Maximising the impact of social prescribing on population health in the era of COVID-19

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Social prescribing involves referring people, mainly from primary care settings, to non-clinical community services, such as exercise classes and welfare advice, with the aim of improving mental, physical and social wellbeing. These activities are typically provided by the voluntary and community sector.

Social prescribing has been increasingly adopted across high-income countries including the UK, United States of America, Canada and Finland.[1] The UK's Department of Health first introduced the term 'social prescribing' in 2006 to promote good health and independence, especially for people with long-term conditions.[2] Over a decade later, in 2019, NHS England committed to funding social prescribing through link workers. Link workers receive referrals, mainly from general practitioners, and are attached to primary care networks with populations of 30–50,000 people.[3]

Here, we examine the impact of different social prescribing schemes in England, from a population health perspective, that focus on individuals, communities or a combination of both. We examine the opportunities to maximise social prescribing's impact on population health, in the era of COVID-19, by realigning social prescribing to a household model that reflects principles of universality, comprehensiveness and integration.

Background

Healthcare contributes approximately 10%–20% of improvements in population health while the remainder is attributed to addressing the social determinants of health.[4] As healthcare costs increase, due to an ageing population with long-term conditions, the focus of health systems has shifted to promoting wellbeing as well as treating illness through a population health approach, which aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population.[5] Where health systems neglect addressing social determinants, such as poor housing and unemployment, people experience repeated cycles of ill health. Social prescribing is perceived by policymakers as a means to address this.[3]

Despite its wide implementation, reviews[6,7] of link worker social prescribing evaluations in the UK found no clear evidence for its effectiveness in changing physical and/or mental health, or reducing healthcare usage. However, generating robust evidence for social prescribing is hindered by heterogeneity in social prescribing programmes and populations, limiting comparison and generalisability. Nevertheless, qualitative evaluations have found that social prescribing has improved wellbeing, mental and physical health.

Different social prescribing models in England

Social prescribing models in England can be categorised according to a variety of features. Here, we identify a spectrum of models that vary according to the focus of their intervention: on individuals, communities or a combination of both. We chose representative examples with available evidence along this spectrum, while recognising that there exists a plethora of good models.

To date, social prescribing schemes in England have commonly targeted older individuals with long-term conditions. In the last decade, people aged over 65 years account for half of public spending on adult social care and over half of the growth in emergency hospital admissions.[8]

Rotherham Social Prescribing, set up in 2012, is an example of a social prescribing model that targets

individuals with long-term conditions and mental health issues, 87% of whom were aged 60 years or over between 2012 and 2015.[9] Individuals are referred by general practices and community mental health teams to advisors who assess their support needs, typically during a home visit, before referring them on to appropriate voluntary and community sector services such as befriending or physical activities. An evaluation of 939 service users found a reduction in emergency department attendances of 17% comparing the 12 months before and after the first contact with social prescribing.[9] However, in the absence of a comparison group, we cannot conclude that the scheme was responsible for the observed reduction in healthcare use; 82% of individuals (876/1068) reported positive change in their wellbeing on at least one of eight measures associated with self-management. However, follow-up assessment was completed with an advisor, thus introducing possible bias, and only at four months, hence limited in assessing impact and sustainable change.

Rotherham Social Prescribing exemplifies a model that targets high-needs individuals with complex health and social problems, including those with low self-efficacy. The use of link workers to build relationships over time enables high-needs groups to be supported holistically. Social prescribing has targeted other high-needs groups, for example with specific conditions such as diabetes or cancer. The charity Street Games[10] supports young people with mental health issues in deprived areas.

On the opposite side of the spectrum, there are models that focus on interventions at the community level, such as Project Smith. This social prescribing model was established in 2015 using local volunteers in Lambeth, London, to become 'Community Connectors'. Volunteers receive free training and monthly supervision in supporting behavioural change and signposting community members to appropriate activities. Findings showed that the use of 'Community Connectors' increased the community's access to services, social connections and knowledge and skills to improve their emotional, mental and physical health.[11] Community level models have a wider reach compared to individual models by creating social networks and increasing social interconnectedness, and are more sustainable as a result of the intrinsic motivation of individuals to improve their neighbourhood. Furthermore, training community members to support each other in the face of social, physical and emotional challenge helps develop community resilience. Community resilience in turn promotes recovery from illness and reduces the healthcare burden by encouraging individuals to support each other. Community volunteers are also better placed to reach vulnerable groups unable to access care[12] such as migrants, homeless, drug users and ethnic minorities.

