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TITLE: UK primary care teams and social determinants of health intervention: A qualitative study

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ABSTRACT

Background: Although inequalities in social determinants of health (SDOH) are linked to poor health, they are often overlooked in healthcare. Primary care networks (PCNs) are an example of neighbourhood-level multidisciplinary teams (MDTs), established in part to address SDOH at locality. Further research is needed to understand how UK primary care health care practitioners (HCPs) understand and manage patient SDOH through these teams.

Aim: To explore how UK primary care HCPs view SDOH and how they perceive working in PCN MDTs influences their ability to address them.

Design and Setting: A qualitative study undertaken in general practice in the UK.

Method: 25 primary care HCPs (GPs, GP trainees, nurses, pharmacists, care coordinators and social prescribers) were recruited via purposive sampling (males=10, females=15). One-to-one semi-structured interviews were conducted between April 2023-May 2024.

Results: Thematic analysis revealed three key findings. First, participants described how primary care is uniquely positioned to address SDOH through community proximity and integrated MDT services. Second, they expressed helplessness to change SDOH, citing barriers outside their clinical sphere of influence. Finally, they raised concerns over tensions between rising expectations of primary care and insufficient structural resources, including staffing, estates and training, to tackle complex SDOH issues.

Conclusion: MDTs were widely viewed by HCPs to improve the ability of general practice to address SDOH in community-based services due to the unique remit of multidisciplinary roles, and the extra time that some roles are allocated for patient consultation. However, further resources are crucial for these teams to achieve meaningful impact.

Keywords: Social determinants of health; primary health care, general practice, multidisciplinary teams, health inequalities

HOW THIS FITS IN

Disparities in social determinants of health are tied to poor health outcomes, yet they are sometimes neglected in healthcare, and UK staff experiences of the role of primary care multidisciplinary teams in addressing them have not been explored. In this study, practitioners recognised the complexity of addressing interconnected social determinants of health and valued working in community-based multidisciplinary teams, particularly with the inclusion of roles like social prescribing, for their unique ability to help. However, they described limitations from the combination of increasing demands on primary care and a lack of resources—including time, training, staff, and space—and expressed a sense of helplessness, believing that effective solutions for these issues were likely outside their clinical power to change. This research suggests that the continued focus on neighbourhood teams in the NHS 10-year plan is likely to be appreciated by primary care staff, although further resource will be required to bridge the gap between the desire to help and the ability to do so.

INTRODUCTION

Health inequalities can be understood as caused by differences in exposure to social determinants of health (SDOH) across the domains of economic stability, educational status, healthcare status, built environment and community context.[1] The WHO defines SDOH as the 'conditions in which people are born, grow, live, work, and age… shaped by the distribution of money, power and resources.'[2] Despite the clear relationship between SDOH and adverse health, there are a range of reasons why they may be de-prioritised in healthcare, including a lack of resources,[3-5] physician burnout,[6] and prioritisation of other local issues.[7] However, in the US, the Centres for Medicare and Medicaid services have required that hospitals screen for SDOH.[8] Research in Canada,[9] found that asking patients about SDOH was associated with a higher likelihood that healthcare practitioners (HCPs) feel that they have helped patients, and research in Japan[10] reported that HCPs believe that this work contributes to excellence in primary care.

In the UK, reducing health inequalities is a core objective of the NHS,[11] which means taking account of the influence of SDOH on patient health.[12] Multidisciplinary teams (MDTs) have been identified as one potentially fruitful route to addressing SDOH within primary care, in part because they can incorporate roles that permit longer consultation times for patients with more complex SDOH needs.[13] A recent example of utilising MDTs at locality are Primary Care Networks (PCNs), established in 2019 to build on current primary care services and enable integration of various healthcare roles, including pharmacy and social prescribing, with the intention of reducing health inequalities and corresponding SDOH in the local community.[14,15] Whether PCN MDTs have allowed staff to improve their ability to address health inequalities in primary care requires further exploration.[13]

Despite the expectation that these teams consider and manage SDOH at locality, little is understood about how UK primary care staff conceptualise SDOH within their roles, or their view on the imperative to address SDOH in primary care. These issues are important to understand because how policy is interpreted may influence whether and how it is delivered.[16] Furthermore, multidisciplinary working and addressing complex SDOH continues to be an NHS priority, as seen in the prevailing emphasis on multidisciplinary neighbourhood health centres as part of the NHS 10-Year Plan care model.[17] It is important to investigate how general practice HCPs in a range of roles understand SDOH and how they perceive their work within MDTs influences their ability to address these factors.

