Transformation Partners
in Health and Care

Social prescribing narrative pack

Helping make the case for social prescribing.

Community Led Prevention

February 2025

Overview of the pack

- The purpose of the pack is to set out the case for social prescribing, how it can be used in practice to support wider priorities and the impact it can have at a patient, community and system level.
- The pack is intended to be a catch all resource that can be used and adapted by anyone across system.
- Example uses for the pack:
  - To set out the case for social prescribing
  - To influence commissioners and strategy leads about social prescribing
  - To adapt to sell the benefits of specific types of social prescribing e.g. CYP, secondary care, Social Welfare Legal Advice (SWLA)

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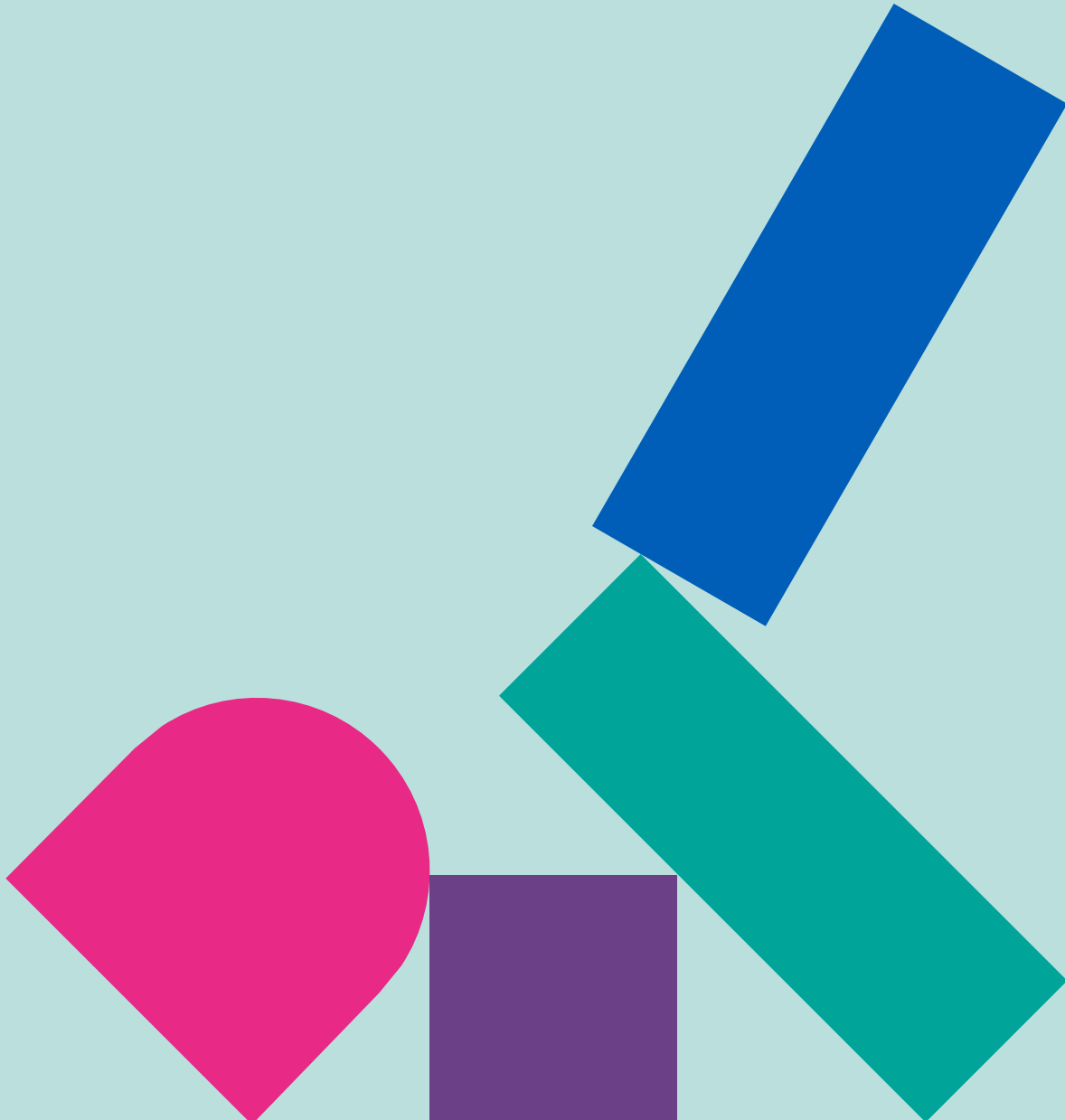
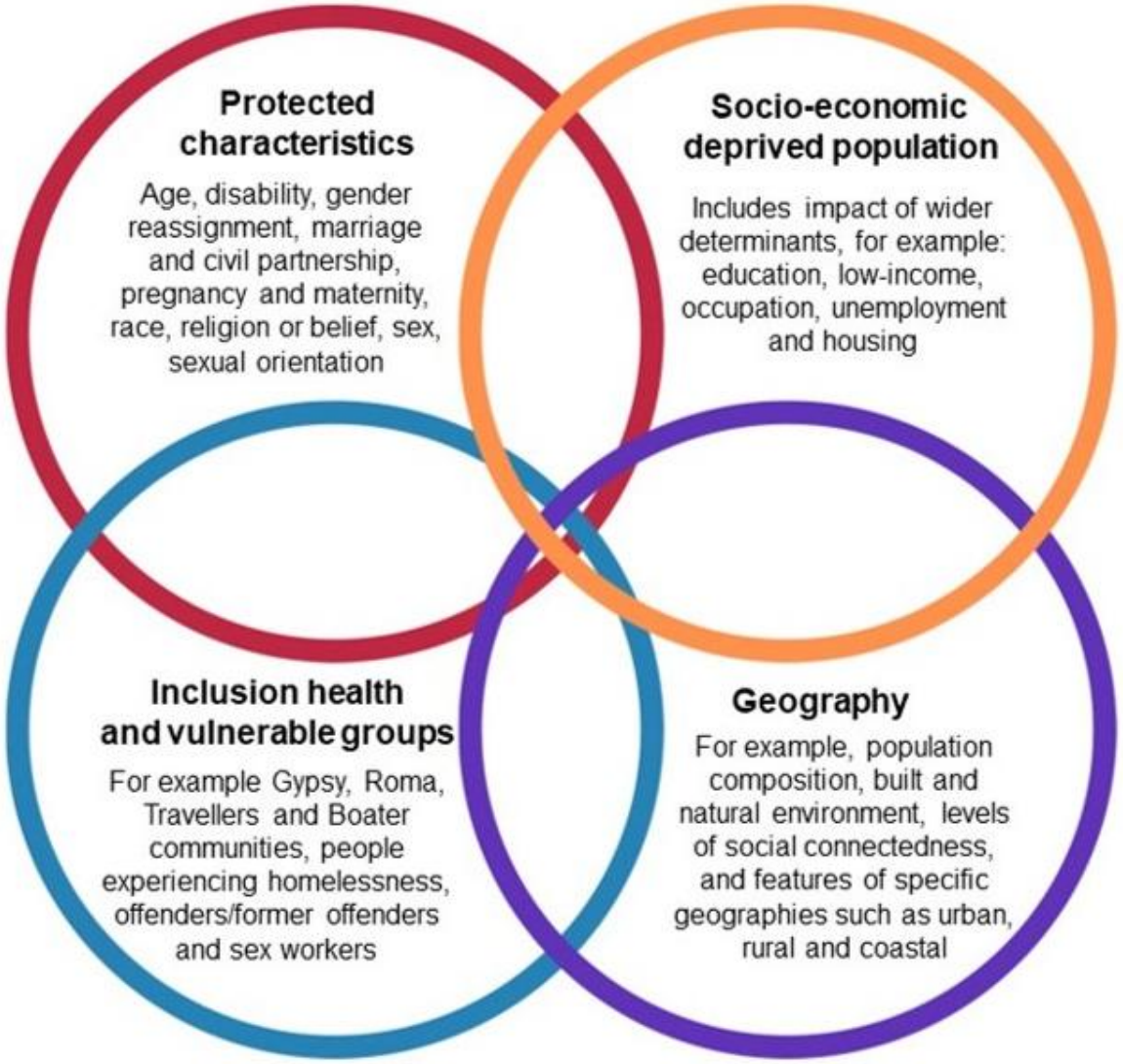
Making the case for social prescribing?

This is the data that helps us understand health inequalities and why social prescribing has an important role to play in addressing them.

