How can social prescribing support older people in poverty? A rapid scoping review of interventions

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About the authors

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Introduction

As the proportion of older people in our population continues to rise, it is important that the health and social care system is able to meet their needs. Over the past 6 years, many social prescribing schemes have supported older people although very few exclusively receive referrals from older people.

The combined knock-on effect of the COVID -19 pandemic and now a cost-of-living crisis has led to an increased proportion of older people experiencing poverty.

The review has looked for published peer reviewed and grey literature that has reported on interventions being tested to support an older population in relation to different aspects of poverty. Implications of the findings regarding social prescribing are reported at the end of this scoping review. In addition, the Rapid Evidence Review methodology that was used to scope, organise and assess the validity of the available literature on this topic is presented.

Methodology

- Scoping is defined here as exploring a range of relevant literature and studies, including emerging evidence, to shape an understanding of the current state of knowledge on a given topic. The aim of including a diversity of evidence that captures both published literature and evidence of real-world projects and services is to give the most up-to-date insight in a rapidly evolving area (Peterson et al., 2017)[1]. This can then inform decision-making about new developments in practice and policy including critical ingredients for delivering defined and emergent outcomes and highlight gaps for future research.

- Scoping work completed in Phase 1 (reported separately) identified a large body of literature from the last five years for each of seven areas affecting older people's health and wellbeing, requiring a pragmatic decision about the priority for this rapid review. Following discussion with stakeholders, in the context of the current cost of living crisis, a focus on poverty and poverty-related issues facing older people such as financial wellbeing, fuel poverty and food insecurity was agreed.

- A Rapid Evidence Review approach was used to provide this evidence synthesis. Rapid Evidence Reviews streamline the steps of systematic reviews to produce evidence in a shortened time frame (Ganann, Ciliska and Thomas, 2010)[2]. We searched PubMed, CINAHL PsycInfo and Google Scholar, and sources of grey literature. The review process was managed in Rayyan.ai, a free software package to support production of online systematic reviews.

Search terms were established using the PICO (population, intervention, control/comparison, outcome) method and applied to each database.

  - Terms for older people included older people, older adult*, older person, geriatric*, elder*, aging, ageing, aged, older age, retired person, senior* plus relevant Medical Subject Heading (MeSH) terms.

  - We used the following terms to identify interventions linked to poverty: finance*, financial service (and relevant MeSH terms); debt advice; legal advice; gambling advice, gambling services; poverty, food banks, food poverty, food insecurity, fuel poverty, energy poverty; welfare benefits, social welfare advice; digital poverty, digital exclusion, digital inclusion, digital inequality, digital divide; and "cost of living" to identify other linked interventions.

  - Terms for outcomes were wellbeing, quality of life, health related quality of life and relevant MeSH terms for these.

- All database, Google Scholar and grey literature searches were limited to the last 3 years given the volume of literature and the fast-changing field - in particular acknowledging that the covid-19 pandemic had a big effect on the types and formats of support interventions being offered to older people.

- When searching in Google Scholar, 'wellbeing' and 'older people' and the following poverty terms were searched: debt; foodbanks; food poverty; fuel poverty; social welfare; digital exclusion; digital. In addition, the general term 'poverty' with 'intervention' and 'wellbeing' and 'older people' was searched to focus on articles reporting interventions. Where multiple pages were found, the first 10 pages of hits were scanned and relevant looking articles saved.

- Grey literature was searched using the National Grey Literature Collection (allcatsrgrey.org.uk) and ResearchGate (other grey literature sources were inaccessible or yielded no relevant hits) using 'older people' and 'wellbeing' and 'interventions' and 'poverty' and in ResearchGate adding financial

wellbeing, debt, gambling, food banks, food hubs, feed up, fuel poverty, energy poverty, warm hubs, warm up, welfare benefits, social welfare advice, legal advice, digital poverty, digital divide, retirement, cost of living.

- Alongside the search for published literature, we issued a call for grey literature and current initiatives to be submitted. NASP created an email (see Appendix 1) and this was sent to the NASP International Evidence Collaborative, the Social Prescribing Network database and the NHSE futures forum in early November 2022. Twitter was further used to publicise the call for evidence. The call out consisted of a link to a Microsoft form which gathered relevant information (See Appendix 1).

- Studies included reviews (including scoping reviews), primary research, evaluations, reports, and grey literature. Studies were included if they were explicitly related to an intervention in one of the above poverty-related areas, and wellbeing outcomes in older people, ie., interventions which help to alleviate financial hardship, food and fuel insecurity, and digital exclusion to improve wellbeing of older people. Only studies written in English were included. Studies from UK and non-UK studies were included if they contained relevant information.

