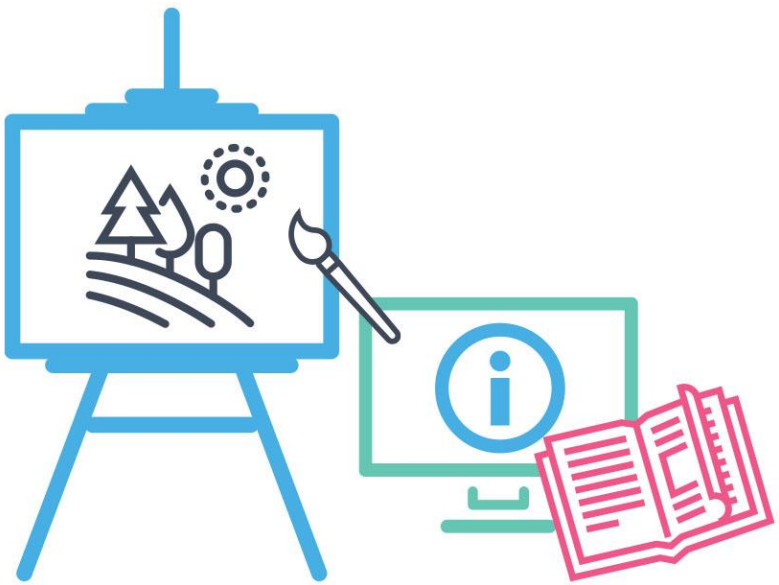
National Academy for Social Prescribing

How to use social prescribing to support Population Health Management

A guide for Primary Care Networks



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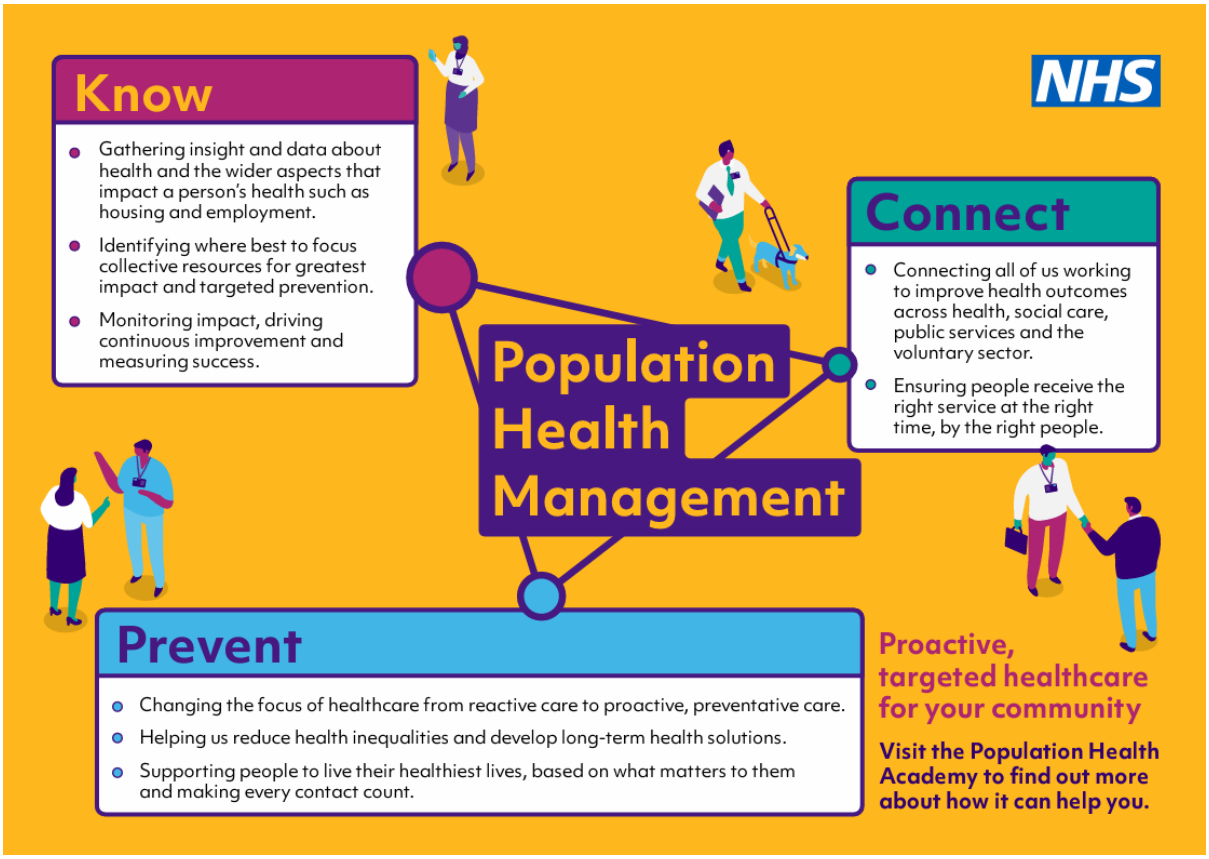
Population Health Management is an evidence-based approach to reducing health inequalities

"Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them." (NHS England).

Population Health Management is a strategic approach to improving population health and reducing health inequalities by **targeting health and care to the places it will make the biggest difference**.

It involves understanding your population's circumstances and needs, connecting together different aspects of care, and moving toward proactive, personalised and preventative interventions.



(NHS England Population Health Academy)

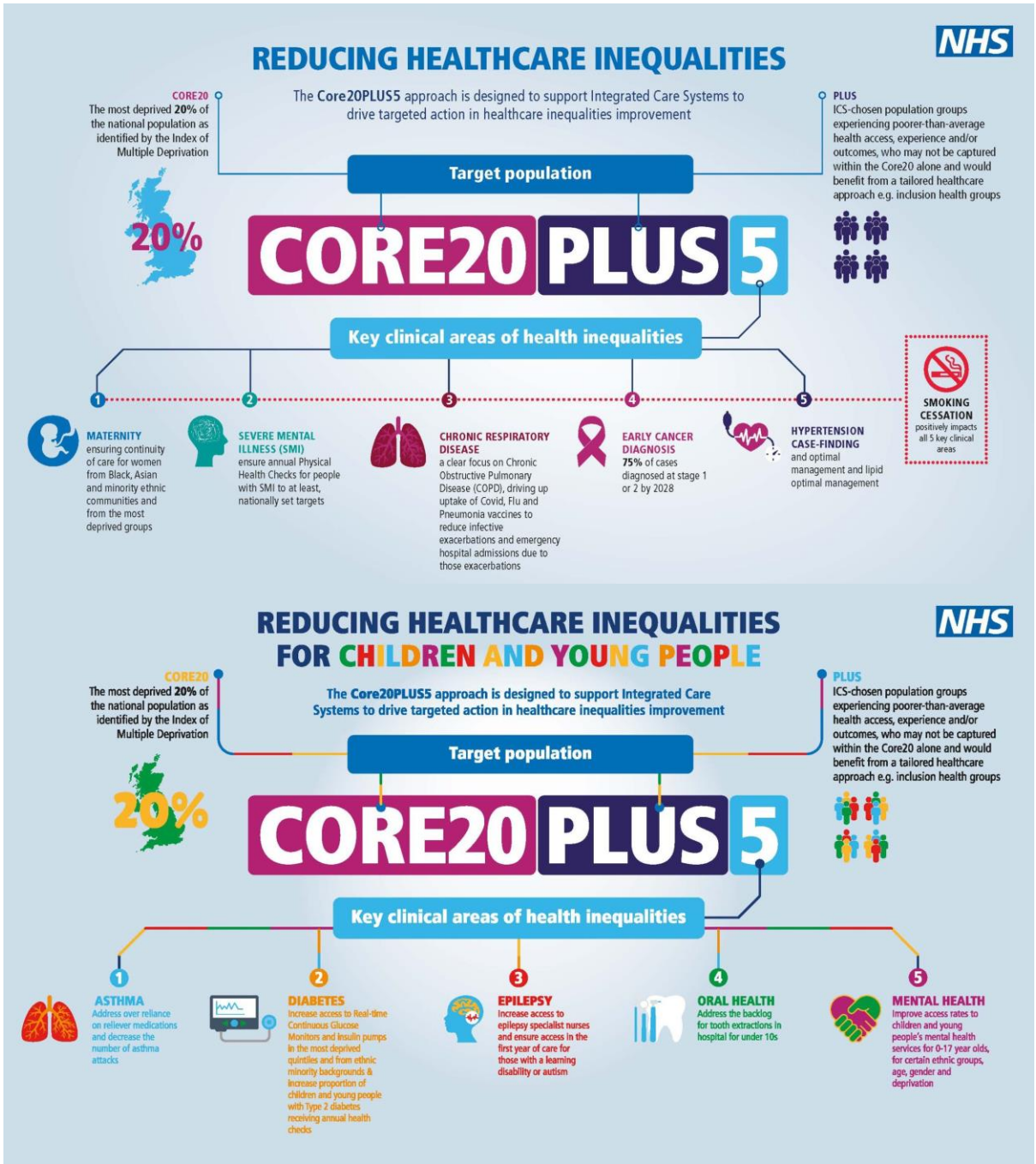
Inequalities in healthcare

Inequalities in access to, experience of and outcomes of healthcare are a sub-set of wider health inequalities. Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level.

“Core20” refers to the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

The “PLUS” population groups are additional groups that suffer from healthcare inequalities and would benefit from a tailored approach; for example, people in inclusion health groups, ethnic minority communities and groups who share protected characteristics as defined by Equality Act 2010, including disabled people. These groups should be identified through local data.

The “5” refers to five clinical areas that need improvement which have been chosen as priorities for adults and for children and young people.



(NHS England)

Social prescribing can be an effective part of a Population Health Management approach

Social prescribing is "a means for trusted individuals in clinical and community settings to identify that a person has non-medical, **health-related social needs**, and to subsequently **connect them to non-clinical support and services within the community** by co-producing a social prescription: a non-medical prescription to improve health and wellbeing, and to strengthen community connections" (global conceptual definition, 2023).[1]