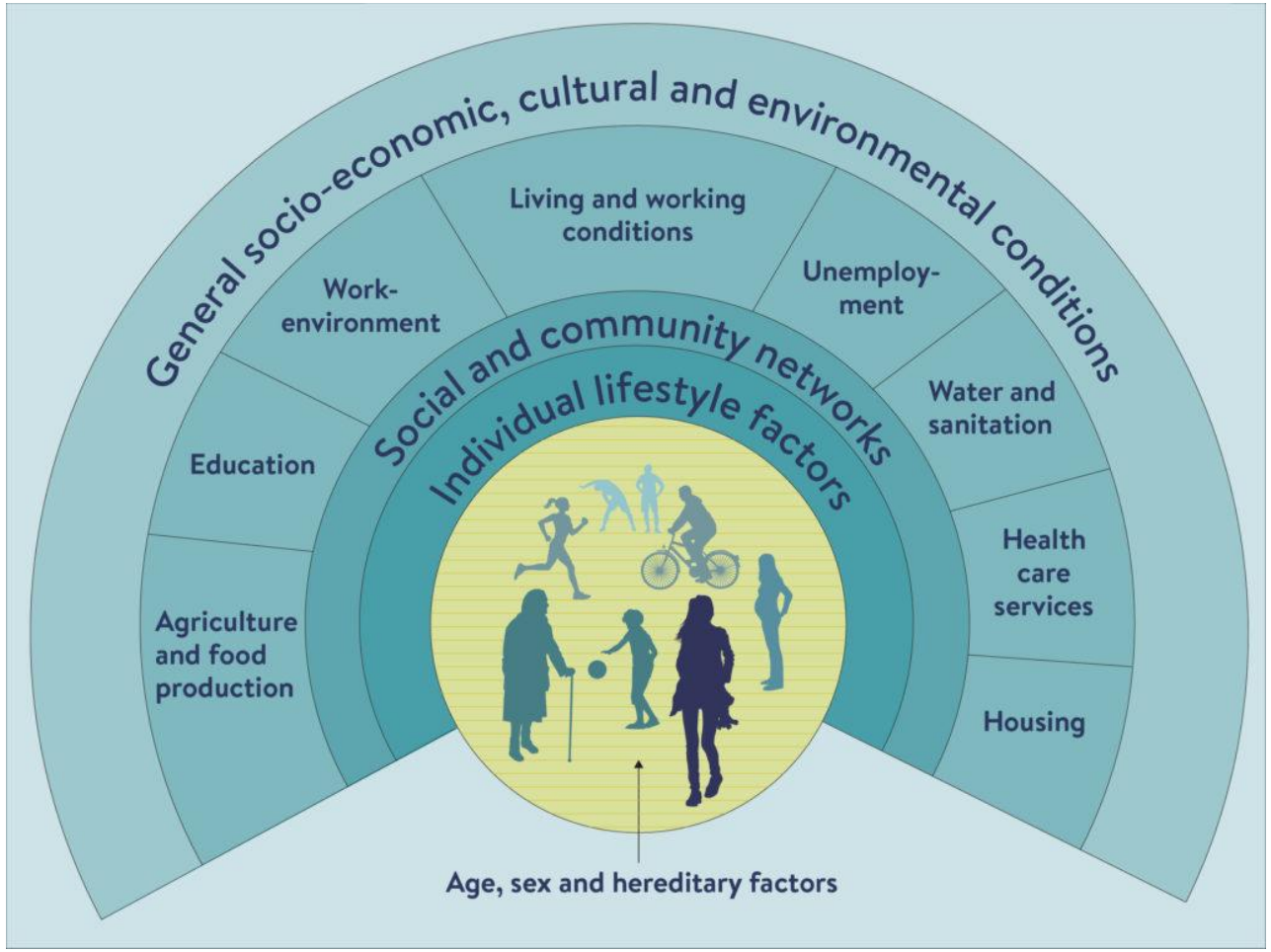


Many factors can contribute to health inequalities

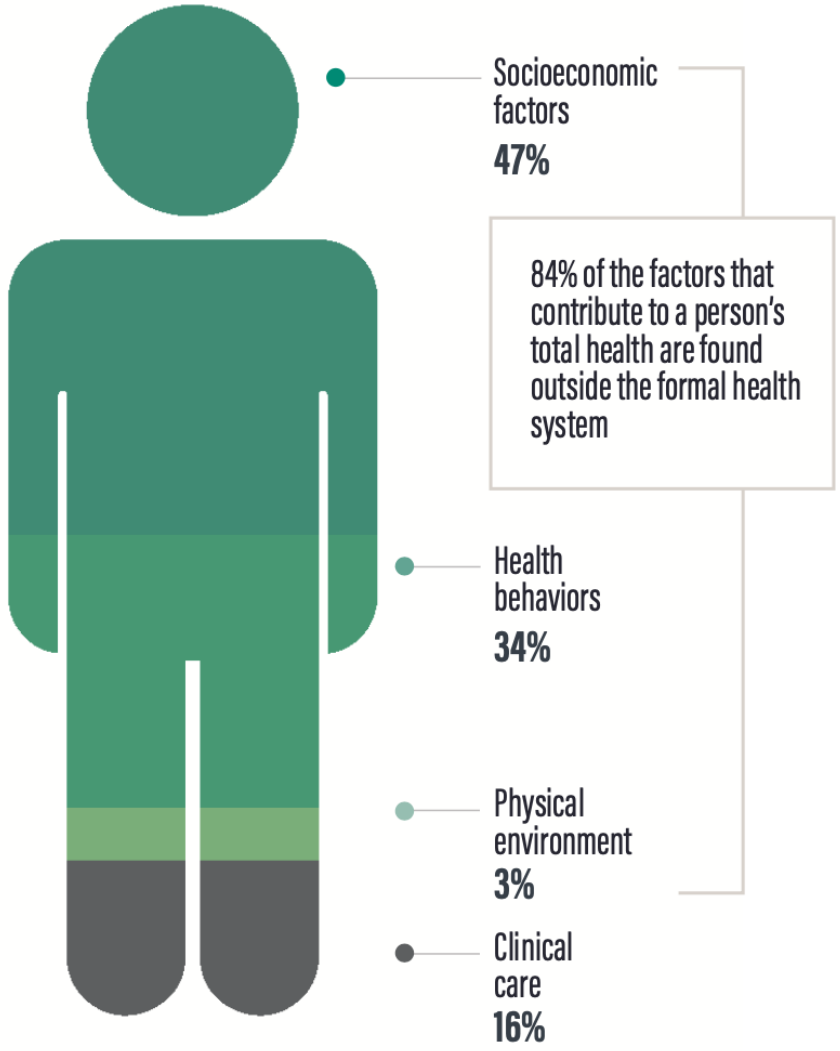


- There are many individual and societal factors that can contribute to health inequalities
- These factors are complex and interact with each other to benefit or disadvantage people or groups, leading to differences in health outcomes.
- People can fall into more than one category and, subsequently, may experience multiple drivers of poor health at the same time.

84% of the factors that influence a person's total health are found outside of clinical care



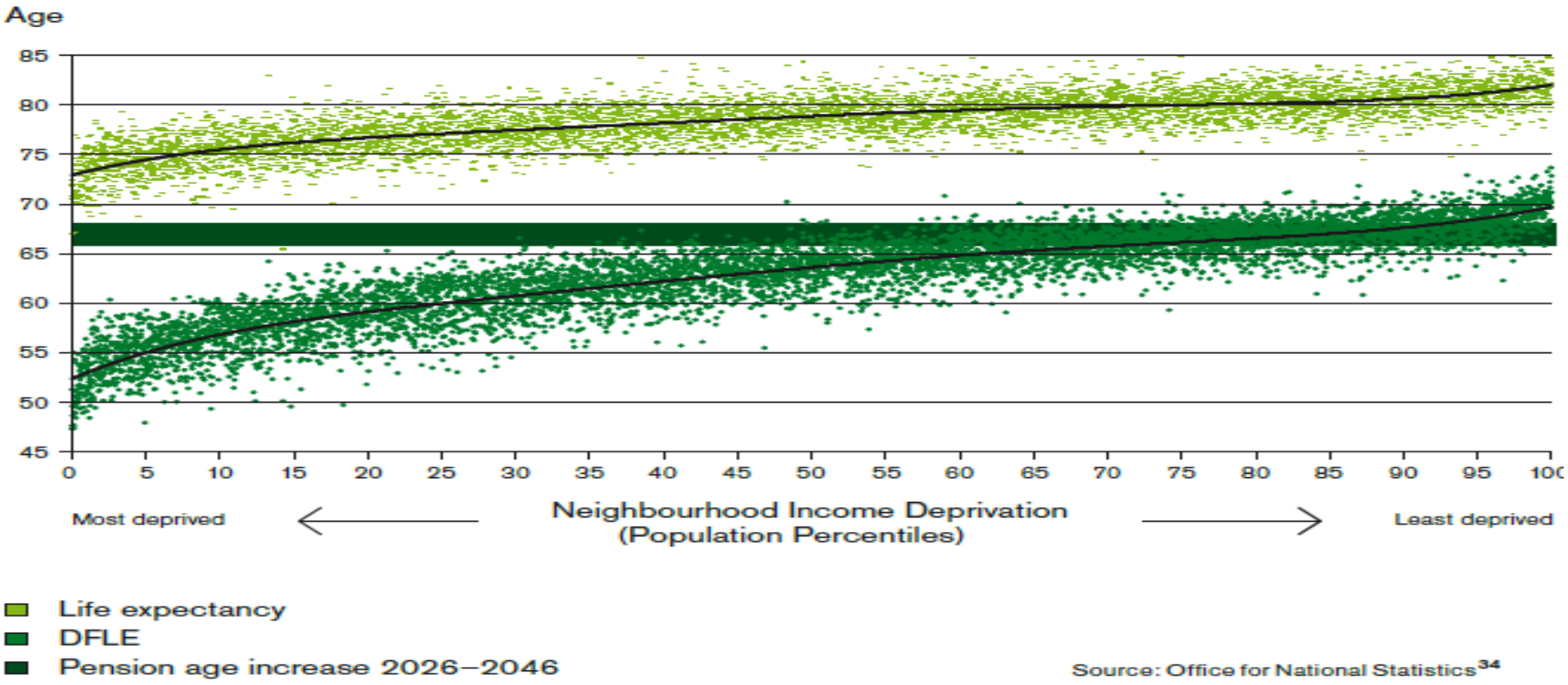
Social, economic, and physical factors significantly influence behavioral health outcomes.



The health gap: socio-economic status is a major determinant of life expectancy

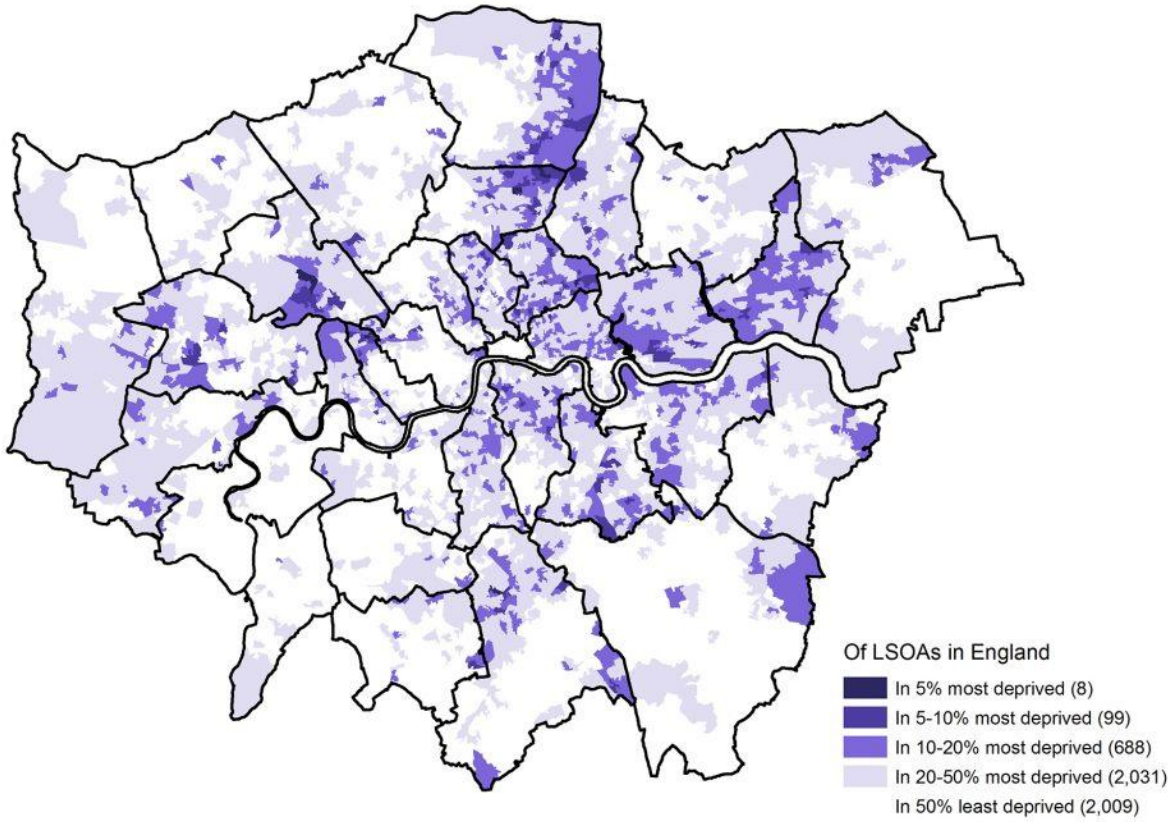
The wealthier / least deprived members of our community will live longer and with many more years in good health… and vice versa. The upper line shows a trend towards higher life expectancy among the least deprived. The lower line shows a trend towards those with the most deprivation living less years disability free.

Figure 1.1 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003



Source: Office for National Statistics[34]

Deprivation is a major determinant of health



Deprivation varies across London. The darker areas show the most deprived areas. This makes it a particular challenge to target these communities, who are often neighbours of more affluent areas.