- All potential studies were imported and managed using Rayyan ai. Software. The searches and screening of sources were independently conducted by both HS and AS to make a preliminary selection of studies for consideration. Final selections for inclusion were then made by both authors (HS and AS) when reading the studies in full. Results of the independent review process were then compared, and any discrepancies discussed and resolved.

Results

- A total of 716 articles were imported into Rayyan. The breakdown of sources was as follows: peer-reviewed databases n= 670, Google Scholar n=31, grey literature n=15.

- Of the 716 sources identified, twenty-two met the inclusion and quality criteria. These comprised two systematic reviews[3,4] two rapid/scoping reviews [5,6], and one other overview report of published research[7]. Primary evidence included six quantitative studies of which only one was a full randomised controlled trial [8], one quasi-experimental pilot study [9], two pre-post designs[10,11], one survey[12] and one pilot trial[13]. Seven studies used qualitative methods [14-20], three used mixed methods [21-23] and one article was a case study[24].

- Thirteen primary studies were from the UK, two were from the US[14,19], two from Australia [20,22], one from Portugal [9] one from Spain[18] and one from South Africa[11].

- Thirteen sources focused exclusively on older people aged at least 50 years or older, and, of these six focused on 60 years or older. The remaining nine

sources had sufficient numbers of older people to justify inclusion, but also included other age groups of younger people.

- Evidence represented five broad themes: three papers on food insecurity [9,14,15] ; seven on fuel poverty [5,12,13,17,18,21,22]; six on income/financial management [6,8,19,20,23,24] ; three on digital exclusion [3,7,16] ; and three on general social vulnerability interventions for older people[4,10,11]. The evidence under each group is summarised below.

- From the call for grey literature to map current services, 37 responses were received. There were six responses about services specifically addressing poverty in older people (fuel poverty, financial support and transport help in particular), four responses from services which indirectly supported poverty e.g. arts services, nine services which supported older people living with dementia (and indirectly supported poverty), two which enabled older people to access nature, eleven which were wider, more general social prescribing services and five were from miscellaneous sources (research projects, policy initiatives). The 37 responses are not included in the main review of this report as they did not relate to the scope of the literature search parameters, and are instead a snapshot of current activity, which may be reflected in the evidence base in the future.

How reliable is this data?

- Grey literature was assessed using the Accuracy, Authority, Coverage, Objectivity, Date and Significance (AACODS) Checklist to ensure these met quality thresholds for inclusion. One eligible item was excluded because it did not meet standards for methodology, objectivity (bias) and expertise in authorship.

- Given that the majority of the peer-reviewed studies were of uncontrolled or qualitative designs, these were not suitable for quality appraisal using a standardised method. Quality appraisal was therefore based on an informed judgement by the authors based on extensive knowledge of research methods. One eligible study was excluded due to being significantly underpowered. In addition, it was noted that for quantitative studies, wellbeing outcomes were sometimes self-reported bespoke questions, as opposed to validated measures, with a range in the amount and timescale of follow up data collected. These studies were included but it should be acknowledged overall that much of the evidence is weak in quality and further evidence using more robust methods is needed to confirm the generalisability of findings in this review.

Supporting food insecurity for older people

Food insecurity refers to a lack of or uncertain access to sufficient and good quality, healthy food. Inadequate or poor-quality food can impact both physical and mental health, disproportionately affecting people who are already living in poverty. The number of people affected by food insecurity in the UK is rising rapidly due to the current high food prices and energy costs. Three studies related

to food insecurity. One UK (Blake, 2019[15]) and one US study (Brady et al., 2022[14]) were based on a mix of qualitative methods; the third study (Gomes et al., 2021[9]) was a non-controlled quasi-experimental study.

Blake (2019)[15] used a case study approach with extensive data collection over three years (2016-2019) with two organisations - a community voluntary organisation offering a range of food-using activities in a deprived village and a community interest company affiliated with a commercial food retailer with five hubs in areas of high deprivation. Data were gathered from focus groups of residents, field diaries of community activities, and observations and interviews over several occasions with staff and community members.

Blake (2019) demonstrated that food insecurity in the context of social deprivation means '*people are not just hungry they are also stressed, isolated and lack confidence*' (Blake et al, 2019, p.18) which undermines a community's resilience and capacity for self-organising. The authors concluded that the ways in which food support was provided had implications for how communities can regain resources to support food poverty. The organised activities included craft activities combined with a snack and drink, cooking healthy options on a budget, as well as hot lunches with a food table with free produce to take away. These community-based food activities can build capacity for self-organisation of community resources, ranging from infrastructure such as spaces and facilities for food making activities, to resources that improve diet diversity, mental health, social networks and community cohesion. Having older people as volunteers had positive benefits for the individuals involved in terms of being part of a group and giving back to the community, helping older people who had lost employment to feel useful and less dependent, as well as helping build intergenerational links within communities. Furthermore, the activities provided skills that enabled people to identify, connect with, utilise and enhance other community-based resources. The authors acknowledged that greater support is needed at the local level to enhance the community-specific self-organisation capacity and resource needs,(e.g., through partnerships with food businesses), particularly in very deprived communities.