Social prescribing can help you to:

- **Know** your communities and their issues. Social prescribing is rooted in communities and is a valuable way to gather insights about the range of challenges they are facing and create realistic solutions together.
- **Connect** people to the help and support they need, from across sectors, to address the wider determinants of health.
- **Prevent** health issues from recurring or deteriorating by supporting people to live healthy lives based on what matters to them, and raising awareness of health prevention offers.

Social prescribing can contribute both to your data and to your community intelligence, providing actionable insights to drive improvement.

The Network Contract Direct Enhanced Service 2023/24 (DES) requires all PCNs to offer a social prescribing service to their patients. However, in many areas there are other commissioned services providing social prescribing support, and PCN-based link workers should work closely with them.

The DES also requires a PCN to "review its targeted programme to proactively offer and improve access to social prescribing to an identified cohort with unmet needs." This should be kept under review and extended further "based on an assessment of the population needs and PCN capacity."

[1] Muhl C, Mulligan K, Bayoumi I, et al (2023) 'Establishing internationally accepted conceptual and operational definitions of social prescribing through expert consensus: a Delphi study', *BMJ Open*;13:e070184. doi: 10.1136/bmjopen-2022-070184.

‘Top tips’ and questions for Primary Care Networks to consider

Understand your populations and their needs

Define the groups who you want to proactively offer social prescribing to: this might not be the patients you see most frequently.