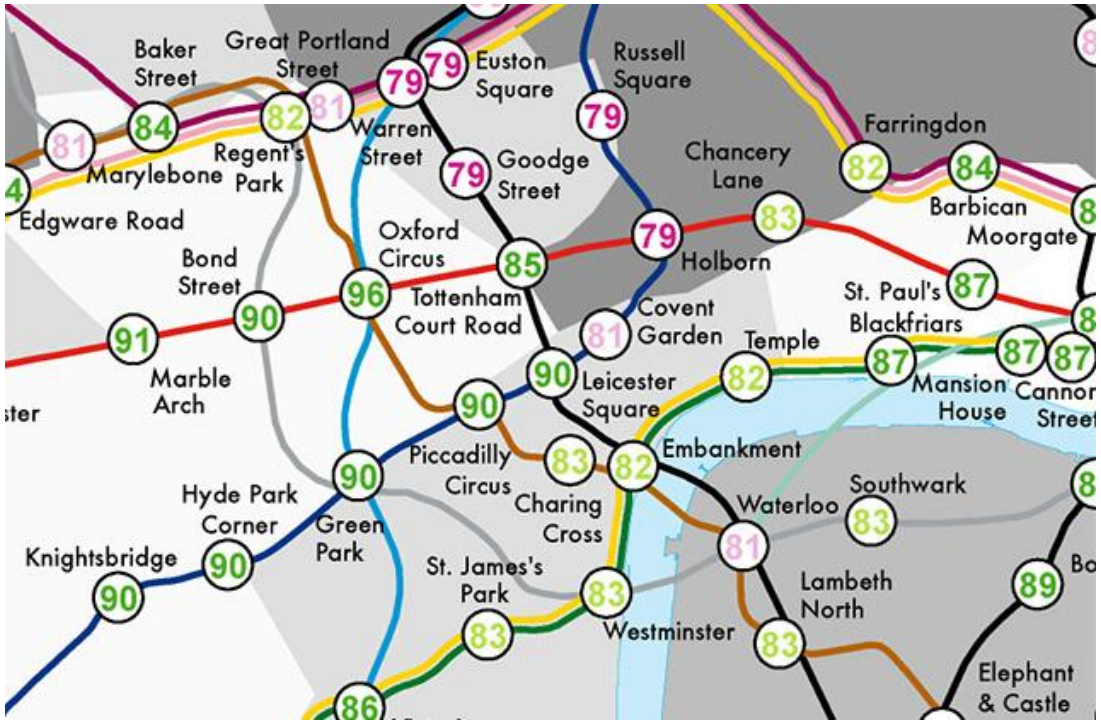


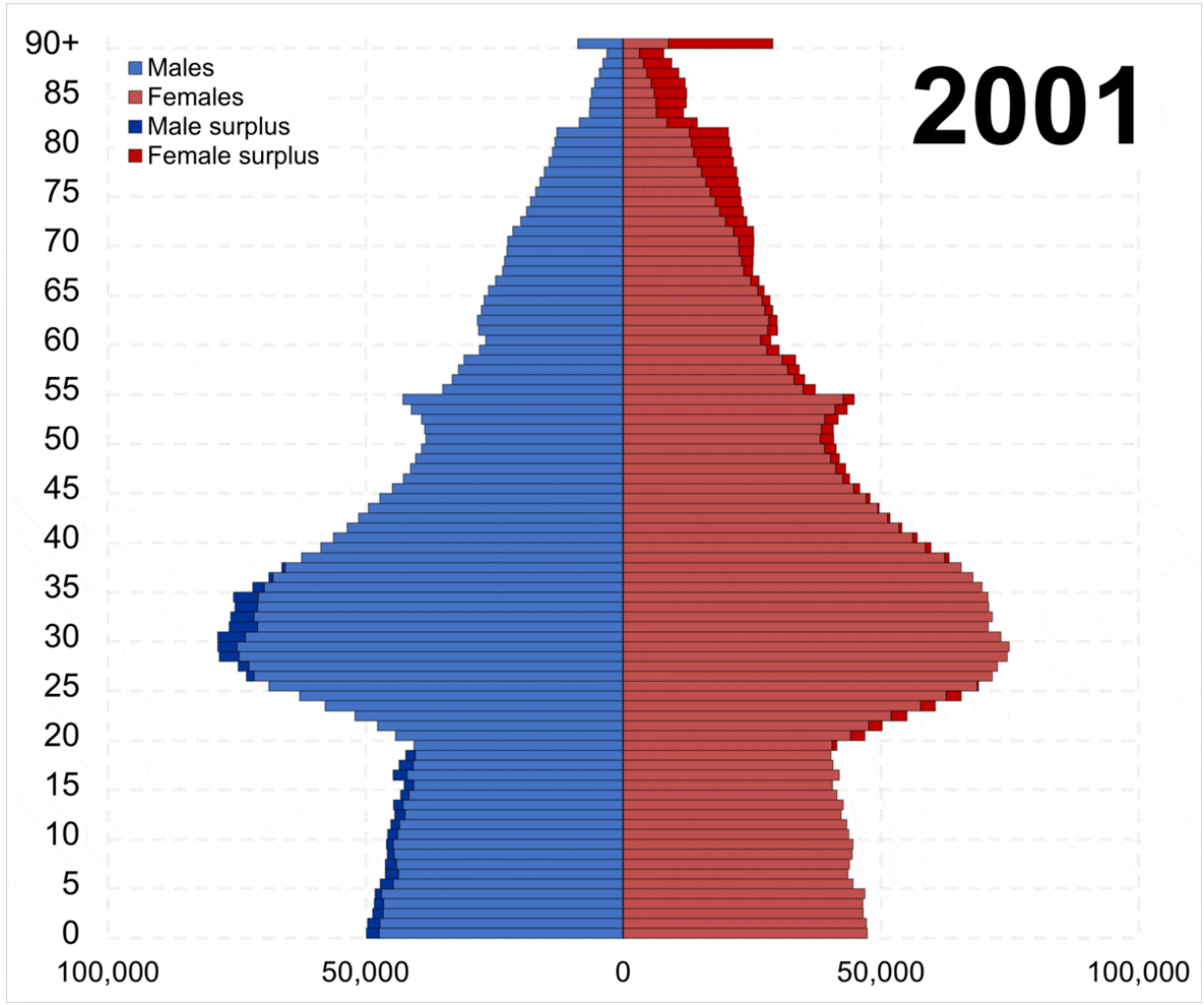
Image: Life expectancy at different tube stations

If you travel eastbound between Lancaster Gate and Mile End (20 minutes on the Central line), life expectancy decreases by 12 years.

The more deprived an area, the lower the life expectancy.

Aging population

- **The proportion of our population that is over 65 is increasing – this puts an increased demand on NHS services**
- Over 11 million people – **18.6%** of the total population – were aged 65 years or older, compared with **16.4%** at the time of the previous census in 2011.
- Rates of pensioner poverty are higher in the capital compared to the rest of England:
  - **5% of older Londoners** (over 50s) live in poverty, compared to 18% in the rest of England
  - **20% of Londoners in their fifties** are in fuel poverty, compared to 15% in the rest of England

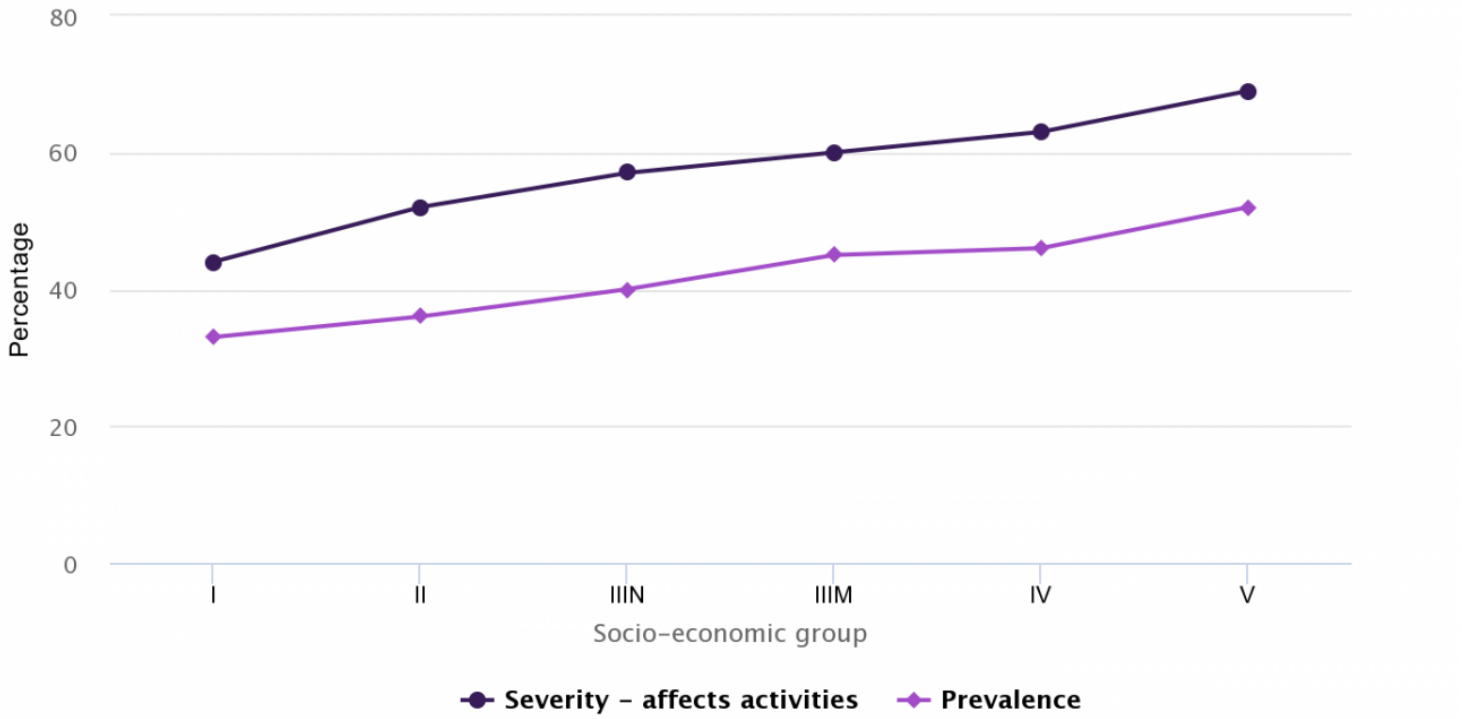


GIF: London population pyramid from 2001 to 2020

Long Term Health Conditions

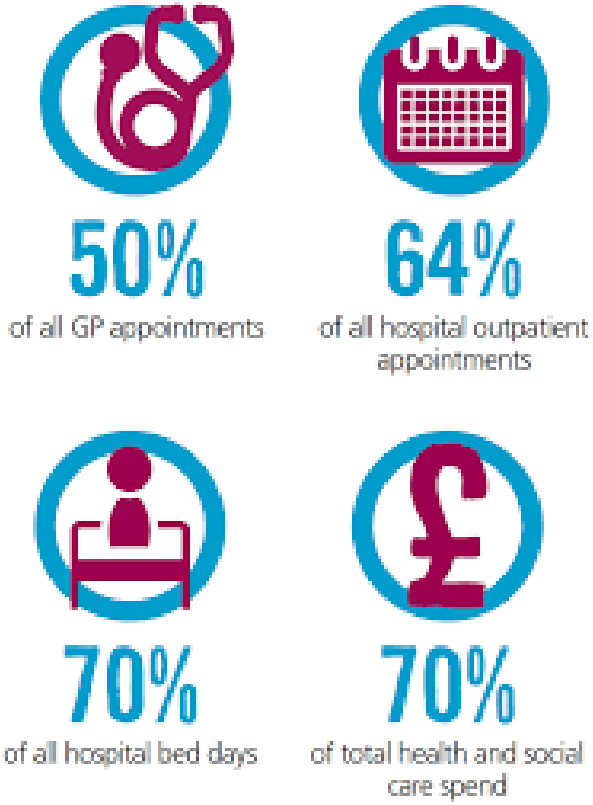
People from lower socioeconomic backgrounds are more likely to have long term health condition

Link between socio-economic group and long-term conditions prevalence and severity



The graph shows that the lower the socioeconomic group (group v being the lowest) the more prevalent and severe long- term conditions are.

People living with a long term condition are more likely to use health and care services.
They account for:



The case for broader multi-disciplinary teams (MDTs)

- Health and mental health problems are common-place in our modern society. The NHS does its best to help, but many challenges people face cannot be resolved by a single medical intervention, other types of support are needed.
- Most health is determined by factors outside the influence of clinical care. non-clinical aspects of their lives, called the social determinants of health, determine 80-90% of an individual's health.
- MDTs are designed to support patients with the right care at the right time, and right place. To truly cater to patient need, we MUST include non-clinical roles that support with these social determinants.
- This includes non-clinical roles such as Social Prescribing Link Workers, Care Coordinators and Health and Wellbeing Coaches
- An additional benefit of having these broader MDTs, is being better placed to prevent conditions, or worsening of conditions, which results in more efficient health care and cost savings.

Current context – these factors all exacerbate the need to support prevention and roles that tackle the social determinants of health

Cost of living crisis (UK Commons)
Many people simply can't afford the basic necessities of life that lead to good health and wellbeing.

Mental health crisis

40 per cent of all GP appointments about mental health.
Referrals to CAMHS has increased by 81%. (Mind)

COVID effects and recovery (Gov)

More than 2M people in the UK say they have symptoms of long Covid. There are over 7M on the elective waiting list and over 400K have waited over a year

Cost pressures on NHS

NHS is expected to deliver more for less – the NHS is facing a real-terms cut in funding of between £4 billion and £9.4 billion. (NHS Confederation)

Access to health care

It is harder than ever to get a GP appointment and people are the least satisfied. (Kings Fund)

Ongoing workforce crisis – recruitment and retention

Nurse vacancies of 43,000
2,000 fewer GPs compared to the September 2015 (BMA)

Social care crisis

Many bed occupancies are unnecessary however secondary care settings don't have the social care support to enable discharge (BASW)

NHS plans and structure

NHSE is committed to delivering healthcare that works for the population. ICSs have a statutory requirement to help tackle health inequalities. (NHSE)

A system that cannot meet demand

A single GP is now responsible for an average of 2,285 patients. This is 348 (18%) more than in 2015. GP appts reached a record high of 36m. (BMA)