Brady et al. (2022)[14] conducted interviews with 16 staff in food banks and local agencies providing care management for older people, and 60 older adults using food banks, in one US state (Iowa) in a large rural area with many smaller communities. The study reported on the success of food banks in meeting food needs and nutritional support for older people. The quality of food provided and the uptake of fresher, healthier food to boost health was enhanced with better cold storage facilities, both in normal food bank settings and mobile services. Access to food was improved if home delivery was offered for people with transportation and mobility problems. Access was also improved if pantries were co-located in other organisations such as medical centres and older people's living facilities. Staff/volunteer capacity was needed for this, as well as access to suitable spaces. Despite different ways of operating food banks staff perceived a stigma among older people around using this facility.

Gomes et al. (2021)[9] piloted interactive TV app software designed to promote lifestyle behaviour changes and education about a healthy diet for n=31 older adults with food insecurity. The 12-week, home-based intervention in Portugal was

shown to be acceptable to those with a compatible TV although 10/31 reported only low use of the app. Short-term effects on food insecurity, fatigue and physical function were measured using objective scales. The intervention significantly reduced ($p<0.001$) food insecurity status and severity at 3 months follow-up. There was no effect on quality of life but significant improvements in fatigue ($p<0.02$) and physical function ($p<0.01$) were shown. It also highlighted that older people do not necessarily prioritise their food insecurity. It was acknowledged that a larger study with longer follow-up is needed but the evidence is useful in highlighting how a low-cost intervention such as this has potential.

In summary

Overall these research articles demonstrate a range of approaches to supporting people with food insecurity are effective, including education, community-based food activities and food bank provision across mobile and other community settings. At least two studies have identified multiple outcomes including improved fatigue, physical functioning, increased skills, connectivity and use of other community-based services, as well as improved access to food.

Barriers and enablers to food insecurity interventions

A number of barriers and enablers to alleviating food insecurity were identified from the research literature:

Barriers	**Enablers**
Funding and support for community spaces to provide food is needed.	Use an assets-based approach, such as setting up a community café/kitchen which builds on resources in the community rather than just providing an emergency food service. Co-locating food distribution in a range of community venues such as medical centres can reduce cost and use existing space.
Lack of staff and volunteer capacity in local services supporting food insecurity can be a limitation.	Recruiting volunteers from within the community may be an option in some areas. Connecting organisations with additional sources of volunteers may reduce burden on paid staff.

Access to food banks for people with transport and mobility issues is not always possible. Some people may not be aware of the support with food insecurity that is available	Provide home delivery service to support people with transport and mobility issues. Having a lead organiser for food activities and developing partnerships between community organisations and local businesses to reducing gaps in food availability, building community self-organisation and helping to reach those who are not using food banks.
Lack of cold storage facilities limits what food and level of nutrition that can be provided by a foodbank.	Source fridges and freezers for organisations and groups providing food, including mobile services.
Some older people experience stigma around using a food bank.	Using older people as volunteers supported relationship building.

Practical implications for social prescribing link workers and policy makers:

- Link workers engaging with older people should be alert to those who are not prioritising their food needs and might need to encourage some older people to do so to protect their wellbeing. This could be through activities or educational videos.
- Link workers can also provide a supportive conversation to try to break down the stigma around using a food bank and promote awareness of food banks and community hubs for wider support e.g., access to welfare, financial advice. Where they exist, referring to shared food activities may be another way to approach this.
- Promoting older people to volunteer at food banks and community food-activities can be a way to help older people feel useful and mutually involved rather than dependent on food handouts.
- Community organisations could seek partners to work with at the local level in the food business, to support on alleviating food poverty e.g., through setting up shared food activities.
- Quality of nutrition can be improved with access to cold storage facilities.

Supporting digital inclusion

Digital access is needed to connect with government and other essential public services to support health and social care, as well as for banking, shopping, entertainment. Digital access is also important for social connection and other aspects of personal life, all of which contributes to positive wellbeing. A lack of

digital access is therefore regarded as a form of poverty. Approaches to improving inequalities in digital access among older people were identified in three papers: a UK grey literature report[7]; a UK qualitative study[16] and a systematic review drawing on international literature[3].