METHODS

This qualitative research adopted a constructivist paradigm in design and analysis, recognising that the meaning of complex phenomena is not fixed but is shaped by

experiences and social interactions particular to the individual.[18,19] This study follows the Standards for Reporting Qualitative Research.[20]

Participants and recruitment:

Twenty-five participants aged 28-55 years were recruited through the researchers' social and professional networks. Participants were GPs or GP trainees (15), nurses (2), pharmacists (2), social prescribers (5), a wellbeing practitioner (1) and were recruited via purposive sampling (males=10, females=15). Years of primary care experience ranged between 8 months to 20 years.

Data Collection:

General practice HCPs were recruited between April 2023 and May 2024. Online one-to-one interviews were conducted via Microsoft Teams, a secure video-conferencing platform, and were undertaken by two members of the research team.

Interviews were guided by a semi-structured interview schedule, which was developed based on themes found in relevant literature[21,22] and through consultation with members of our partner organisation (a large GP super partnership including general practice surgeries in rural and urban, affluent and deprived areas). Demographic information was collected to contextualise the data (Table 1). Participants were assigned pseudonyms, participated voluntarily and were able to withdraw at any time. Interviews were transcribed verbatim. Data collection continued until the researchers determined that data saturation had been reached, indicating no new themes were identified.

----------Insert Table 1 Here----------

Analysis:

Data were analysed using an inductive, experiential approach through reflexive thematic analysis, following the principles outlined by Braun and Clarke. Data were coded using semantic and latent approaches, capturing both surface level meaning and underlying interpretations.[23-25] Codes were then developed into themes that represented core patterns in the data (Table 2). Although the lead author, AH, had primary responsibility for theme development, an interpretive process was used in which the researchers actively considered how meaning was constructed and how broader social contexts shaped participants accounts.

Reflexivity was embedded throughout the analytic process, recognising that AH's background in health inequalities would inevitably shape, but also enrich, the interpretation of participants' perspectives and experiences. Rather than aiming to minimise this influence, the team engaged with it critically through regular reflexive discussions. The research team, whose clinical and academic backgrounds offered diverse interpretive lenses, used these conversations to examine how assumptions about the role of primary care in addressing SDOH might shape meaning-making. This process supported interpretive depth while ensuring that the analysis remained

closely connected to participants' perspectives. Consistent with reflexive thematic analysis, the aim was not to reach consensus but to value the team's varied perspectives.

----------Insert Table 2 Here----------

RESULTS

Three themes were developed from the data, with the analysis supported by specific examples selected from participants' accounts.

Theme 1: General practice at the coalface: *'Who else is gonna do it?'*

Primary care was widely regarded as well-positioned to address SDOH due to the regular contact they have with members of their community.

'We see the biggest proportion of patients… and they will, erm, they will, you know, more likely come in contact with somebody from a primary care team than more, so than you know even secondary care... even the Council.' (Aqsa, p.23)

Participants expressed how primary care HCPs had a clear understanding of their patients' social and environmental context and were positioned to deal with the realities of patient health due to being embedded in the community. This proximity along with the continuity of care inherent to primary care, created an opportunity and trusted space for patients to discuss SDOH.

'People in primary care, you know, are at the coalface. They see people where they live, and they have the most continuity and people often open up about things that are going on in their lives that they wouldn't open up to anyone else.' (Hassan, p.13)

Teamworking was widely identified as essential to addressing SDOH in primary care, with nearly all emphasising that responsibility for initiating conversations about SDOH should be shared across MDTs.

'You've got all the healthcare professionals, the nurses, the pharmacist, physios, everybody. I think, definitely we can all [address SDOH], if we all think outside the box and sort of remember that we're part of this multidisciplinary team.' (Tony, p.9)

However, participants cautioned that distributing responsibility for addressing SDOH across the team could risk diluting care, rather than strengthening it.

'When you say to someone it's all your job to ask about, you know, making every contact count… it gets spread so thin that everyone else thinks that everyone else is going to do it.' (Adam, p.5)

Primary care networks were widely perceived as valuable in supporting patients with SDOH, due to their capacity to provide a broader and integrated range of services.

