MEAM:
Policy into practice series

*The **Policy into Practice** briefing series from **Making Every Adult Matter (MEAM)** explores key national policy developments, what these mean for local people and local services, and how you can get involved in shaping what happens next.*

Social prescribing and multiple disadvantage

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In the NHS Long Term Plan, social prescribing is highlighted as an issue that will receive significant development over the next few years. There is an expectation that over 1,000 **trained social prescribing link workers** will be in place by 2020/21, and an aim for over 900,000 people to be referred to social prescribing schemes by 2023/24.

In this latest Policy into Practice briefing, our Policy and Practice Manager Richard Lewis outlines the key elements of social prescribing and the implications it has for people experiencing multiple disadvantage.

What is social prescribing?

Social prescribing is 'a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services'[1] to achieve better outcomes for their physical and mental health and general wellbeing.

In its simplest form, social prescribing is a way of getting people in touch with non-medical community support that can help improve physical and mental health, reducing pressure on health systems. The concept takes a view that health and wellbeing support goes beyond the traditional doctor/patient

[1] https://www.kingsfund.org.uk/publications/social-prescribing

relationship and recognises that a person's health is determined, and can be supported, by wider aspects of individuals' lives and their communities.

One of the most prevalent approaches to social prescribing in the UK was developed by the Bromley-by-Bow Centre in East London during the 1980s. In response to widening levels of inequality in the area, the centre created its own GP practice including a number of on-site activities. These focused on community building, employment and education, along with having on-site social care teams to give advice about money, welfare benefit s and housing. This was seen as a new model of primary care focused on the social determinants of patients' health[2].

Since then, several approaches to social prescribing have developed, but a common feature involves the use of a *link worker*[3]. Link workers connect people who could benefit from non-clinical interventions to organisations and activities which can help. For example, instead of treating someone's low mood only through anti-depressants or talking therapies, if appropriate, a link worker could support an individual to access physical activity, or financial advice and support.

The types of activities offered under social prescribing services aim to help address the wider wellbeing of frequent GP attenders.[4] By addressing these, it is hoped that there will be a subsequent positive impact on mental and physical wellbeing and in turn frequency of future attendance.[5]

The King's Fund estimated in 2017 that there were more than 100 social prescribing schemes running in England[6].

NHS England and Social Prescribing

Social Prescribing was described as an *emerging model* in NHS England's Five-Year Plan (2014), briefly touching on the outcomes of a pilot in Rotherham[7]. In 2016, NHS England's *Five-Year Forward View* for mental health discussed the

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[2] British Journal of General Practice 2018; 68 (672): 333. **DOI:** https://doi.org/10.3399/bjgp18X697733 https://bjgp.org/content/68/672/333
[3] They may be described as "link workers," "key workers," "social prescribing link workers," etc.; there is not a common title, but they do very similar things from scheme to scheme.
[4] Bickerdike L, et al. BMJ Open 2017;7:e013384. doi:10.1136/bmjopen-2016-013384
[5] Kimberlee R, Ward R, Jones M, et al. Measuring the economic impact of Wellspring Healthy Living Centre's Social Prescribing Wellbeing Programme for low level mental health issues encountered by GP services. Bristol: University of the West of England, 2014
[6] https://www.kingsfund.org.uk/publications/social-prescribing
[7] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

importance of personalised care and the social determinants of poor mental health[8].

IN 2019, NHS England published its Long Term Plan,[9] which sets out its vision of how healthcare will develop for the next 10 years. The expansion of social prescribing is described as an important element of delivering the plan, a key component of Universal Personalised Care[10]. Over 1,000 **trained social prescribing link workers** will be in place by 2020/21, rising further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes by then.

Social prescribing schemes that are already in place have mainly been commissioned by NHS Clinical Commissioning Groups (CCG) or, in some places, local authority Adult Social Care teams. Delivery of the schemes might be carried out through a Primary Care Network (PCN), local authorities, voluntary organisations or a mixture of bodies.

The concept of social prescribing is still relatively novel and as a result most evidence of its effectiveness and efficacy is based on small-scale evaluations and studies. However, there is increasing evidence which shows that social factors such as education, income and housing influence health behaviours and have a major impact on health. There is a growing interest in a more personalised approach to healthcare delivery, with more effective partnerships between patients and professionals.