Piercy[7] investigated which interventions could support digital inclusion among older people with care and support needs, drawing on findings from a range of initiatives and research reports. Active steps can be taken to identify older people who might benefit from digital skills support, as not all will feel motivated. One project provided free digital skills classes to older people in deprived locations and arising from this, local social care teams saw the opportunity to build support for digital skills into a person's care journey and established referral routes to digital skills support. In another project, a peer support network was used to build digital skills among disabled older people living in supported accommodation. A third project provided peer-led model basic digital skills workshops to people in supported living schemes. The introduction of new technologies i.e., voice activation and the use of peer mentors helped older people to find or use relevant information. Older people valued peer recommendations and the social aspect of digital inclusion workshops.

Betts et al. (2019)[16] carried out focus groups (n=17) to explore older people's definition of digital technology and their experiences of digital inclusion classes. The research identified the importance of building trust into learning sessions for older people, as part of reducing digital exclusion. This study emphasised having targeted and personalised training to ensure relevance to the needs of older people, including building confidence. Examples of personalised training included having an assessment of each learner's needs and different levels for people with different starting points, providing sufficient time to learn new tasks as well as addressing issues around data security and trust in using digital technology.

The third evidence source in this theme was a systematic review[3] of 25 qualitative, quantitative and mixed method studies on the use of digital technology for social wellbeing. This concluded that engaging older adults at the community-level can facilitate effective use of social isolation interventions as well as address cognitive, visual, and hearing needs and increase digital use self-efficacy in older adults. Researchers found that mobile applications helped families to stay connected, linked older adults to resources in healthcare and encouraged physical and mental wellbeing. There was concern about the ability to connect and assist low-income, high health risk older adults who may stand to gain the most from digital inclusion. Researchers also found that intergenerational training programmes could engage older adults in an informal way, improve digital confidence and reduce anxiety. Authors concluded that developing community-based skills programmes can reduce barriers to technology utilisation and relieve the emotional stress of social isolation.

In summary

These three sources of information have identified a range of approaches to engaging older people to promote digital inclusion and improve digital skills, including building into the care journey where appropriate for the individual.

Intergenerational and community-based skills programmes may reduce barriers to digital inclusion for older people helping to promote social wellbeing.

Barriers and enablers for digital inclusion interventions:

Barriers	**Enablers**
Some older people may not be able to access digital hardware and software, or affordable technology support and training.	Digital skills training hosted in community spaces like libraries promotes inclusion. Health and care staff can promote digital inclusion in care planning and other points of contact but must be sensitive to trust and confidence barriers. Care and other organisations such as housing associations could negotiate better deals with internet providers, to improve affordability for older residents.
Some older people may lack the skills to use digital tools linked to health, care and support. Some older people may have a lack of awareness of relevant apps.	Focusing support on technology interventions that match the older people's interests ie, voice activation, instant messaging apps and Zoom may encourage more older people.
Some older people may lack trust in using the internet and have concerns about safety and wanting to keep personal data secure.	Individual sessions or group sessions with some individual attention for learners, may help to overcome trust and safety concerns, as well as meet different learning needs. Using peer mentors for digital learning is powerful.
Some older people may have anxiety around computers and the internet,	Group sessions offering a social aspect are important to older people and help

making it hard to engage them in supportive activities. Loneliness may make it more challenging to engage with digital technology.	with loneliness; Intergenerational training approaches may also help. Building trust and confidence into support courses supported engagement. Having enough time for older people to learn how to carry out tasks and not be rushed was important for engagement too.
Peer mentors to support digital skills/use need training and support.	Training for peer mentors should be given to help them respond to concerns about online safety and data security.
There are barriers in design of technology and applications for use by older people.	Design of care apps e.g., NHS app, should consider older people's skills and needs. Online health and care services should be co-designed with and for older people to improve accessibility. Advertising digital products aimed at older people and learning content for digital skills sessions should promote positive images of older people using technology.

Implications for social prescribing and policy makers

- Link workers and health and social care professionals can have an active approach to digital inclusivity with their clients by asking about internet use and confidence in initial conversations to encourage awareness of digital resources. Link workers can refer to community based digital skills support and health, or social care professionals can add in digital skills training into an older persons' care plan.
- Developing trust and confidence is essential to positive learning experiences for older people, therefore community services offering social aspects to the group sessions as well as for one-to-one learning should be commissioned. These should preferably be in accessible community spaces, especially in deprived areas.
- Training link workers and peer mentors in supporting older people to access digital support is needed, to ensure this is approached with care and

compassion, accounting for additional issues such as anxiety, low confidence and self-efficacy.
- Digital policy in NHS and social care services must take account of older people's needs in app design to make these more accessible to those with limited digital confidence. Positive images of older adults in advertising and learning content.
- Housing policy should encourage greater investment by housing associations and other low-cost housing providers, in affordable internet access to support digital inclusion of older people.