'PCNs and super partnerships is is all about working at scale.' (Sanjay, p.10)

Damon also saw the benefits of working in the PCN model.

'If you want to give someone well-rounded care and well-rounded support, you've got to look at it all and I think with the PCN model… we can do that. And whilst the traditional clinicians do their work, and we [social prescribers] can see people, and give them more time to see people that really need the clinical help.' (p.15)

Participants expressed that doctors are spending significant time on non-clinical tasks better suited to other services, rather than focusing on core health responsibilities:

'Doctors, you know, like if only they could, you know, help people with erm physical health problems or mental health issues, rather than, you know you know you know, numerous times writing to [redacted] Council, or you know, [redacted] housing, and and you know, 10 years get trying to get their patients into better accommodation.' (Esra, p.10)

GPs recognised the value of having social prescribers within primary care networks, acknowledging the importance of their specific expertise in addressing SDOH.

'A good social prescriber is worth their weight in gold.' (Ricardo, p.5)

The ability to refer patients to a range of HCPs for issues relating to SDOH was also acknowledged as beneficial and was recognised to improve appointment availability statistics.

'You're being told you need to provide access..."I'll send you to the social prescriber..." Fewer appointments blocking us up so we can look good and make sure our metrics are OK in terms of having available appointments.' (Adam, p.6)

Theme 2: Helplessness to change SDOH: '*There's a limitation of what you can do in that situation*'

Although participants reported that general practice was placed well to discuss SDOH with patients, they also expressed a sense of helplessness to meaningfully address the wider determinants of health in their consultations. Concerns ranged from perceiving barriers that limited patients' abilities to make healthy changes, to the lack of available referral services. Many expressed that SDOH would be more effectively addressed further upstream by government.

Participants expressed concerns about their ability to intervene to meaningfully support patients with SDOH lifestyle factors in primary care.

'[Patients] come out and say "Oh, but I don't have the money to buy lots of fruit and vegetables like you're telling me," or "I don't have, I don't have the money to go to a gym," erm, or you know, or all all sorts of things like that.' (Rachel, p.2)

Ben shared that health risks need to be extreme before he was empowered to act.

'I can conclude that someone has a horrible house or whatever, or needs social help with various things, but unless it's like, so extreme it's an acute risk to health or whatever, and that's kind of a different question, I can't do anything about it.' (p.6)

Participants shared that the complex nature of SDOH made it challenging to engage with these issues during consultations, unless there was a clear and actionable intervention available.

'To get buy in, I think, from clinicians, you need to choose things which then there's a clear pathway erm that leads to an intervention at the end of it.' (Hassan, p.7)

Scott reflected on the risks of being aware of the difficult circumstances patients face but feeling unable to take meaningful action to address them.

'Cause you you go to social services, and then they don't wanna know. All the hospitals don't wanna know. You know, so [there's] a load of risk really that you're then sat with and can do nothing about.' (p.4)

Many participants noted limited availability and resources for patients, hindering efforts to address SDOH.

'At locality I'm seeing these families really struggle, and I'm seeing these people really struggle, and there's no resource so yeah I find it quite stressful.' (Louise, p.12)

Although participants expressed that general practice was well positioned in the community to discuss SDOH with patients, they emphasised that meaningful change ultimately needed to come from both local and national government.

'I don't think you can say primary care should you know be the main delivery tool for addressing you know the wider determinants of health because it's impossible, you know. It's not going to be a healthcare intervention that does that. It's going to be in the hands of, erm national and local government, erm, and they're doing a pretty lousy job of it.' (Hassan, p.14)

Theme 3: Lack of resource: '*The resource has gone down and the needs and expectations have gone up*'

All participants raised concerns about overload in primary care, noting that the sector was already burdened with responsibility, even before the government formally added health inequalities into their remit. It was widely acknowledged that additional resources are essential to effectively address SDOH. Whilst theme two focusses on emotional responses to the perceived helplessness that practitioners experience, theme three reveals the tension between the growing expectations on primary care, which are not matched by the necessary resources.