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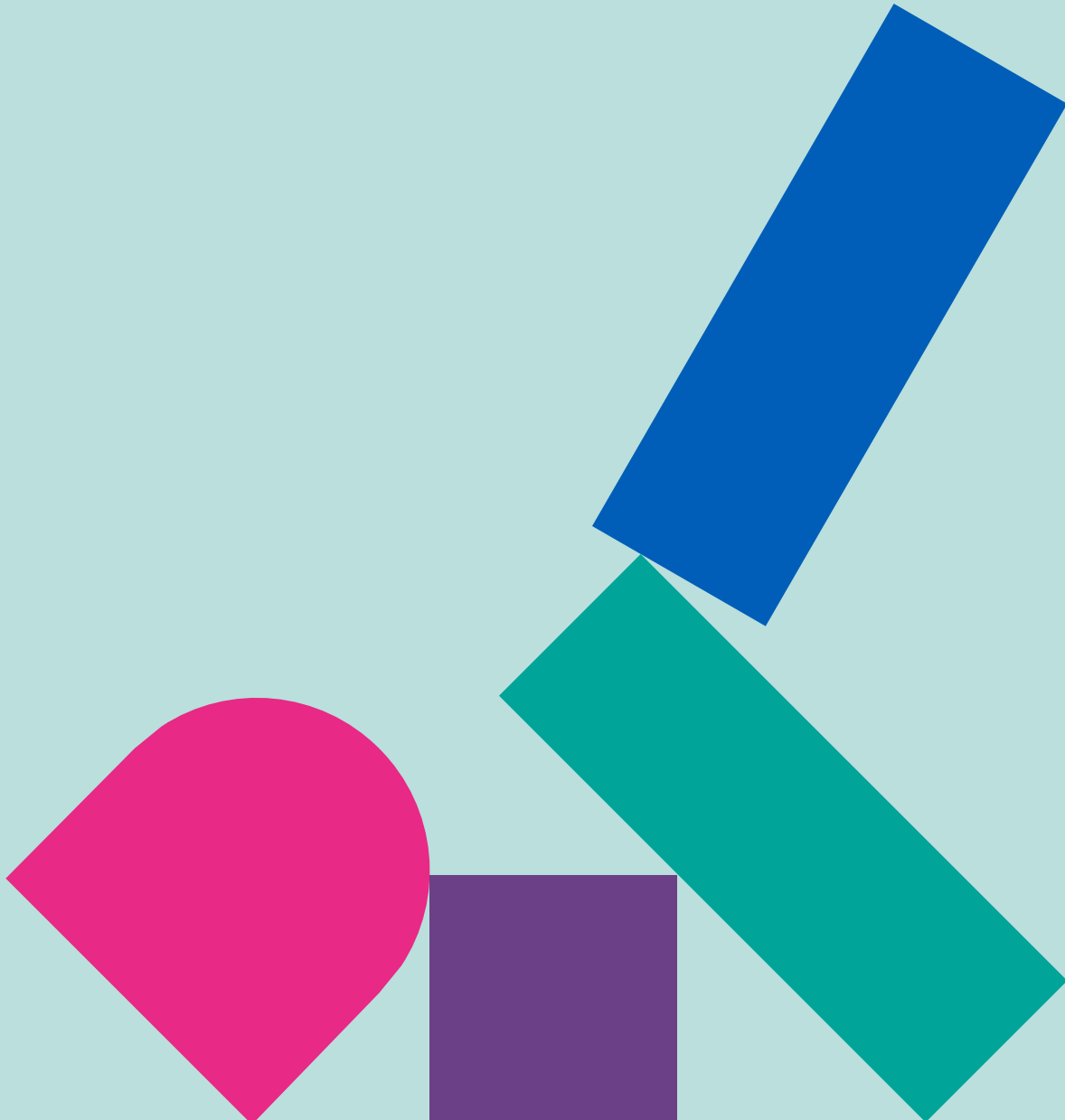
What is social prescribing?



What is social prescribing?

Social prescribing is a holistic approach to health and wellbeing that helps to reduce health inequalities by tackling barriers to good health and improving access to health care

Social prescribing aims to:

- support individuals to take **greater control of their own health and become better** integrated within their community to improve health & wellbeing
- build on community assets **creating thriving communities** through connecting voluntary organisations with those in need
- help to **relieve pressures on NHS** services through enabling GPs, nurses etc to refer patients with non-clinical needs to community based support

“There is no immediate or easy fix to the current challenges facing the health and care system… what is needed is a shift to models of care that support prevention, earlier intervention and living well with long-term conditions”

Sally Warren, director of policy at the King’s Fund

What can social prescribing do?

Social prescribing:

- Addresses the social determinants of health to help to **improve health outcomes and reduce inequality.**
- **Improves outcomes** for people by giving more choice and control over their lives and an **improved sense of belonging** when people get involved in community groups.
- **Bridges the gap between NHS and communities**, bringing the VCSE alongside local health services to create health and wellbeing.
- Creates **thriving, resilient and more cohesive communities** through taking the time to understand and address local needs.
- **Increases access to healthcare and wellbeing support** for marginalised groups through proactive social prescribing targeting specific cohorts.
- **Develops agency and self-confidence** by recognising that people may need support in realising their goals.
- Supports the **creation of new models of multi-disciplinary teams** within primary and secondary care that works around a greater understanding of the patient.

What can social prescribing help with?

- Social prescribing can meet many different types of non-clinical needs, ranging from support and advice for individuals experiencing debt, unemployment, housing or mobility issues to tackling loneliness.
- It can be particularly useful for people who need help with:

- Non-clinical needs E.g. employment or housing
- One or more long-term conditions
- Mental health needs
- Loneliness or isolation
- Complex needs

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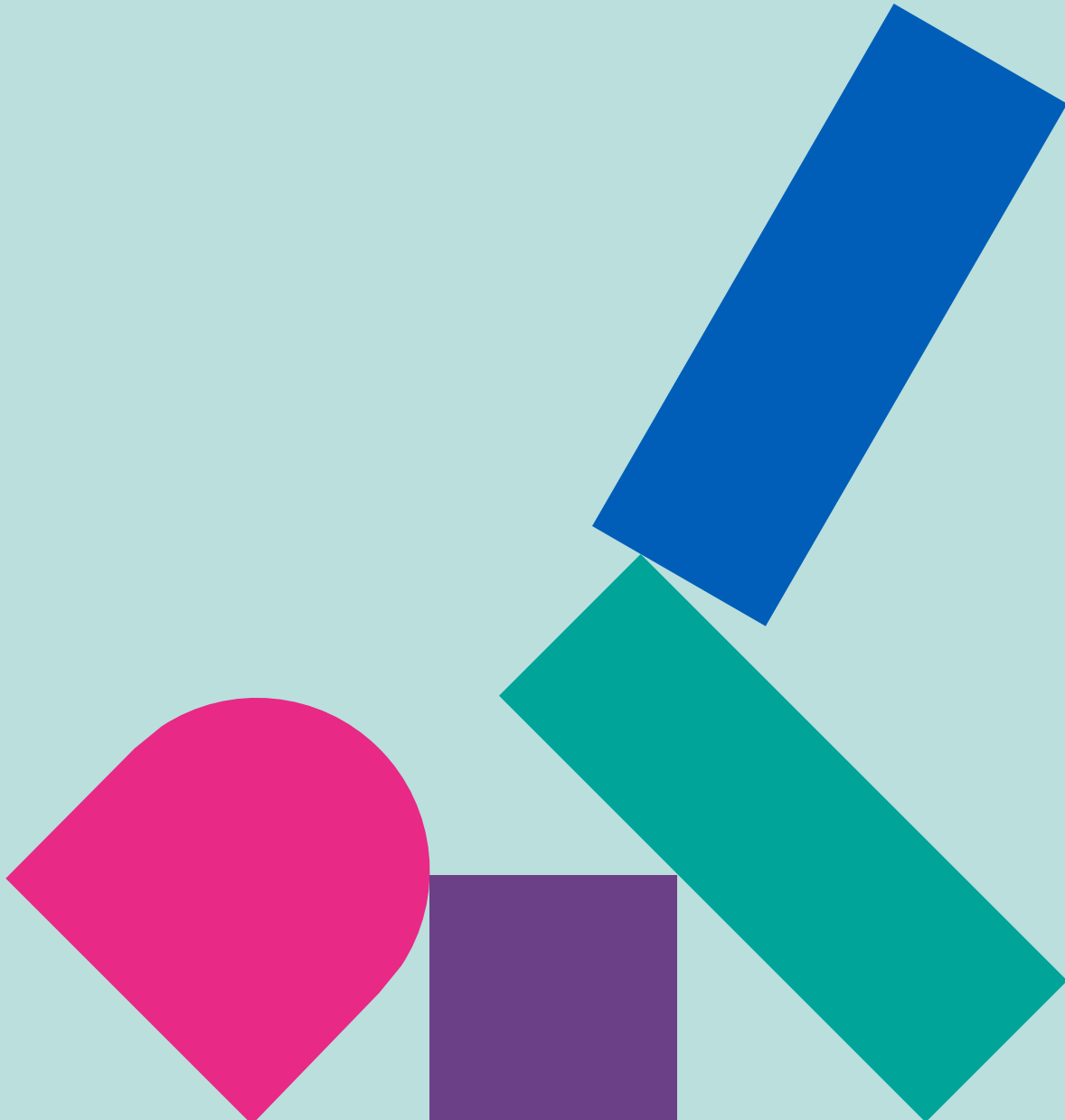
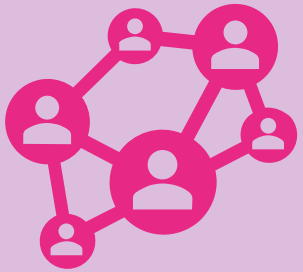
How does social prescribing support wider NHS priorities?



Early intervention:

Social prescribing can proactively support patients to avoid negative health outcomes by targeting at risk cohorts, signposting to appropriate support, and increasing trust in and access to the healthcare system to enable earlier diagnosis.



Population health:

Social prescribing improves integration of health and social care systems in the community and proactively targets groups facing higher levels of health inequalities thereby improving population health.

Personalised care:

Conversations are driven by what a patient wants and helps people to find the support they need, Taking a 'what matters to me' rather than 'a what is the matter with me' is an approach the whole NHS is working to adopt, social prescribing champions this.

Partnership working:

Social prescribing link workers build effective working relationships between health systems and VCSEs, LAs and a whole range of community organisations.

Complex needs:

Social prescribing link workers can help patients unpick the complex nature of all the issues impacting their health & wellbeing, where a GP would not have the time, ensuring patients get the help they really need.

Misplaced demand:

20% of GP appointments are driven by social need – link workers would be more appropriate to deal with this demand which would lead to cost savings in primary care

Health inequalities:

Social prescribing proportionately works with those with greatest health inequalities and helps address the social factors that influence people's health. This aligns with NHSE's Core20PLUS5 approach.

Workforce retention

Social prescribing helps to make the primary care model more fit for purpose, increasing capacity, reducing burnout and supporting retention of the workforce.

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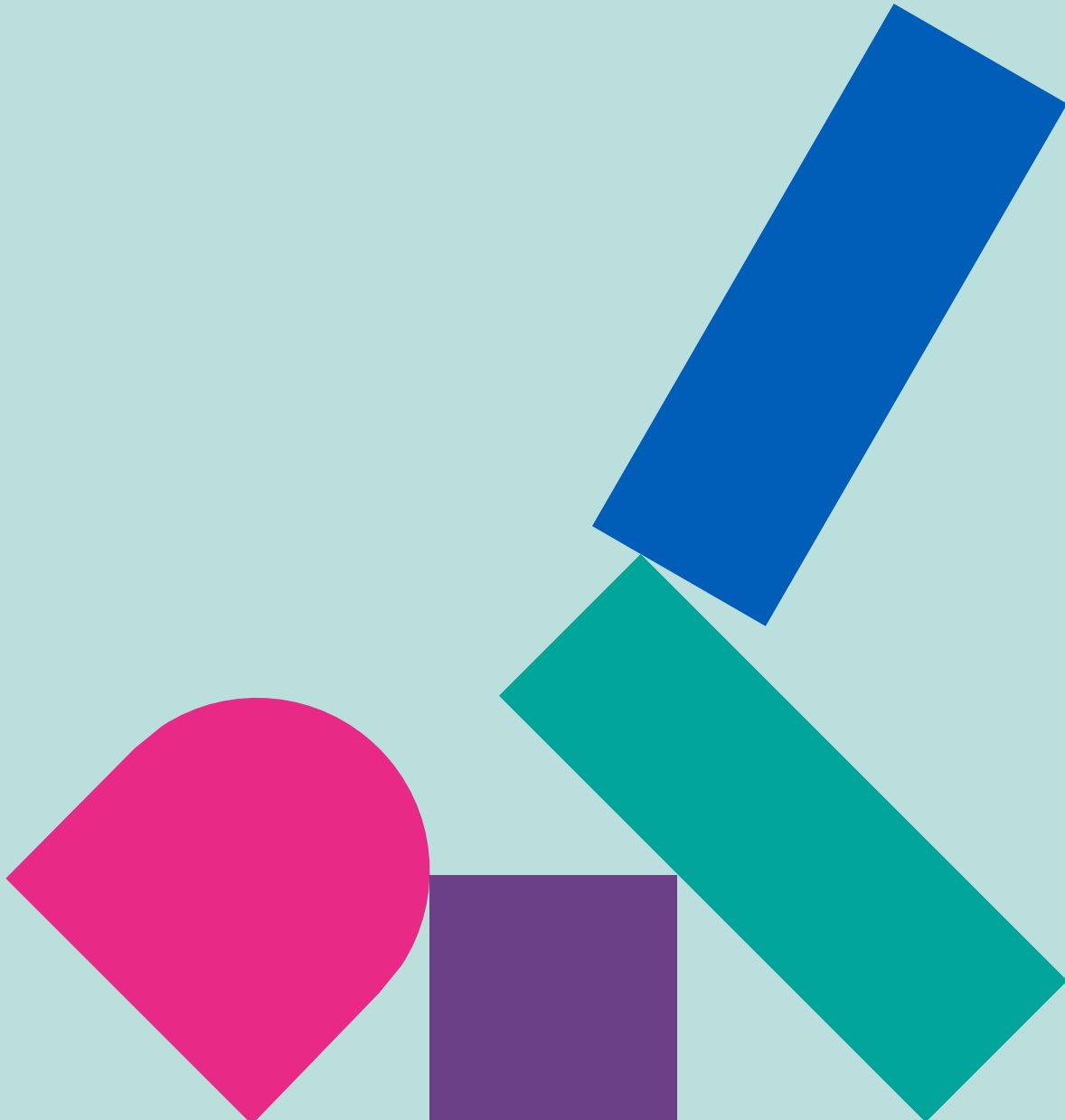
What are the impacts of social prescribing?