- Use the Core20PLUS5 approach and tools to choose the groups you want to target with your proactive social prescribing offer. Your Integrated Care Board’s population health management team will be able to advise on ways to explore your data.
- Analyse the patterns of referrals to social prescribing within your network. Which groups of patients are getting most and least referrals? Which are taking up the referrals and engaging well with link workers and which are not? Which are engaging in the advice and activities they are prescribed to, and which are not?
- Think about who is missing from your data too. Compare the data that you hold about your patients to what you can find out about the wider population. Which groups are not registered with, or make very low use of, primary care? What about transient groups that can be missed from population data altogether, like seasonal migrants or people with insecure housing? What do you know about their needs, and how could social prescribing help?
- The PCN DES specifies that PCNs must “work in partnership with commissioners, social prescribing schemes, Local Authorities and voluntary sector leaders to create a shared plan for social prescribing.” Are there any other social prescribing schemes that support your local population, for example schemes funded by charitable organisations or commissioned by your local NHS or local authority? How can you best work together to offer a complete and effective service to all parts of your population?
- The DES also states that your proactive social prescribing offer should “take into account the views of people with lived experience.” Does your Patient Participation Group include people who have had experience of social prescribing? How can you gain a representative selection of views, including from people who disengaged following referral? How can you raise awareness of social prescribing among the people who will benefit from it most? You will already have relationships with Core20PLUS5 community connectors and other community leaders: ask them to gather views on social prescribing on your behalf.
- Your social prescribing link workers and activity providers will have rich information about the health and wellbeing needs of your communities, often detecting issues before they have emerged in the data. Involve them in designing and co-creating effective responses to those needs and draw on their insights in your conversations with your place-based commissioners.

See our case study about how social prescribing link workers in Slough researched their communities’ needs.

Develop and value your link workers

Think about how you can get the best out of your social prescribing link workers.

- Link workers can be relatively junior in the practice team or neighbourhood team, but they are uniquely positioned to feed back information from your communities about the challenges they are facing, barriers to accessing healthcare, and so on. Make sure all members of the team understand and value this part of the role. Involve the whole multidisciplinary team in discussions about how you will develop and deploy your link workers.
- To improve your reach into communities, draw your workforce from them. While recruitment and selection needs to be based on skills and competencies, there are steps you can take to make it more proactive and inclusive. You could also consider involving patients in your selection panel so you hear their views directly.
- All your link workers should have an understanding of the basics of cultural competence and health inequalities, as set out in the social prescribing workforce development framework, but this is just the start. How can they hear from and learn from people with lived experience? How can you continue to offer them professional development for their knowledge and skills? For example, they could access RCGP e-learning on health inequalities, inclusion health and allyship, NHS England e-learning on cultural competence and cultural safety, or benefit from the development offered by becoming a Core20PLUS5 ambassador.
- The PCN DES identifies that link workers have responsibilities beyond direct patient care, including to "draw on and increase the strength and capacity of local communities" and to "work collaboratively with all local partners to contribute towards supporting the local voluntary, community and social enterprise (VCSE) organisations and community groups to become sustainable and that community assets are nurtured."
- Your link workers should have protected time to build links with the places and groups in your communities where they will refer people for social prescribing activities. You can also encourage self-referral from people who would be less likely to present at primary care by enabling your link workers to hold sessions in, for example, foodbanks or places of worship.
- As these community links grow stronger, you can empower your link workers to identify the need for and develop new initiatives to tackle healthcare inequalities. Some services allocate their link workers a 'micro-commissioning' budget of a few hundred pounds to invest in boosting the capacity of existing activities or starting up new ones.
- You can use the Additional Roles Reimbursement Scheme funding for roles targeted to specific population groups, such as young people and young adults, or migrants and refugees.

See Transformation Partners in Health and Care's Social Prescribing Innovators Programme for examples of empowering link workers to address healthcare inequalities, and our guide to employing specialist link workers for young people.

Doctors of the World have produced a toolkit for link workers and other frontline workers on how to recognise and address healthcare barriers for refugees and migrants and NHS England has published a social prescribing migrant health guide.

National Development Team for Inclusion published a report with recommendations for adapting social prescribing for people with learning disabilities and autistic people.

Understand the case for investing in social prescribing

Social prescribing has the potential to improve outcomes for all patients and add value throughout your network's plans, but it needs to be linked in properly.