'GPs, they're already feeling swamped by extra stuff that the government keeps adding on, and tallies, and saying we'll pay you only if you do this, just different from before.' (Mufty, p.6)

Participants were concerned that responsibilities previously held by secondary care had increasingly shifted to primary care, as well as social care responsibilities, due to ongoing cuts to social care resources. This redistribution was described as intensifying workloads in primary care. This was seen to overlap with and contribute to worsening health inequalities, leaving patients more vulnerable. A reduced capacity to address these issues was reported to coincide with rising patient expectations of primary care.

'I don't think there's enough resource there to address these needs and erm address these health inequalities... especially along with all the other things that we've been that are being piled on for us to look at. (Aqsa, p.26)

The interconnected nature of SDOH was reported to make it challenging to know which factors to address first.

'People come to us, and they've got a multitude of so many different, different issues that they're struggling with and and it can be hard to sort of decipher which goes first.' (Leigh, p.1)

Participants related SDOH to both physical and mental health problems, further emphasising the complexity involved with addressing these issues in general practice.

'I see onset in younger patients who often time have shit life syndrome. I can't think of a better way of putting it - just everything's gone wrong for them… They've got poor health... and they live in poor housing, and they've never really had much of a crack of the whip at life. And yeah, they get they develop these chronic diseases… and poor mental health.' (Mary, p.12)

Participants highlighted that many GP practices operate a one issue per appointment rule, which can hinder discussions around interrelated concerns such as SDOH.

'A lot of surgeries now have, like, a one issue per appointment rule, don't they? Which makes it really difficult when everything sort of coincides.' (Leigh, p.7)

The wide remit of care that primary care was expected to deliver was discussed by most participants.

'Primary care is the only place, really, where you can book an appointment and have someone listening to you for whatever you have to talk about for for 10 minutes.' (Ben, p.8)

Mary, a care coordinator, questioned the extent to which some of the issues that come to primary care are suitable, despite their link to health and wellbeing.

‘Got a patient [who] is an elderly gentleman…he wants a partner... and it would make him feel a lot happier if he had one... But my colleague spent about an hour on the phone this afternoon talking about dating apps… wow, really the remit of the NHS and primary care has expanded so much.’ (p.17)

Esra contrasted the work of GP surgeries with the Council, who were perceived to be allowed to be less responsive.

‘When you ring the Council, 60 minutes you wait on the line… they don't even answer. But you go to the GP, and they listen, poor doctors and nurses (laughs), they try to listen to people and respect what they want, and you know try to help them.’ (p.10)

Participants spoke extensively about the limited time available to address SDOH in practice. Raising such issues was often likened to ‘opening a can of worms,’ suggesting these conversations could be complex, time-consuming and difficult to resolve within a typical consultation.

‘People worry that, oh if I start asking about these things, erm, I'm gonna open this can of worms … and then I'm gonna be running behind, and then everyone else is gonna be really annoyed that they're having to wait… I'm going to leave work later than I should.’ (Hassan, p.6)

Participants expressed that increasing staff would support more meaningful engagement with SDOH in primary care.

‘Primary care doctors are supposed to have a holistic view of patients, and part of that is understanding their social determinants, although I think we'd need more staff and more funding (laughs).’ (Melanie, p.13)

However, a lack of physical space in premises was seen to be a barrier to recruiting additional staff to address SDOH.

‘I don't think all practices have the facilities, have the access to social prescriber as much as they would like to. And also the availability of rooms.’ (Anna, p.5)

Many participants stated that they would need further resource in the form of training to meaningfully address SDOH in primary care. Iain makes the point that although PCNs have been given funding to address SDOH, they lack training to know how best to allocate this funding.

‘They've [PCNs] been funded reasonably [but] they've been under skilled… They don't necessarily have the training to be able to make meaningful interventions.’ (p.14)

DISCUSSION

Summary

Primary care staff view addressing SDOH as a vital but overwhelming responsibility. While their community presence makes them well-positioned for this work, the complex, interrelated nature of these issues complicates prioritisation. Workers advocate for multidisciplinary teams and referrals but feel hindered by systemic "upstream" causes. Ultimately, severe resource shortages—including time, space, training, and staffing—leave many feeling helpless and concerned that primary care is too overloaded to intervene effectively.

Strengths and limitations

Participants were recruited from a variety of primary care HCP roles and with varying lengths of time in post, providing insight into how different disciplines view addressing SDOH in a multidisciplinary context. Participants reported engaging with a wide range of patient populations, including affluent/impoverished, rural/urban and across a wide range of ethnicities, suggesting that participants reflected diverse general practice areas.