Supporting fuel poverty and housing

Fuel poverty occurs when a household cannot afford to keep adequately warm in relation to the income of the house. Fuel poverty is a risk for older people as living in cold homes has implications for increased ill-health. Seven sources were selected on the topic of fuel poverty interventions, one narrative scoping review [5], two qualitative studies [17,18], two mixed methods studies [21,22] and two pilot studies [12,13]. Two studies focused on energy efficiency education [17,18], and five looked at the impact on health and wellbeing when fuel poverty interventions were tested [5,12,13,21,22].

Energy efficiency education

Ramsden et al. (2020)[17] conducted 40 qualitative interviews in Hull (33% over 65 years) with members of the public and GP practice stakeholders. Researchers explored participants' experiences of using a UK charity's energy poverty advice and support service. This service provided energy monitors and advice to track and reduce energy consumption.

Jacques-Avino et al. (2022)[18] used interviews and focus groups (N=89, 33% over 65 years old) to explore people's views on a Spanish energy poverty reduction intervention called *"Energia, la Justa"*, aimed at addressing social vulnerability. The intervention provided insulation, energy saving devices and advice on efficient energy consumption, energy tariffs and optimum energy contracts with suppliers.

In both studies participants reported saving money, increased knowledge and confidence in managing their energy consumption. Furthermore, participants reported improved thermal comfort, increased knowledge and empowerment about energy-related rights and reduced number of power cuts[18]. Home visits were also valued by participants in Jacques-Avino et al. (2022), although some participants could not remember the energy saving tips or were confused by a complex energy tariff system.

Ramsden (2020) recommended that activities to help vulnerable people to address fuel poverty should be coordinated at a local level, for the long-term, involving local authorities, charities, and other wider stakeholders.

Health and wellbeing

An international scoping review of 38 studies (from Europe, North, and South America and Australia), published in 2022 (Ballesteros-Arjona et al.)[5] reviewed the

evidence for the effect of energy poverty and energy poverty interventions on people's health and well-being. Five studies focussed on interventions for people over the age of 50 years. Energy poverty resulted in inadequate temperatures, increased allergens, risk of mouldy and damp conditions. This led to increased respiratory and chronic health conditions, poorer general health and mental health, increased use of health services and higher mortality. Energy poverty was worse for vulnerable groups, including vulnerable older people.

Improving home insulation, heating systems and ventilation resulted in improvements in patient reported levels of mental health and physical health. The scoping review authors pooled the studies and stated that statistically significant results were found for reduction in self-reported mental health measures due to inadequate temperatures, financial strain of heating and poor housing conditions (note authors did not give the actual statistical test result values for these findings in the paper). Studies using medical records and retrospective self-recollection reporting physical health symptoms were also pooled. The authors stated broadly that statistically significant improvements in general, respiratory, cardiovascular health, chronic conditions and mortality (again no actual pooled statistical details reported). Recommendations included providing interventions that combined structural policies with an equity perspective to improve the situations of people living under energy poverty. Workshops on energy tariffs and energy efficiency were also recommended.

A mixed methods study[21] also investigated the health and wellbeing impact of a fuel poverty programme in East Sussex in the UK. 149 people on low incomes (ages range 22 to 94 years; average 57.7 years) had new heating systems and insulation installed. After six weeks participants reported statistically significant improvement in the self-rated questions about physical health rating (p=.001) and mental health/wellbeing (WEMWBS p=.001). Reduction in fuel poverty relieved financial stress, which then improved mental health. Despite the intervention's benefits, some people were still unable to afford their energy bills due to extreme deprivation and poverty.

Pollard et al. (2019)[12] carried out a pilot study of 22 households in Cornwall, UK, to see the impact of reminding older people living with long term conditions in cold homes to improve their home temperature. People wore a bamboo brooch to monitor temperatures they experienced in their house and were provided with alerts and reminders if the temperature went below 18 degrees Celsius. Alerts prompted a person e.g., to switch on the central heating, turn up the thermostat, close windows, make a hot drink, add clothing, be more active and to make use of their Winter Fuel Payment from the government. The average temperature was raised in homes and there was less self-reported casual medicine use. This data signals an improvement in health and potentially less reliance on health care systems. The authors concluded that a larger study to confirm findings and explore any cost-benefits of this approach is needed.

