietetic Association	WMA	World Medical Association
CAB	Citizens Advice Bureau		
CCG	Clinical Commissioning Group		
CMA	Canadian Medical Association		
COP	College of Paramedics		
COT	College of Occupational Therapy		
CPD	Continued Professional Development		
CSP	Chartered Society of Physiotherapy		
CVD	Cardiovascular disease		
DH	Department of Health		
DSC	Dental Schools Council		
GP	General Practitioner		
HEE	Health Education England		
HEI	Higher Education Institution		
HI	health inequality/ies		
HSCA	Health and Social Care Act		
HWBB	Health and Wellbeing Board		
IHE	UCL Institute of Health Equity		
JHWBS	Joint Health and Wellbeing Strategy		
JSNA	Joint Strategic Needs Assessment		
LA	Local authority		
LETB	Local Education Training Board		
LGA	Local Government Association		
MIHL	minimum income for healthy living		
NCT	National Childbirth Trust		
NGO	non-governmental organisation		
NHS	National Health Service		
NHSCB	NHS Commissioning Board		
NHSI	NHS Institute for Innovation and Improvement		
NHSOF	NHS Outcomes Framework		
NICE	National Institute for Clinical Excellence		
PCHR	Personal Child Health Record		
PCT	Primary Care Trust		
PHE	Public Health England		
PHOF	Public Health Outcomes Framework		
QALY	Quality Adjusted Life Year		
QOF	Quality Outcomes Framework		
RCGP	Royal College of General Practitioners		
RCM	Royal College of Midwives		
RCN	Royal College of Nursing		
RCOG	Royal College of Obstetricians and Gynaecologists		
RCP	Royal College of Physicians		

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Denoted by (n) in the text

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