Most social prescribing schemes sit in between and intervene at both the individual and community level. For example, Frome Medical Practice, a single general practice of 30,000 people in Somerset, collaborates with the voluntary and community sector on their compassionate community model. The practice embraces an enhanced model of primary care whereby individuals who would benefit from care plans are systematically identified and undergo personalised care planning. Anyone with clinical concern is eligible. Individuals are then offered referral to the social prescribing scheme where a 'Health Connector' recommends tailored community activities.[13] At a community level, members effectively signpost people to community services, and talking cafes help connect the community.

During the period April 2013 to December 2017, emergency hospital admissions were significantly reduced in Frome.[14] Meanwhile, over 90% of people seen by a 'Health Connector' felt more able to access community support and manage their own health.[13] While these results are positive, it is important to emphasise that the results are likely due to a combination of an enhanced primary care model as well as social prescribing.

Irrespective of where the social prescribing scheme sits on the spectrum of individual to community models, no one model can fulfil its potential impact on population health without adequate community resources. The voluntary and community sector has experienced a decade of reduced social finance, which has seriously undermined its sustainability and capacity to see all the additional people identified from social prescribing schemes.

## Population health: universality, comprehensiveness and integration

Improving population health requires social prescribing to be comprehensive and to address domains beyond the traditional biomedical model to include health promotion and the social determinants. To impact the entire population, it needs to be universal and accessible to everyone. Fragmentation in care means that those less able to manage their own health are more likely to 'fall through the gaps', and thus, integrating social prescribing into the healthcare system can improve accessibility and navigation through services. Furthermore, where health systems are integrated, they have an increased ability to adapt in tandem with other services. Table 1 shows to what degree the aforementioned social prescribing

Table 1. Degree of alignment with principles of universality, comprehensiveness and integration of social prescribing models in England and in the Community Health Worker Model in Brazil.

	Universality	Comprehensiveness	Integration within healthcare system
Rotherham Social Prescribing	Social prescribing is aimed at patients with complex long-term conditions and mental health issues who are high users of primary care resources. Specific support for the carers of case-managed individuals can also be provided. To access the programme individuals require a referral from a general practitioner or community mental health team. ■	Activities offered include volunteering, physical exercise, and arts and crafts. Social determinants are addressed through advice and information services and mental health through a counselling service. Health promotion includes self-care courses. Finally, there are services for specific groups such as individuals with dementia and carers. ■	Voluntary Action Rotherham, a local charity, delivers the programme on behalf of NHS Rotherham Clinical Commissioning Group. The service works with general practitioners and mental health services, planning integrated and pre-emptive care for individuals at increased risk of unplanned hospital admissions, presenting to the emergency department, going into residential care prematurely or becoming dependant on mental health services. VCS advisors work with general practitioners, community nurses, social workers and mental health teams to address clinical and social care as well as the holistic needs of individuals. ■■■
Street Games	Street Games social prescribing is specifically aimed at helping young people (aged 14–25 years) and requires referral. ■	Youth link workers can provide individuals referred to social prescribing with free counselling, sport and volunteering opportunities and support with literacy, training or employment. Outside of the social prescribing programme Street Games deliver community activities aimed at improving community safety, increasing access to sports and developing skills to support employment. ■	Street Games is a charity run in partnership with local organisations., general practitioners, teachers, police officers, counsellors or community workers can refer individuals to the charity, which exists outside of primary care. ■
Frome Compassionate Community Model	The social prescribing programme is aimed at high-needs individuals and requires a referral though individuals can self-refer. To reach further, local volunteers are trained to signpost families, friends and neighbours to	VCS activities include services addressing mental health, health promotion groups include smoking cessation as well as specific groups, e.g. diabetes support. Groups	The compassionate community model is a collaboration between Frome Medical Practice and Health Connections Mendip – a team working for the NHS to provide a directory of community assets and services. Health

Table 1. Continued.