In a study from the same research team as Pollard et al. 2019[12], Sharpe et al. 2022[13] investigated the impact of a first-time instalment central heating intervention on mental wellbeing in the context of fuel poverty in Cornwall, UK. A waiting list control pilot study was used with a control arm (n=83 on the waiting

list only; mean age 66 years) vs an intervention arm (n=71 receiving a new heating system; mean age 61 years). Overall, participants who had the intervention (central heating) reported greater perceived satisfactory indoor temperature (71%) than the control group (22%). They also had less falls ($p<0.01$), and fewer arthritis symptoms ($p<0.04$). The intervention group had statistically higher mental well-being (WEMWBS scores, $p<0.01$) than the control group. Intervention participants reported improved finances as a result of the intervention ($p<0.03$) compared to the control group, however, some households (number not reported) still had mould and damp and a risk of fuel poverty which worsened people's mental health. The researchers note that ideally retrofitting the whole house with energy efficiency measures are necessary for a successful improvement of fuel poverty and reducing fuel poverty. Also, some older people may struggle with using modern central heating thermostats or digital systems and may need education or peer support to overcome problems.

Hansen et al. (2022)[22] used a mixed methods approach to investigate the effects of extremes of cold and heat on older people in Australia. 303 independently living older people aged 61–98 years participated in the different stages of this research, including interviews, focus groups, surveys. The researchers also created building simulations and guidelines for best practice. The optimum temperature for wellbeing of older people was found to be between 18.4C and 24.3C. Participants reported that their ailments and self-perceived health were impacted by temperature variations. Cold temperatures resulted in coughs, colds, influenza, painful joints, and shortness of breath, and hot temperatures provoked shortness of breath, sleeplessness, dizziness and tiredness.

The authors suggest that designers need to be mindful that temperature regulation within houses is a key determinant of health therefore the latest technology to monitor and regulate house temperature should be used.

In summary

In this section, the seven studies provide overlapping and confirmatory results. Firstly, educating and empowering older people to be more energy efficient can improve their home environment and as well as their health and wellbeing. Secondly all interventions that improved the home temperature improved the physical and mental health of most of the participants. Some participants were still at risk of fuel poverty and it is possible that their housing needs a range of energy efficient measures, as opposed to one intervention in isolation.

Barriers and enablers for energy poverty interventions

Barriers	Enablers
Some older people may have poor knowledge of how to be energy efficient.	Link Workers actively ask people if they need support with energy efficiency advice and refer to community-based activities or home visit-based support.
Some older people may not be able to remember or implement all of the energy saving tips.	Find support and interventions that implement visual and easy-to-remember strategies. Co-design interventions with older people. Use electronic monitoring and prompting technology to help older people know when to take positive action to stay warm.
Some older people may be confused or obstructed by any complex bureaucratic procedures which may be needed to gain optimum energy tariffs. Lack of digital technology or internet access makes it difficult to determine best energy tariffs.	Link Workers and care coordinators can discuss and refer older people for support with energy billing issues and navigating complex systems. Ensure that digital poverty is not a factor in being able to access information on energy tariffs and energy efficiency.
Some older people may be uncomfortable or resistant to some new home heating/ monitoring/ smart metre technology	Use the latest technology in the home to achieve optimum temperatures - this is between 18.4 and 24.3 degrees.

Some older people may not want to use their Winter Fuel Payment from the government, and any other benefits they may receive due to financial strain or confusion.	Older people may need an income maximisation check, to ensure they access all relevant government payments and schemes.
. Payment vouchers for energy metres can appear similar to energy bills.	Link workers and other professionals can reiterate that not every letter is a bill and check if energy vouchers for people on meters have been received. If not received, support the older person to get the voucher reissued.
Even after some fuel poverty interventions some people may not be able to afford to heat their homes due to extreme deprivation.	Further coordinated support to review the situation for this person is needed via social prescribing referrals and coordinated local support.
Some energy poverty interventions may be short term.	Interventions should be commissioned for the long-term and should be joined up to the wider community initiatives and stakeholders.

Implications for social prescribing and policy makers for energy poverty interventions

- The general public, commissioners of services and stakeholders in health, social care, local authorities and some VCSE organisations appear unaware of the extreme detrimental impact of fuel poverty on the health and wellbeing of older people (and people with long term conditions of any age). Support to address this lacks priority. Research shows that a suitable home temperature for older people is 18.4C-24.3C and leads to statistically significant health and wellbeing benefits. The wider implication is therefore of reducing demand for the health and social care services.

- Link Workers and other relevant professionals could ask about the quality of heating and temperatures in the house at first assessment to assess the

home environment, to actively identify vulnerable older people in need of support.

- Link Workers and other relevant stakeholders should have training and latest guidance to be able to support or fast track people with the greatest levels of need. This is especially important for those who do not have enough ability to improve their home environment or are classed as being in energy poverty.

- Link Workers should have up-to-date guidance on latest fuel poverty support from the national or local government. Also, Link Workers should have clear, practical strategies to give out to older people to support fuel poverty issues.