Social prescribing is also seen as an effective way of addressing social determinants of health while potentially reducing healthcare demand and costs. Research suggests[11] that it can improve referrals to in-house expert non-clinical services that support patients with root causes of poor health which aren't medical in nature. This might allow GPs to better concentrate on the medical needs of patients.

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[8] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[9] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
[10] https://www.england.nhs.uk/personalisedcare/upc/
[11] British Journal of General Practice 2018; 68 (672): 333. **DOI:** https://doi.org/10.3399/bjgp18X697733

Social prescribing: Opportunities and challenges for people experiencing multiple disadvantage

The increasing recognition that social inequalities are at the root of many health inequalities means that social prescribing, and a wider approach to health more generally, could be beneficial for people experiencing multiple disadvantage. As the use of social prescribing is set to rise, there will be more opportunities for people experiencing multiple disadvantage to interact with social prescribing. However, there are also a series of challenges to the model being appropriate for people facing multiple disadvantage, which are discussed below.

Opportunities

The flexibility of approach and variety of activities on offer through social prescribing are likely to appeal to people who are marginalised from traditional approaches to health and social care.

It is possible that social prescribing could support people experiencing multiple disadvantage to be better able to engage with more formal services in the future. The activities they might be linked to could lead to an increase in the number and richness of social relationships. These non-conditional relationships, in which someone is given the power to pick and choose how and when they interact with different activities, could improve faith and trust in local services, something that can often be lacking for people experiencing multiple disadvantage. It could challenge assumptions about support service or offer a different way of engaging with a service, for example, attending a previously refused appointment with a new friend, who may offer some social support.

Increasing activities and social interactions, in tandem with receiving mental and physical health services, could lead to better outcomes for people experiencing multiple disadvantage, provided that potential challenges are acknowledged and addressed. It may help stabilise mental health and reduce social isolation. As a person tries to get involved with different activities and the social network that they are able to develop enlarges and diversifies, there is the possibility that feelings of stigma may decrease.

For some individuals experiencing multiple disadvantage participating in positive physical activities can be an incentive to improve their physical wellbeing. This could mean reflecting on certain behaviours and improving engagement with primary care.

Challenges

To be effective for people facing multiple disadvantage, social prescribing must be done in a way that puts an individual's needs first, rather than the needs of the service. It is unlikely to be successful if link workers only provide a referral or simply signpost to activities. For an individual facing multiple disadvantage, a genuine relationship will need to be built between the link worker and the individual before a referral is made. This will help build trust in them and the activities they prescribe. Any rules creating a finite number of meetings with a link worker will likely need to be relaxed for individuals facing multiple disadvantage and caseload numbers will need to allow time for the level of engagement needed. Based on a person's needs, an individual may want to be accompanied by their link worker to make introductions and develop new relationships, and the link worker may need to attend for a few, initial sessions.

It is also vital that social prescribing is treated as a complementary activity to healthcare for individuals facing multiple disadvantage. There is a risk and possible concern that it could become a conditional gateway that must be taken up in order to access other healthcare services. This must be avoided and challenged anywhere where it occurs.

The social prescribing offer needs to give an individual the opportunity to try (and refuse) several opportunities and activities that are relevant to their needs and take into consideration their specific circumstances. This will involve taking time and possibly multiple attempts to get to know an individual's wants and wishes as they explore and experiment.

For those delivering socially prescribed activities, who may not have had much contact with people experiencing multiple disadvantage, reconsidering how their organisation and service takes into account increased vulnerabilities and disadvantages could be a challenge. Adopting a trauma-informed approach to challenging behaviour can avoid further feelings of detachment and isolation from the activities and support on offer.

Co-producing and co-commissioning social prescribing services with people experiencing multiple disadvantage could help ensure the right activities are identified, as long as adequate time is set aside for relationships to be built with link workers.

Concluding thoughts

The development of social prescribing has resulted in a new service offer to better respond to the social determinants of poor health outcomes. It can generate new perspectives on the systemic issues surrounding poor health and inequality and provide the opportunity to empower people experiencing multiple disadvantage to develop greater control over their health through new and wider choices.

As it enters a new phase of expansion within NHS England, we need to ensure that social prescribing is as accessible as possible to people experiencing multiple disadvantage. Adopting a flexible and pragmatic approach, co-producing the type and range of activities on offer and taking a trauma-informed approach will help to achieve this and ensure that social prescribing is effective in offering real change for people experiencing multiple disadvantage.