	Universality	Comprehensiveness	Integration within healthcare system
	community services. Additionally, talking cafes have been set up to connect local people. ■ (medium)	offering advice on housing and debt to address social determinants. ■ (medium)	connectors are employed by the medical practice. A discharge liaison service was set up to integrate primary and secondary care. ■■■ (high)
Project Smith	Community workshops are held throughout the year open to everyone. Community connectors aim to create networks in the community. ■ (medium)	Community connectors act as a link between other wellbeing staff such as the Primary Care Navigators, Community Health Champions, and Parent Champions. The local services funded by Project Smith include group exercise activities, grief events and English lessons. ■ (medium)	Project Smith is funded by NHS Lambeth Clinical Commissioning Group and Lambeth Council. It is independent of primary care services. ■ (low)
CHW model	All households are visited routinely by their CHW regardless of expressed need or demand on a monthly basis. ■■■ (high)	CHWs role is wide including chronic disease management, health promotion, clinical care, triage, screening, household data collection and community liaison. ■■■ (high)	CHWs are a core part of the primary care team feeding into multidisciplinary meetings and supporting navigation through the health and care systems. ■■■ (high)

Degree of alignment to principle: low ■; medium ■; high ■■■.
CHW: community health worker; VCS: voluntary and community sector.

schemes in England demonstrate universality, comprehensiveness and integration, using a traffic light rating system. We contrast these social prescribing models to the Community Health Worker model in Brazil – an internationally recognised model that fulfils all three criteria.[15]

Impact of COVID-19 on population health

The COVID-19 pandemic in England, as elsewhere, saw the introduction of social distancing measures to reduce transmission of infection and prevent the health service being overwhelmed. The ramifications of social distancing on population health and the economy long term are as yet unclear.

Notably, workers in the hospitality sector, who are already on low incomes, are likely to face closure of their workplaces and individuals with zero-hour contracts have no recourse to accessing furloughing schemes. Meanwhile, school closures not only hamper education but also result in low-income families losing benefits such as access to free school meals and incur additional expense, such as an increase in home utility bills. The association between poor economic conditions and poor health is well-established.[16] The economic consequences of the COVID-19 pandemic are set to widen existing health inequalities by affecting the most vulnerable. Unemployment and debt can exacerbate mental health problems as can the impact of isolation from wider social networks.

In the face of this public health emergency, which has exacerbated existing shortcomings in population health that social prescribing aims to address, there is an opportunity for social prescribing to be remodelled to meet these challenges. A social prescribing model that embraces the key principles of universality, comprehensiveness and integration is vital, and with the newly introduced link workers already aligned to primary care, increasing their numbers further to provide place-based outreach work would build on existing infrastructure.

Re-aligning social prescribing to households: Brazilian case study

While social prescribing models in England focus at the level of individuals, communities or both and depend to a large degree on referral processes, community health workers in Brazil operate at a household level. The Family Health Strategy, initiated in 1994, is a nationally scaled model of primary care services. Each team of doctors, nurses and community health workers cover a population of approximately 4000. Community health workers are local lay people who are trained over a few weeks and employed by the local health municipality. They conduct monthly visits to each household within their micro-area of approximately 100–200 households. Community health workers help to manage chronic diseases, promote health education, collect household data and address the social determinants by referring to community activities and support. Importantly, community health workers are members of the micro-community they serve and understand existing assets and issues arising in that community.

Through the community health worker model, Brazil saw large population health improvements with reductions in infant mortality, increased screening uptake, reduced hospitalisations and improvements in health equity. The model was also associated with high user satisfaction and cost-effectiveness.[15,17] Although their role is not labelled 'social prescribing', community health workers set out to achieve similar outcomes for individuals and communities as social prescribing models in England (Table 1).

The community health worker scheme has previously been modelled in England with results suggesting that it is a viable policy option and that 110,585 community health workers would be needed to cover the population, costing a relatively modest £2.2 billion annually.[18] While link workers only see a selection of individuals referred, the universal nature of community health workers ensures that all households within their catchment area are reviewed. This puts them in a unique position to identify vulnerable individuals, deliver health education and monitor chronic disease, thus providing comprehensive care. Similar to link workers within social prescribing, they can signpost individuals to voluntary and community sector services appropriate to their needs. Community health workers have the advantage that they are fully integrated into primary care teams, which facilitates feedback, development and support from the wider multidisciplinary team. The additional benefit of integrating their role within the primary care team means they will not be 'left behind' as healthcare services continue to change their ways of working in response to the pandemic.

Conclusion

The COVID-19 pandemic shows the importance of strong social support within the community to meet major public health challenges and presents an opportunity to rethink social prescribing nationally and globally. A household social prescribing model for the UK, as in Brazil, that embeds principles of universality, comprehensiveness, and integration is

urgently needed to improve population health along with adequate community funding.

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