While participants largely affirmed the critical link between SDOH and health outcomes, they highlighted a professional divide, noting that some colleagues remain indifferent or sceptical towards primary care's role in SDOH. This variation in attitudes links with one of the key methodological limitations of the present study that should be considered to ensure a balanced interpretation of the findings: self-selection. Staff members who view SDOH as peripheral to clinical duties or who lack fundamental understanding of the concept may have opted out of the study. Consequently, these findings may mask the true extent of professional apathy or resistance within the primary care workforce and underestimate the training and cultural shifts required to implement multidisciplinary SDOH interventions. Recruitment was primarily facilitated through professional networks, which introduces a risk of social desirability bias. Participants recruited via peer connections may have felt a pressure to provide progressive answers that align with perceived professional values. Finally, because recruitment relied on established networks, the sample may lack the geographical diversity needed to capture the full spectrum of primary care experiences.

Comparison with existing literature

The inherent complexity of SDOH is exacerbated by a lack of theoretical consensus. Many different conceptual frameworks have been designed to define SDOH and illustrate these associations, sometimes even disagreeing with each other, reflecting the extensive and diverse scope of these factors.[27] The lack of theoretical consensus among conflicting SDOH frameworks mirrors the practical complexity of care, yet primary care may be evolving past historical silos, which have often been characterised by a poor understanding of colleagues' specific remits.[13] Our data indicates an evolution toward integrated practice. Participants showed a recognition that while the *moral* mandate to address SDOH is universal in primary care, the *operational* capacity is specialised. Consequently, effective intervention relies on

shifting from generalist concern to leveraging the distinct clinical and administrative attributes of roles like social prescribers.

Despite its promise, conclusive evidence of the efficacy of social prescribing is wanting, partly due to inconsistent recording of SDOH data[28] in primary care and because of the complex range of activities that the term covers.[29] Additionally, the ability of some patients to engage with social prescribing activities may vary due to location and capacity.[30] Regardless, in this study of primary care HCPs, social prescribing was widely felt to be beneficial in allowing general practice to manage SDOH. There were concerns, however, over the capacity of general practice surgeries to accommodate additional staff in their premises. The RCGP have recognised the need to improve space and conditions for patient consultation, recommending that insufficiencies in estates are resolved,[31] which resonates with the findings of this research.

The RCGP data highlighting the surge in patient-to-GP ratios in deprived areas[32] underscores an Inverse Care Law for the 21st century. In these deep-end practices, the complexity of interconnected SDOH factors requires more time per patient, yet skyrocketing list sizes (now 2,450 per head)[32] necessitate shorter interactions. Concern has been voiced over the burden of adding responsibility for addressing inequality in deep-end practices, due to the time required per patient to address these complex and interconnected factors.[5] Participants in the present sample identified the MDT not only as necessary to collaborate and share specialist skills, but also as a temporal tool. By utilising MDT staff—who operate with longer appointment blocks—the system attempts to decouple ‘social time’ from ‘clinical time’.

The move of responsibilities from secondary and social care into primary care reflects a broader NHS strategy of decentralisation that has outpaced resource allocation. Participants’ concerns suggest primary care is being positioned as a final buffer for an overburdened system, absorbing the failures of upstream social care systems without the requisite training or estate infrastructure to sustain such a role. The traditional primary care model is simultaneously experiencing a paradox of expanding expectations:[13] while the shift toward addressing SDOH is clinically necessary, it is occurring within a system suffering from structural exhaustion. The present findings reveal a critical tension between the expansion of responsibility and the contraction of capacity, which is vital to understand for the future success of the planned integrated neighbourhood teams.

Many participants voiced disappointment at the lack of available referral services, referencing long wait times. Previous research has found that doctors experience a sense of powerlessness[33] and moral distress[34] when adequate interventions to help patients in poverty are not available. This is particularly concerning, as moral distress is related to physician burnout,[6] which is linked to reducing clinical hours and intention to leave the profession.[35] This suggests that the inability to provide

adequate interventions may not merely be a logistical failure but also a psychological burden for the clinician. By failing to provide the external infrastructure necessary to address patient poverty and social complexity, the system shifts the burden of solving these issues onto the individual practitioner.