- Think about where the leadership for social prescribing sits within your organisation. How does it link to wider plans for health inequalities, integrated neighbourhood teams, access and recovery? It takes time and effort to embed this cultural change.
- Think creatively about how social prescribing can contribute to your other plans and priorities. For example, can patients with predominantly social needs be triaged and referred directly to social prescribing? Can your link workers help to facilitate group consultations?
- Make plans to evaluate your social prescribing offer, so that you can keep improving it. What did patients think of the support they were offered? How will you gain feedback from people who didn't take up social prescribing as well as those who did? The NIHR Applied Research Collaboration has produced some tips on how to think about inequalities when evaluating social prescribing.
- How can you link information about your patients' engagement with social prescribing with other local health data set so that you can monitor its impact? The Social Prescribing Information Standard mandates GP IT systems and social prescribing software suppliers to enable recording of patient level social prescribing, through a minimum data set and use of additional SNOMED codes. Some areas also have local agreements linking social prescribing case management systems with the electronic health record. What support do your social prescribing colleagues require to routinely record high quality data?
- If you are seeing that social prescribing reduces demand for further healthcare, what is the value of that saving and where is the greatest potential to increase it? Combine quantitative data with patient stories on the impact it has had on their lives to gain the best insights.

NASP hosts resources on the evidence that social prescribing can reduce costs and pressures in the health and care system. We are always interested in hearing about the findings of evaluations, however local. If you'd like to share some evidence with us, please contact evidence@nasp.info.

Case studies

These are some examples of where social prescribing has been targeted towards health and healthcare inequalities:

- Using social prescribing to support population health management in Slough
- Creating the culture for social prescribing to thrive in Walsall
- Browse our innovation hub for examples of creative ways of using social prescribing to address a range of needs.

We are always interested to hear about innovation in social prescribing and what we can learn from it. If you think you have a relevant case study you'd like to share with us, please contact healthcare.integration@nasp.info.

More resources from the National Academy for Social Prescribing

- Our team of experts is here to support you. This includes cost-free advice and guidance as well as a costed training and consultancy offer.
- Read our guide to employing specialist link workers for young people and our guide to employing a social prescribing advice worker.
- Find out about becoming a Social Prescribing Champion.
- See our support offer for Social Prescribing Link Workers
- Read the evidence on social prescribing.

Further resources

- The resource hub of the Social Prescribing Collaboration Platform on FutureNHS has numerous guides, webinars, case studies and training links on health inequalities, proactive social prescribing, and related topics (registration required)
- Reducing health inequities in London by improving access to social welfare advice at Bromley by Bow Insights
- Health inequalities, population health and proactive prescribing at Transformation Partners in Health and Care
- Tips for evaluating your social prescribing service with an equity lens at NIHR Applied Research Collaboration North West Coast
- Inclusion health tool for Primary Care Networks at Friends, Families and Travellers
- Social prescribing toolkit for working with refugees and migrants at Doctors of the World

- Social prescribing: migrant health guide at NHS England
- Building Bridges: Social prescribing for people with learning disabilities and autistic people at National Development Team for Inclusion
- Inclusion health framework at NHS England
- Link workers for population health at The King's Fund
- Personalised care guidance for the Network Contract DES 2023/24 at NHS England
- A video explaining proactive social prescribing by the National Association of Link Workers
- Social Prescribing Innovators Programme at Transformation Partners in Health and Care
- Population Health Management – a GP's view on YouTube
- Guidance on connecting with the VCSE sector through social prescribing, including a self-assessment for organisations hosting SPLWs, at NAVCA
- Guide to screening for social needs in primary care at Health Equity Evidence Centre
- Complete Community Care programme at NHS Arden&GEM
- Reducing health inequalities in your local area: a toolkit for clinicians at British Medical Association
- Tackling health inequalities: Practical steps to help PCNs lead change at Healthcare Leader

Thank you

To all colleagues who shared their expertise with us when developing this resource.

Feedback

We would love to hear whether you found this resource useful and what you do as a result of using it.

Please contact us at healthcare.integration@nasp.info

National Academy for Social Prescribing

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