Key statistics

- A review of 16 studies found improvements in health and wellbeing, health-related behaviours, self-concepts, feelings, social contacts and day-to-day functioning post-social prescribing (1)
- There is also evidence for improvements in three categories of outcome measures: Physical and psychological wellbeing; Health behaviours and self-efficacy; and Health care resources end economic evaluation. (2)
- However, evidence quality is variable, and a range of methods are used, further research is required to understand how social prescribing can be most effective.
- Strong comprehensive evaluations, such as Ways to Wellness (3) have found that:
  - Social prescribing can improve patients' physical and mental health and wellbeing
  - Social prescribing can provide cost savings to the NHS
  - Social prescribing can encourage partnership working and integration

Reducing inequalities and improving social determinants

Social prescribing can help:

- improve access to NHS services
- support people with social welfare legal advice and housing issues
- reduce inequalities in outcomes/experience

Receiving social welfare legal advice has been shown to **reduce levels of anxiety and depression** and enable people to resume daily activities.

There is also evidence for it leading to **better physical health and access to health services.** Read more

Citizens Advice collaborated with Macmillan Cancer Support to deliver welfare benefits advice to cancer patients.

The scheme has helped over **39,000 people** with over 190,000 issues - **78% of these were related to welfare benefits.**

Some studies have found that those referred to receive advice through GP referral, would not have usually sought help.

This **demonstrates an important impact on access**, through the Social Prescribing route. **Read more**

Individual impact: wellbeing and life satisfaction

Social prescribing can help:

- improve patients' overall quality of life, physical and mental wellbeing
- improve clinician life satisfaction, relieve stress and share the burden

In Newcastle, over 4,500 patients had completed two or more measures of wellbeing at time of writing.

On average, these patients **improved 3.6 points (12.4%)** across the eight domains of wellbeing.

"We have seen the **health and wellbeing of clinicians themselves improve** as social prescribing has provided real solutions for patients with complex social needs"

Dr Mohan Sekeram

A two-year evaluation of the Young People Social Prescribing (YPSP) pilot

The report found that social prescribing **improved the personal and mental wellbeing for the CYP cohort** and **levels of loneliness declined**, despite the Pandemic.

Individual impact: health and clinical outcomes

Social prescribing can help:

- support with specific clinical areas e.g. obesity/diabetes
- help patients manage long term health conditions

Preliminary findings on social prescription to improve the health outcomes for those with Type 2 Diabetes

A **statistically significant average reduction** in **blood sugar level, waist circumference, weight and BMI** were detected from 3 - 6 months onwards.

In Rotherham, 81% patients with Long Term Conditions experienced **improvements in their mental health, life satisfaction or ability to manage symptoms**

Well London, a community programme promoting healthy eating, physical activity and mental wellbeing in deprived neighbourhoods.

A random sample of 4000 adults were surveyed before and after the intervention across sites and found that **they ate more healthily**

Community impact

Social prescribing can help:

- harness the power of community-based assets
- build resilience and strengthen communities

Social prescribers fully understand the assets of the local community, and also support it and feed into the mapping process of activity.

Social prescribing link workers in Bethnal Green coordinate an '**E2 Breakfast**' which brings together community-based orgs from across the local area to build partnerships.

VCFSE organisations have supported one another to **harness community assets.**

The **Community Chest project** has funded VCFSE organisations across North East London to deliver social prescribing activities for those with unmet needs.

Decision making has been co-owned by stakeholders from across the local system, such as SPLWs & community reps

System impact: cross-sector working and integration

Social prescribing can help:

- strengthen partnerships between VCFSE organisations and the NHS
- support efficiencies through integrated working

Social prescribing **bridges the gap between primary health care and the voluntary sector**. It not only provides a means to alternative support but also acts as a **mechanism to strengthen community–professional partnerships.**

Paper: Can social prescribing be the missing link?

Social prescribers in Southwark have **proactively worked** with the local adult social care team to streamline the referrals process.

By asking additional questions to capture information needed by the adult social care services, link workers have helped cut **waiting times for services by 4-6 weeks.**

Social prescribing can redefine relationships and commissioning structures between health, local authority and the voluntary sector.

The Community Chest Programme found that participatory VCFSE-led models to grant distribution foster greater collaboration and stronger relationships. Evaluation paper

System impact: reducing the demand on healthcare services

Social prescribing can help:

- reduce the demand on GP consultations
- reduce the demand on secondary care especially A&E attendances

The University of Westminster found a **28% reduction in demand for GP services and a 24% fall in A&E attendances** for patients referred to a social prescribing scheme.

A social prescribing site in Shropshire found that GP consultations among participants were **down 40 per cent** compared to a control group.

"The Social Prescriber role has been immensely helpful to the practice as a whole. **GPs are able to give more time to clinical discussions…**as link workers are able to provide more non-clinical support than would have been in a 10 min consultation"

GP feedback

In Rotherham, cost of inpatient spells and A&E attendances was reduced for patients with Long Term Conditions who accessed Social Prescribing.

Social prescribing schemes in West Kent found **significantly reduced demand** on NHS acute care, A&E attendances were reduced by up to **23%.**

System impact: economic impact

When targeted appropriately, social prescribing has the potential to:

- increase cost savings to the NHS
- increase social return on investment

Social prescribing for frequent attenders in primary care: An economic analysis

For all of the patients who participated in the intervention there was a **direct cost saving of £78.37 per participant or £6,113** for the total cohort over the 5 months of the intervention.

Evidence suggests that the social return on investment for SP activity can be between **£3-5 for every £1** invested.

Ways to Wellness is showing an annual saving to the Newcastle health system of **£1.3m a year**.

The programme has worked with 9,000 patients with long term health conditions for up to 24 months to achieve long term health condition management and of their social determinants of health.

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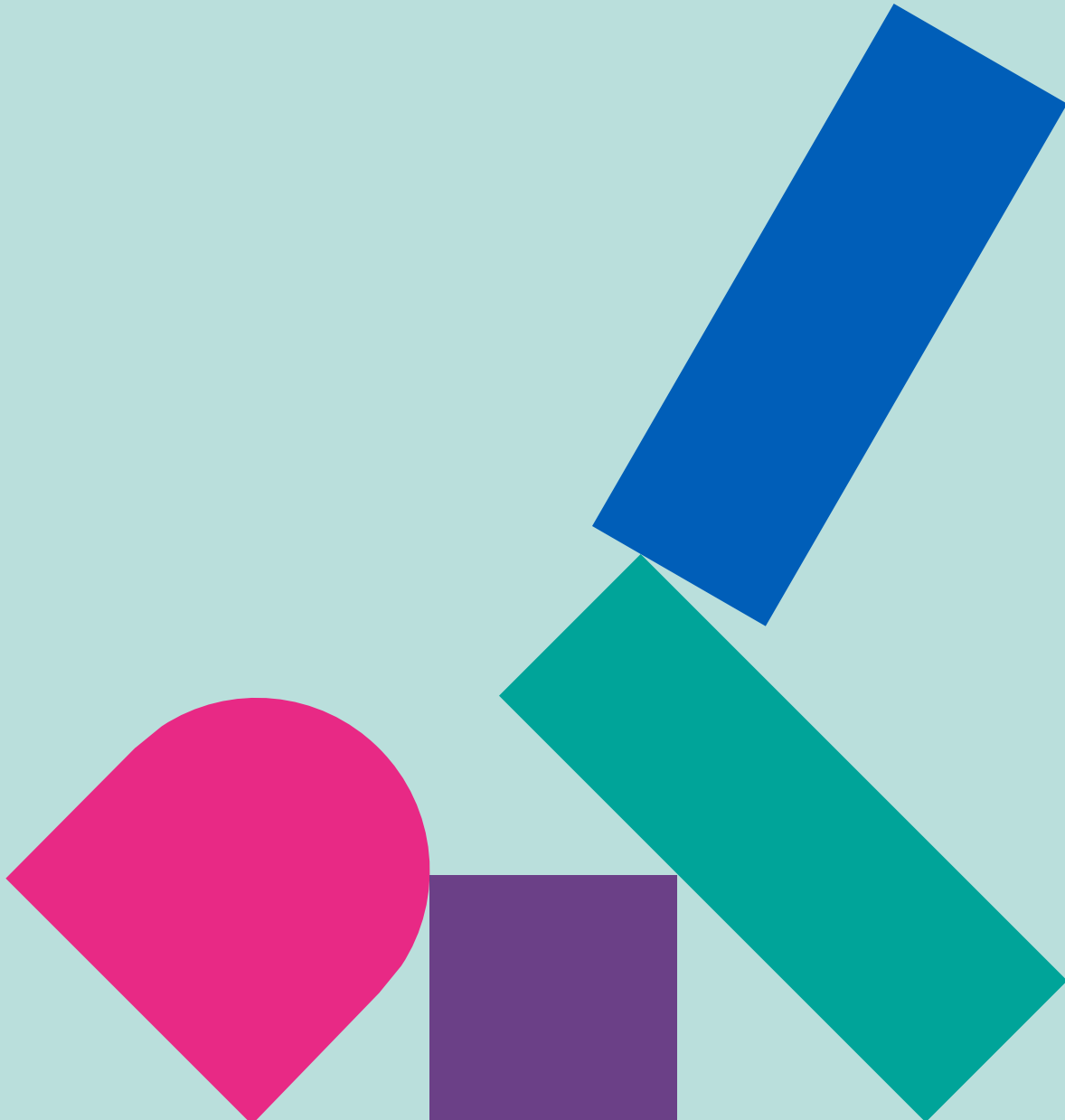
How does social prescribing work in practice?



What are social prescribers, health and wellbeing coaches and care coordinators?

- They support patients with the social determinants of health and non- clinical needs, this addresses the causes of the causes of ill health, and supports the prevention agenda
- They champion personalised care, supporting the entire system to take a 'What matters to me' approach
- Their goal is tackling health inequalities, improving access, experience and outcomes for patients, by working with specific groups
- They work closely with other services in and outside of the NHS, including the voluntary sector and local authority, they can help understand unmet need and encourage partnership working
- They are a part of a scheme in primary care to ensure GP surgeries have the right roles to deliver the support that needed from their population

Read more about the individual skills and abilities of each role here, including necessary training

Health and Wellbeing Coach One-pager

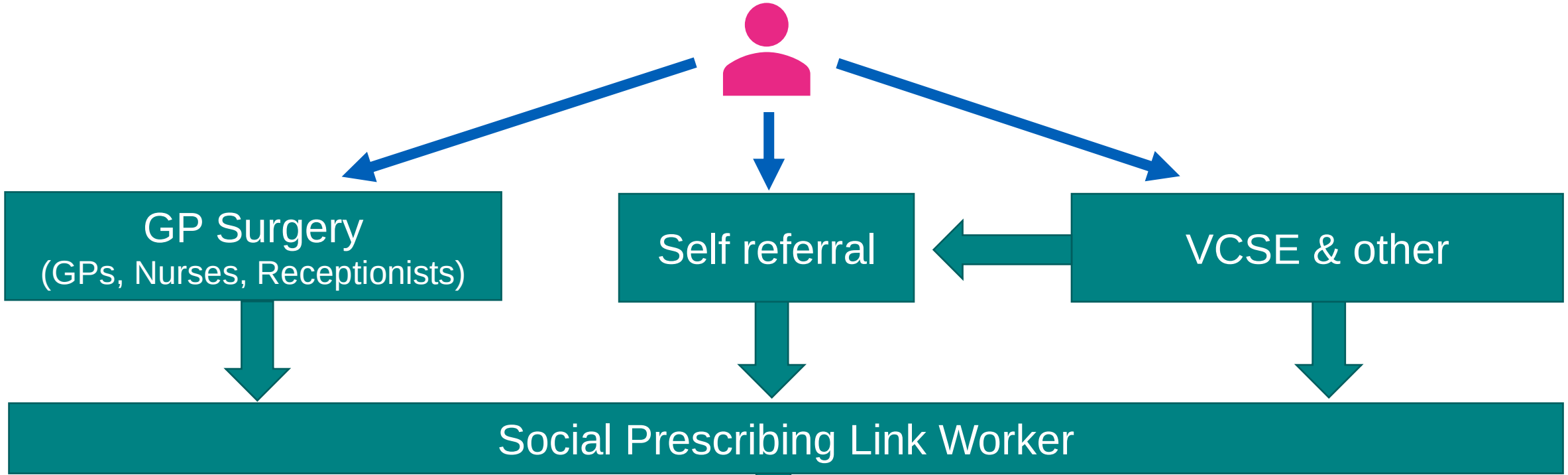
Social Prescribing Link Worker One-pager

Care Coordinator One-pager

How are the three personalised care roles employed?