Implications for research and practice

Many participants mentioned the need for training in discussing SDOH. This dovetails with recent initiatives to support GPs in discussing poverty[36] and poverty-related mental distress.[13] The present findings reveal that there remains a widespread need for systematic and sensitive training for supporting all members of primary care MDTs to manage the full breadth of circumstances that fall within the SDOH remit. The disagreement between various SDOH frameworks indicates that training should move away from teaching a single, rigid definition. Instead, practitioners need critical health literacy[37] to navigate the diverse factors impacting patients. Training programs should emphasise how interrelated factors—ranging from housing instability to digital exclusion—manifest in local patient populations. To mitigate the feeling of helplessness among staff, training should incorporate systems thinking.[38-40] Understanding the complex pathways between socioeconomic causes and clinical outcomes may help staff see their role as a vital link in a larger chain, rather than a failing endpoint.

Neighbourhood MDTs are one of the core components of the NHS 10-year plan,[17] and this research suggests that many primary care staff would welcome this course of action, particularly if further resources and referral pathways are made available. While the study suggests a positive shift in role awareness, the historical lack of clarity regarding professional remits may remain a barrier. Training should move beyond clinical silos to include interprofessional education.[41] By explicitly mapping the unique role attributes of the wider PCN team, traditional medical staff (GPs and nurses) can better delegate and collaborate, reducing the helplessness gap identified by participants.

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Pseudonym	Age	Gender	Occupation	Years in Current Position	Years in Profession
Adam	39	M	GP Partner/PCN Clinical Director	7 years	15 years
Alannis	36	F	GP Trainee	<1 year	3 years
Anna	29	F	PCN Pharmacist	2.5 years	5 years
Aqsa	30	F	GP Trainee	3 years	6 years
Ben	33	M	GP Trainee	2.5 years	7 years
Damon	36	M	Social Prescribing Link Worker	<1 year	3 years
Esra	51	F	Wellbeing Practitioner	4 years	4 years
Harriet	39	F	Practice Nurse	1.5 years	13 years
Hassan	41	M	GP Trainee	2 years	17 years
Iain	43	M	GP Partner/PCN Clinical Director	4 years	15 years
Leigh	28	F	Social Prescribing Link Worker	1.5 years	1.5 years
Louise	39	F	Social Prescribing Link Worker	<1 year	3 years
Mary	55	F	Social Prescribing Link Worker	3 years	5 years
May	33	F	GP Trainee	2.5 years	6 years
Melanie	28	F	GP Trainee	2.5 years	4.5 years
Milly	41	F	Practice Nurse	2.5 years	18 years
Mufty	30	F	GP Trainee	3.5 years	5 years
Naomi	28	F	GP Trainee	<1 year	5 years
Rachel	28	F	GP Trainee	<1 year	2 years
Ricardo	40	M	GP	< 1 year	15 years
Sanjay	--	M	GP	3 years	17 years
Scott	42	M	GP	15 years	20 years
Susan	--	F	Social Prescribing Link Worker	<1 year	<1 year
Ted	29	M	GP Trainee	<1 year	4.5 years
Tony	46	M	PCN Pharmacist	3 years	19 years

Table 1. Participant demographic information

Themes	Codes
General practice at the coalface: 'Who else is gonna do it?'	Continuity of care helps with SDOH conversations HCPs understand needs of their local population HCPs have a responsibility to address SDOH Importance of other HCPs outside of GPS in targeting SDOH Addressing SDOH in primary care is a team effort PCNs are valuable for working at scale Social prescribing needs more prominence
Helplessness to change SDOH: 'There's a limitation of what you can do in that situation'	Helplessness to change SDOH SDOH contextualises patients' health, background and behaviour Challenges to addressing barriers to improving health Uncertainty about the use/impact of SDOH to guide care Referral to other services or agencies Government initiatives are designed as 'one size fits all' Structural barriers to addressing SDOH
Lack of resource: 'The resource has gone down and the needs and expectations have gone up'	Health problems are impacted by psychosocial factors SDOH are multiple and interconnected Time as a barrier Primary care is being overloaded More resources are needed to address SDOH More training is required to address SDOH Need for primary care to adapt to changing environments (e.g., rising inequalities)

Table 2: Themes and codes constructed from data.