- Policies for best practice in home building need to consider heating and cooling issues. UK homes are not constructed well for extremes of heat, and this impacts the health of older people in heat waves. Link Workers should therefore ask about cooling in summer as well as heating in winter and provide advice for older people on how to keep cool should be available to Link Workers.

Income and financial management

Knowledge, confidence and skills in managing finances is an important part of adult life and can significantly impact wellbeing. Six papers were about income and financial management. The six evidence sources included one international scoping review [6], three papers from the North of England (a case study [24], a mixed methods study[23] and a randomised control trial [8]), one qualitative study from USA [19], one qualitative study from Australia [20].

A scoping review including searches for papers about social prescribing published in 2021[6] pooled 214 papers. The researchers mapped primary care-based interventions to support financial needs for people (including older people) living with poverty in high-income countries and identified key barriers and enablers. They found that primary care-based interventions operated at lots of levels, from passive sociodemographic data collection to referral to external services and direct interventions addressing needs. A barrier to connecting people to services included embarrassment of the service users, social stigma of admitting poverty and the navigation of complex services. Enablers were clear referral pathways and staff delivering the interventions having a sense of mutual respect and shared aims.

A study from the North of England [24] presented case studies from people aged over 50 years, selected from a project providing financial support around managing debt, claiming benefits and budgeting. The case studies showed that being in extreme debt led to feelings of a loss of control, a source of embarrassment which led to social withdrawal and reduced social activities, which then impaired mental health and wellbeing and quality of life. The qualitative findings of the financial support intervention identified a reduction in isolation, and improvements in mental health and financial wellbeing. Authors recommended early and tailored,

one-to-one intervention about financial support with vulnerable older adults as most beneficial.

Another study from North West England [23] investigated the impact of financial debt amongst older women and explored themes of shame, abuse and resilience. The research used a mixed-methods approach using national survey data (one cohort over 55 years n= 4107, and one over 65 years n=7221) and qualitative interviews with older women who were receiving debt advice. Older women between 55 and 64 years who were living on low incomes, separated or divorced were more likely to have financial problems then older men. Coercive control and economic abuse from former partners were recorded. Shame and stigma and not disclosing financial issues was found for older women. The authors' state that reforms to pensions, minimum wage, divorce, domestic abuse and welfare policies should note the circumstances of older women and that more specific financial support and advice needs to be provided to these people facing financial difficulties.

A further paper[8] reported the trial of an intervention to provide tailored welfare rights advice and assistance with benefit entitlements to older people in their own homes, in a deprived area of the North East of England. 562 volunteers over 60 years registered with a GP took part. At 24 months follow-up the proportion benefitting from personal care in their home had increased in the intervention group compared with controls (+5.6% vs -11.6%). The intervention may have helped participants gain access to much needed care, which could help them maintain their independence and access to beneficial social relations. These findings were supported by qualitative data which showed the receipt of care support in the form of additional financial and non-financial benefits was perceived as having a positive impact on health-related quality of life. There was, however, no measurable effect on quality of life for the whole cohort as many people were already receiving their full entitlement of benefits.

An interesting qualitative study from Australia (2022)[20] explored the retrospective experience of gambling and homelessness in older adults who had used homelessness or gambling support services. 48 people were interviewed in in-depth semi structured face-to-face and group settings. The authors found a complex and interconnected link between gambling and homelessness with one often contributing to the other. Factors which activated gambling in older people included comorbidities such as substance use, past trauma, mental illness and the environment for the older person (e.g., access to gambling, poverty, housing issues). Gambling was frequently masked or hidden and service providers were often unaware of it when supporting an individual. Large losses from high intensity gambling often led to first time homelessness in older adults, this type of gambling was triggered by events such as bereavement, job loss, divorce. Gambling operators and creditors often worsened outcomes for the older people in the study.

A small USA qualitative study from 2021[19] interviewed 29 participants and explored the potential benefits from a financial wellbeing programme - "Money Smart for Older Adult". This programme advised on spotting online fraud scams, exploitation and making informed financial decisions. Participants felt the programmed raised awareness of financial wellbeing. Findings were that financial literacy (insurance

plans, including planning for retirement, investment, mortgages and borrowing) requires a lifelong approach which should be supported by relevant agencies. Furthermore, financial education was advised to be tailored to a specific population e.g., older people or different cultures. The study also found that a whole family financial literacy intervention was beneficial as it supported older people who may have cognitive impairment and enabled other family members to benefit from the support, while also supporting the older member.

In summary

These six papers reveal several target groups of people that may be experiencing financial issues and who may be too ashamed and embarrassed to tell anyone about them. The repercussions are extreme, including job loss, loss of home as well as health and wellbeing issues. The need for joined up coordinated multi agency support is once again recommended, in recognition that financial poverty is interlinked with other situations in a person's life.