- Personalised care roles can be employed directly by GP practices, Primary care networks (PCNs) or Local Authorities.
- A person may work for one GP practice, several GP practices or across a PCN or larger geographical footprint.
- They can be funded from various places, traditionally they have been employed through the Additional Roles Reimbursement Scheme (ARRS), which is a bursary for salaries available to PCNs. However, ARRS funding is often used to subcontract VCSE organisations to employ the roles.
- Some of the roles are funded through the Local Authority or from VCSEs directly.

Accessing social prescribing



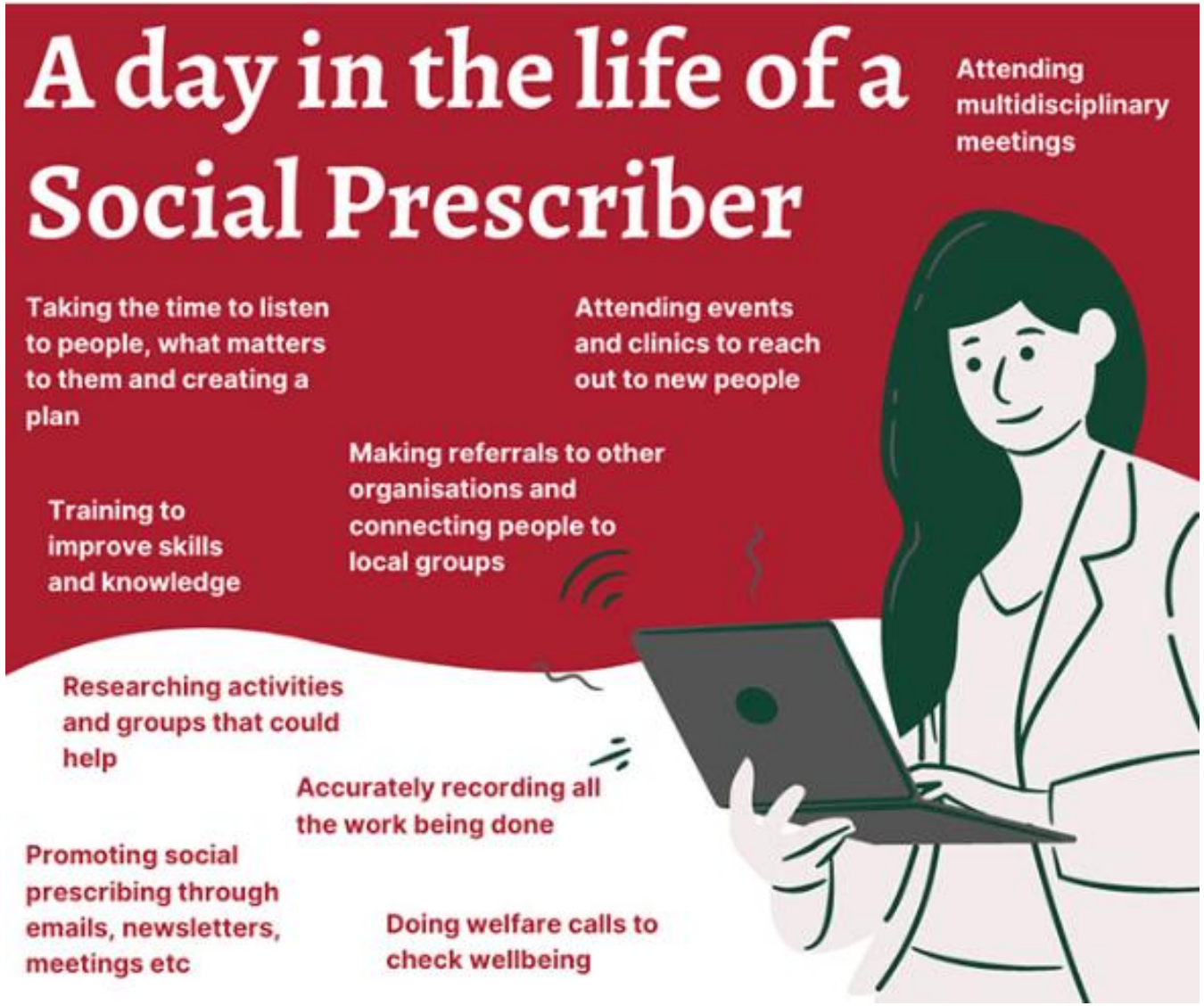
- walking group
- art classes
- creative writing
- community centres offer
- volunteering opportunities
- free programmes for new parents
- housing support
- employability programme
- community building activities
- gardening
- free counselling
- wellbeing programmes
- ESOL classes
- food bank vouchers
- asylum seekers and refugees' support
- free legal support
- IT classes religious offer
- grants
- training & education
- sport and leisure activities
- referrals to VCSE & other

Day in the life of a link worker

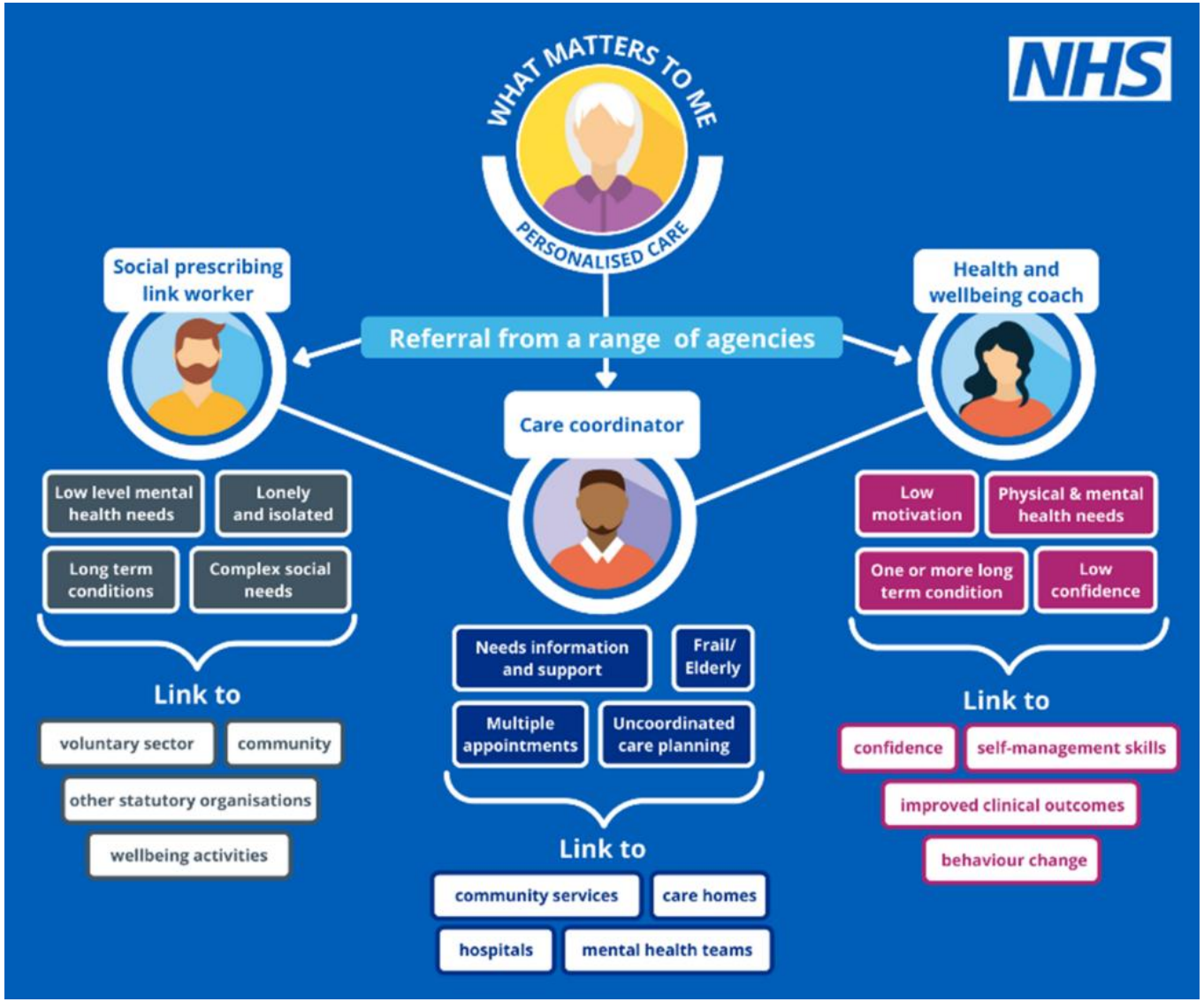
- Social prescribing link workers can help to reduce health inequalities by supporting people to unpick complex issues affecting their wellbeing.
- They enable people to have more control over their lives, develop skills and give their time to others, through involvement in community groups.

Role expectations:

- Each SPLW can support **up to 250 patients per year**
- Approx. 1 hour long initial assessment focusing on what matters to the patient
- 30 min to 1 hour long follow up meetings (usually up to 6 appointments)
- Evaluation: ONS4 questionnaire during the first and the last appointment.



The three personalised care roles



What the three personalised care roles and how they differ

Social Prescribing Link Workers	Health & Wellbeing Coaches	Care Coordinators
Address wider issues (social determinants of health) that impact people's health & wellbeing. **Take time with patient**, using personalised care support planning, motivational interviewing & health coaching approaches, **over several sessions to identify what matters to the person and connect them with:** •practical, social and emotional support within their community •activities that promote wellbeing e.g. arts, sports, natural environment. **Act as a bridge between primary care and the community** - Identify and nurture community assets by working with partners such as VCSE, LA and NHS. **Tend to support people** experiencing loneliness, complex social needs, mental health needs or multiple LTCs.	Work with patients to help them take **proactive steps** to improve the way they manage their **physical and mental health conditions**: •**Goal setting** - Guide and support people with LTCs to set self-identified health and wellbeing goals •**Behaviour change** - Use specialist coaching and behaviour change techniques, usually over a number of sessions •**Help patients to develop their knowledge, skills and confidence** in managing their own health to improve their quality of life **Tend to support** with physical and mental health conditions, and with one or more LTCs such as type 2 diabetes, COPD, or those at risk of developing a LTC.	**Work within the MDT, acting as a point of contact connecting** patients, their clinicians and other teams involved in their care. **Can support proactive and reactive identification of patients** who would benefit from different schemes including social prescribing. **Take time with patient, using personalised care support planning** to identify patient needs and offer to coordinate various aspects of care. **Manage their own caseload of patients** offering: •**Continuity of care** – a point of contact enabling a clearer vision of patient's care for the patient, services and professionals **Allyship & advocacy** - conversations to support understanding health conditions and preparation for appointments and accessing support. **Tend to support** those with long term conditions, vulnerable patients or those with complex needs.

Supporting the three personalised care roles

- The workforce development frameworks (WDFs) focuses on the core functions, skills and competencies of the three personalised care roles, alongside the professional support, training and development required to enable the three roles to practice safely, work effectively, and support improved outcomes for people and communities.
- TPHC have summarised the key points and resources from the full 22-page WDFs. Click on the images below to view the summary document for each of the three roles:

Access full WDF here

Access full WDF here

Access full WDF here

Frequently asked questions… from clinicians

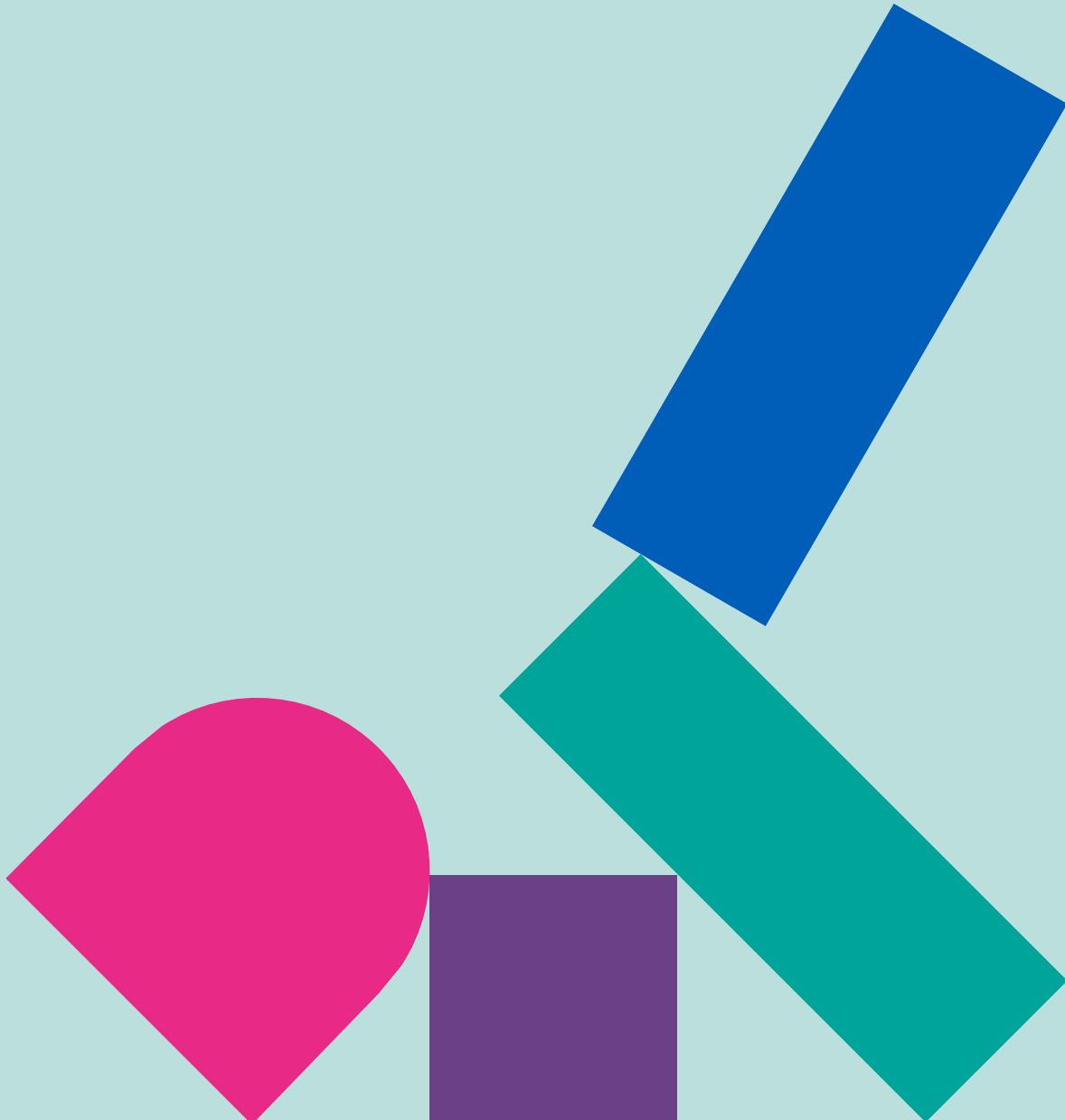
- **What are some top tips for recruiting Social Prescribing Link workers?**
  - Understand what Social Prescribing Link Workers exist already in the borough and who employs them
  - Think about where in the community you can advertise to attract a candidate with the right skills to engage local communities
  - There is a template JD and advert in the SPLW Workforce Development Framework
- **What is the yearly caseload for a social prescribing link worker and the other roles?**
  - The recommended caseload for a full-time Social Prescribing Link Worker is 200-250 annually. This means 200-250 different people seen by one full-time SPLW within a year. More information is in the Ways of Working section of the SPLW Workforce Development Framework.
  - Care Coordinators are a patient facing role, that holds a case load. This number will vary hugely depending on what kind of patients they work with and other aspects of their role. More information is in the Care Coordinator Workforce Development Framework.
  - Health and Wellbeing Coaches hold a case load of patients, but the number will vary on how many sessions are being offered and the intensity of supported needed. More information is in the Health and Wellbeing Coach Workforce Development Framework.
- **What support do the roles need?**
  - Each of the roles require clinical supervision, for HWBCs this must be from a qualified coach. Social prescribing link workers also require managerial supervision.
  - Each of the roles require regular line management, and benefit from local peer support. More detail is outlined in each of the Workforce Development Frameworks.
- **Where should the personalised care roles be based?**
  - Ideally the roles would be able to work together in a space, whilst still being connected to their GP surgeries. Where Social Prescribing Link Workers are based in community settings, they are better able to link into community assets, voluntary sector and engage local people

Frequently asked questions… from personalised care roles

- **What professional development opportunities are available for the personalised care roles?**
  - There are a number of programmes and resources which aim to enable Social Prescribing Link Workers to invest time and effort in continuous professional development. Below are some examples that we collated so far:
    - ❑ Our monthly London SP Newsletter - previous issues are available here
    - ❑ Social Prescribing – Learning for Link Workers programme (12 e-learning modules)
    - ❑ Peer Learning sessions recordings - available here
- **Where can I find information related to services that personalised care roles can refer people onto?**
  - Approach your local CVS
  - Check what resources your local authority have collated
  - Connect with other SPLWs and social prescribers in your borough
- **What opportunities are out there for professional development and career progression?**
  - Developing social prescribing in your local context allows you to apply and develop a wide range of skills that would allow a natural transition to more senior roles within the broader context of social prescribing.
  - Career progression ideas include becoming a SPLW manager, commissioning and community development, training and development, or other roles in health.

Transformation Partners in Health and Care

How is social prescribing embedded across the system?



Social Prescribing within Secondary Care

Social prescribing link workers or similar roles based in secondary care can enable proactive targeting of 'at risk' groups with inequality in access, experience or outcomes to reduce health inequalities.

This helps to improve **population health and prevention**, for example:

Personalised care roles like Social Prescribing Link Workers, Health Coaches or Care Coordinators can support **pre-diabetic patients** to live healthier lifestyles through signposting to or improving access to information. – *See slide 42 for case study*

A social prescribing link worker based in hospital settings can provide **holistic support to specific cohorts of patients**, such as children & young people with sickle cell anaemia or thalassemia – *see slide 52 for a video showcasing CYP SP at Royal London*

Wellbeing coaches can work with the local community to provide **community-based alternatives** to patients attending A&E & Urgent & Emergency Care (UEC) services to reduce frequency of attendances – *see slide 45 for case study*

Social prescribing within secondary care – Pre-Diabetes case study

As part of the Social Prescribing Innovators Programme, Walthamstow West Primary Care Network in collaboration with Blossom CIC and NHS Diabetes Prevention Group, set up a Diabetes Prevention Group in a community setting with language and culturally adapted support.

- Patients were **proactively** contacted by a Social Prescribing Link Worker in the PCN to attend the sessions.
- **100%** of those attended were provided with additional support including access to a dietician and physiotherapy, weight management, mental health and Social Prescribing support.
- **100%** of those attended felt more supported, motivated and knowledgeable about making changes in their lifestyle to support **Diabetes Prevention**.

Read more about the project and impacts here.

Social prescribing for High Intensity Users (HIU)

- Urgent & Emergency Care is a key priority area mentioned within the **2023/24 NHS priorities and operational planning guidance**

- People from the **most deprived areas and most impacted by health inequalities** are more likely to be in poor health & **most likely to attend A&E more frequently**

Nationally HIUs account for:

<1%
of the population

>16%
of HIU attendances in emergency departments (ED)

29%
of ambulance journeys

26%
of hospital admissions

£2.6 billion
to the NHS per year

British Red Cross: Nowhere else to turn

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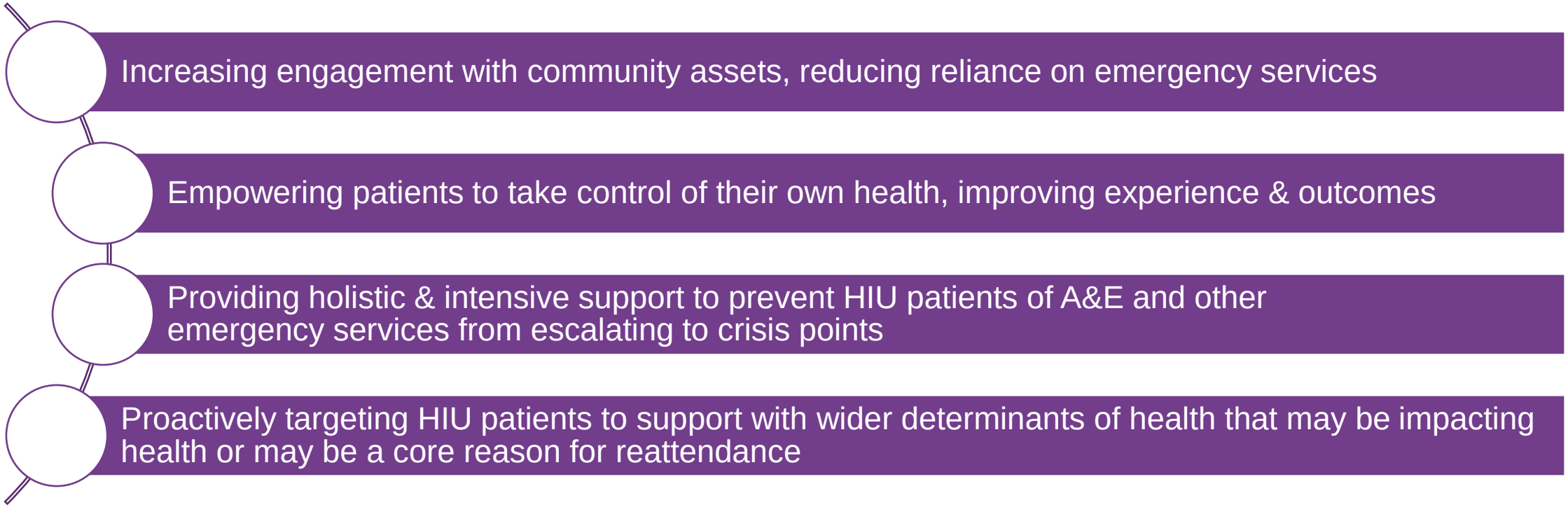
Social prescribing can **reduce pressures on hospitals and emergency services** through:



Social prescribing within secondary care – HIU case studies

Two projects working in conjunction in NWL aimed to reduce patient clinical contacts by providing holistic support to HIU patients to reduce need for and pressures on NHS services.

NHS Biborough Place Based Partnership in collaboration with Westminster resident & community organisations.

What: A 12 month pilot project working with **Community Champions** and **Wellbeing Coaches** in North Westminster.

Aim: To provide **community-based alternatives** to patients attending A&E & UEC services to **reduce frequency of attendances** in the Biborough (Royal Borough of Kensington & Chelsea and North Westminster).

Read more here.

NWL ICS in collaboration with resident & community groups in Royal Borough of Kensington & Chelsea (RBKC).

What: A project to mirror the similar piece of work in North Westminster, instead using Health Navigator Clinical Coaches working with patients living with long term conditions and frailty who had a history of frequent visits to GPs and primary care services.

Aim: To reduce HIU patient risk of hospitalisations in RBKC.

Impact: 41% reduction in clinical contacts by patients receiving the service

Read more here

Social prescribing within secondary care – HIU case study

SWL Innovation Fund - **£4.9 million** made available to local organisations to bid and awarded funding to **25 projects**:

- **Help is at hand scheme** – A skilled parent and carer support worker providing winter crisis support and advice to reduce GP and ED contacts.
- **Supporting High Intensity Use (HIU) in Merton and Wandsworth** – Hosted by Wandsworth Enable & Merton Connected involving two HIU leads reducing unnecessary primary care appointments by identifying, supporting, and signposting to more appropriate services.

South West London Integrated Care System

Social prescribing within mental health services

People living in London are more likely to suffer from poor mental health than someone living outside the capital [Centre for London 2019].

1 in 6 (17%)

of people over the age of 16 in UK were thought to have a common mental health problem in 2014 and this has dramatically increased since the pandemic

[NASP Social Prescribing and Mental Health Evidence]

40%

of all GP appointments are about mental health

[Mind]

43.4%

of adults in the UK report having had a diagnosable health problem at some point in their life

2.8 million

people in the UK were in contact with NHS-funded secondary mental health, learning disability and autism services in 2020/21

[Mental Health Foundation (2022)]

Social Prescribing facilitates non-medical referrals to community support, including befriending services, community activities, financial/benefits advice, which help to alleviate loneliness, stress, or depression, and reduces demand on healthcare services.

Social prescribing within secondary care – mental health case study

SWL Health Inequalities Fund - **£4.3 million:**

- £1.6 million invested in **system wide health inequalities programme**
- £2.7 million available for **boroughs/places for local** projects – 55 Health Inequalities projects for local and system wide delivery

- **Social Prescribing pilot for people with learning disability in Merton –** Morden PCN rolling out social prescribing for people with a learning disability, creating connections between the Primary Care Network and the learning disabilities community sector.

South West London Integrated Care System

Social prescribing within secondary care – mental health case study

Mental Health Link Workers – work in various services within West London NHS Trust, which provides mental health, community, and social care for people in both hospital and the community. Link Workers also sit within the Mental Health Integrated Network Teams, the providers of secondary mental health care within the London Boroughs of Ealing, Hounslow, and Hammersmith & Fulham.

Community Mental Health Link Workers in Mental Health Integrated Network Teams (MINT):

- Support and empower individuals to engage in meaningful activity within their local community.
- Have strong links with primary care, other parts of the Mental Health service, statutory services, and key community partner organisations.
- Carry out Dialog Based Assessments with new clients and work collaboratively to formulate a plan based on identified needs/priorities of the individual.
- Offer between 2 and 6 sessions working towards identified/agreed SMART goals based on current support needs and wider social challenges, areas of strength/success, interests/hobbies, and what is important to each individual.
- Can inform/advise on what's on offer and support individuals to refer and connect with/access community services and groups.
- 16 to 25 Link Workers – work specifically with individuals aged 18 to 25 within MINT, as well as support CAMHS transitions for 16 to 18 y/o where need is identified.

Other aspects of the role:

- Run or co-facilitate various groups within MINT, as well as with community partners where possible.
- Attend community events to meet residents, carers, and professionals within the community in order to share knowledge on what is available to support an individual with their mental health recovery journey.
- Keep an up to date database of resources and share this information with the teams
- Wide offer of training and learning opportunities to support in upskilling and career progression

NHS West London NHS Trust

Social prescribing within cancer

A quarter of a million

people are currently living with cancer in London

- Often the medical team are not picking up cancer patient's wider needs as it takes time to understand and signpost to support.
- Many patients lack understanding of their cancer, treatment and side effects, perhaps due to language barriers of use of clinical jargon, and are unaware of available support.

Embedding social prescribing within cancer clinical pathways presents opportunities to:

- Provide holistic, wraparound support to the patient throughout their cancer journey, ensuring fluid communication between healthcare professionals across all cancer pathways
- Free up capacity for clinicians and nurses through attending to social and emotional needs of the patient often associated with or exacerbated by cancer diagnosis and treatment
- Improve outcomes for cancer patients through enabling access to support around physical activity, rehab & lifestyle changes to help reduce side effects and factors that increase risk or worsen outcomes

Social prescribing within secondary care – cancer case studies

Two projects working in collaboration with Macmillan Cancer Support to improve quality of life and patient experiences for those living with and beyond cancer.

Enable, a non-for-profit organisation, in partnership with Macmillan Cancer Support.

What: A Macmillan Community Cancer Link Worker supporting cancer patients with wider social needs in Wandsworth.

Aim: To improve quality of life as well as improve the awareness of, access to, and uptake of services available for those living with and beyond cancer.

Impact:

- 350 referrals with 290 patients supported
- Increases in life satisfaction, happiness and decreases in anxiety

Read more here.

Macmillan in collaboration with Tower Hamlets.

What: An 18 month pilot using an Macmillan Care Navigator embedded within the Multi-Disciplinary Team enhancing cancer patients experience in the borough.

Aim: To improve cancer patient experience by improving information sharing & communication between the multidisciplinary team supporting cancer patients.

Read more here

CYP social prescribing

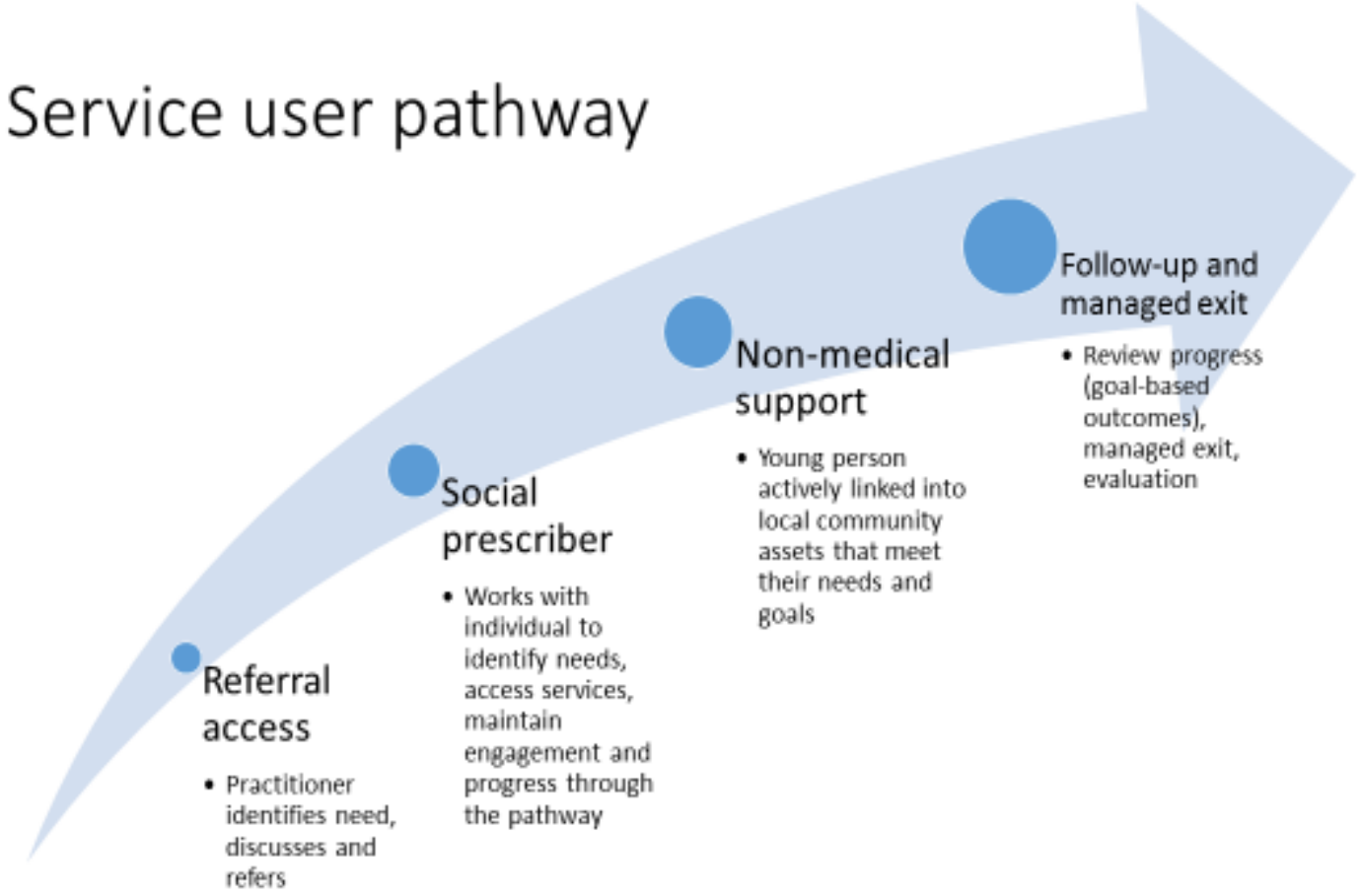
- There is a gap for babies, children and young people that needs to be addressed more now than ever, recognising that 40% of activity in primary care relates to them.
- Social prescribing for CYP is an emerging area nationally and there is growing energy and commitment to develop approaches across London.
- It provides a mechanism for connecting children and young people with community-based assets and activities to enhance health and wellbeing, prevent exacerbation of current issues and conditions, and ultimately help tackle health inequalities.

Video showcasing CYP SP at Royal London

Video showcasing CYP SP at the Well Centre

CYP social prescribing – Isledon service model

- For young people aged 11-25 who live, attend education, work OR have a GP in Islington, who have mild to moderate well-being needs.
- Public health commissioned Isledon Arts CIC, a group of companies who manage three youth hubs (Platform, Lift and Rosebowl), to deliver the social prescribing pilot service.
- Takes a proactive approach, by offering an early non-clinical intervention pathway for young people who are showing very early risk factors for longer-term poor mental health.



Emerging areas

Social welfare legal advice:

Over the past year, social prescribing schemes across London have reported a substantial increase in the numbers of clients needing advice around housing, welfare benefits and debt issues.

TPHC, in collaboration with the GLA and Bromley by Bow Centre, have delivered a programme aiming to support the collaboration between SWLA and social prescribing.

There are currently around 100 link workers who have specialised in providing SWLA support.
Read the report on SP and SWLA

Older people:

Older people's health and care needs are changing, as increasing numbers live with the combined effects of chronic disease or disability, social isolation, loneliness and poor mental health.

In Ireland, social prescribing emerged as a community led approach focused on supporting older people. Several types of professionals can refer people to a social prescribing link worker, including mental health professionals, community orgs, doctors, self-referral and more.
Read more here.

Armed Forces Community:

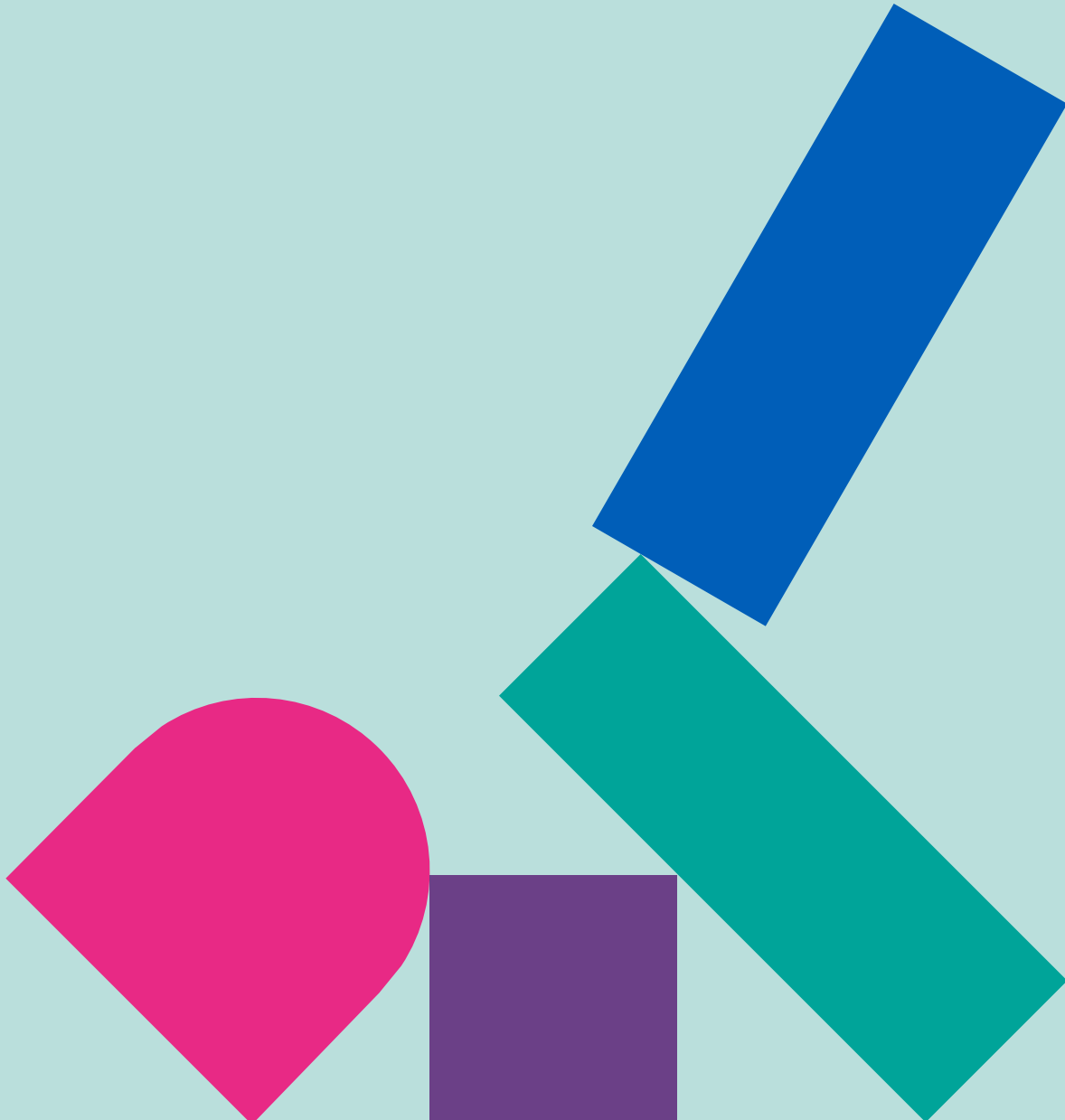
People who are currently or have previously served in the armed forces can

A new e-learning module to support the health of the armed forces community (AFC) has been added to Health Education England e-learning for social prescribing.

Find the e-learning module here.

Transformation Partners in Health and Care

Additional resources



Useful resources

- Fuller report - the final report of the stocktake undertaken by Dr Claire Fuller looking at what is working well, why it's working well and how we can accelerate the implementation of integrated primary care across systems.
- NASP Evidence Reviews – see the latest evidence for social prescribing here
- All key resources made by and used by TPHC Community Led Prevention Team can be found on our resource pages on our website