Barriers and enablers for income/financial interventions

Barriers	**Enablers**
Social stigma around financial issues and poverty may prevent older people disclosing these issues and therefore getting help.	Identification of target groups of people who have been reported to hide their financial issues will enable an active approach for professionals to bring this up in conversation. Appropriate training for Link Workers is needed to spot signs of non-disclosure or stigma around financial issues. Using peer support and peer volunteers may help to destigmatise issues.
Risky financial behaviour such as gambling can be hidden by older people at the point of referral or service providers making it hard to spot.	Appropriate training for Link Workers to spot the signs of gambling in older people.

Lack of financial literacy may make it difficult for some older people to have an ongoing approach to managing their finances.	Access to appropriate and early tailored welfare advice for older people receiving benefits and help with personal care at home that enables them to remain independent. Banks and charities could provide supportive programmes about financial literacy and wellbeing to help make good decisions about insurance/ mortgages.
Some older people's financial literacy may be constrained by cognitive impairment e.g., dementia.	Whole family support may facilitate better decisions around financial planning for older people and enable conversations with people who may have cognitive impairment to be supported by caregivers.

Implications for social prescribing and policy makers for income and financial management interventions

- Social stigma and embarrassment prevents many older people from revealing their financial issues. The research papers identified several target groups of people who have been reported to experience issues. Where older people are vulnerable or do not fit into one of the target groups, all local professional stakeholders should be actively and compassionately starting financial based conversations with people. This may be via a link worker, GP, social worker, bank or other professionals. This requires a joined up and coordinated approach. The professionals also need resources to help identify potential older people who need support. This could be a financial version of the NHS initiative of Making Every Contact Count

- Link Workers should pay attention to older women (aged 55 plus) who may be reluctant to speak about financial issues due to stigma, coercive control or economic abuse. Link Workers should receive financial training to spot signs of this and be able to provide appropriate support.

- Gambling in older people: Link Workers should be provided with training to spot signs of problem gambling and homelessness in older people and should be given help to identify the right gambling support interventions.

- Link Workers should be able to refer to accredited and reputable financial advice or wellbeing service to support older people with issues like scam protection, making good financial decisions re mortgages, insurance, savings, benefits. Services could be supplied to involve wider family members to enable best information support and help. For people who cannot afford to pay for these services, they should be available at no cost.

- Appropriate interventions should be sought which are tailored to older people's needs. Some older people cannot manage group support, therefore need one-to-one support - this is especially important due to the social stigma of financial issues.

- Financial issues are interlinked with many other aspects of wellbeing, such as health, housing, employment and remaining independent in one's home. The approach to supporting financial issues therefore needs to support the whole person and understand what other interrelated issues are also present, using a social prescribing approach for instance.

Supporting social vulnerability

Social vulnerability relates to any person's social circumstances such as the conditions in which they live, work or age, and the extent to which these make them vulnerable to other adverse health or social events. Three papers related to a mix of interventions to support social vulnerability in older people, two were pre/post intervention studies [10,11] and one was a systematic review drawing on international literature[4].

McGuire et al. (2022)[10] evaluated the impact of an initiative with vulnerable households to encourage the uptake of government benefits and grants to tackle poverty and social isolation. The four areas for support were: warm homes subsidies for insulation and boiler repairs/replacement; occupational therapy advice and grants; transport provision and lastly, connection to community facilities like libraries, education and arts. Survey data on poverty, isolation and health were gathered at baseline and after contacting vulnerable households about the new support. All ages in several rural communities in Northern Ireland were included (n=1031) although the most common group to utilise the support (78%) were people aged 60+. The study found that the initiative countered overall levels of deprivation. Home safety improvements, connection to community services and 'warm homes' all had a statistically significant impact on self-reported improved health (no p value reported). Improving access to local services was the most successful intervention in reducing social isolation among older people. However, the authors point out this is strongly dependent on a robust rural transport support network. The importance of access to rural broadband was also shown. The paper also found that men's health (across all ages) did not improve, highlighting the particular challenge of helping rural men to seek help.

A second intervention study (Geffen et al., 2019[11]) with older people (mean age 69; n=212) in a low-income, urban area of South Africa evaluated a peer support intervention aimed at improving wellbeing and isolation. Peer supporters were trained to provide companionship, community engagement, emotional and

information support and promotion of healthy living, as well as low level health screening and referral access to primary care and social workers. The study showed that peer supporters giving help to less able older people in their communities significantly increased ($p<0.000$) self-reported wellbeing and social interaction as well as other outcomes such as loneliness, mood and depression. Qualitative data also revealed benefits to the peer supporters in terms of self-esteem, sense of purpose and empowerment from helping others.

The systematic review (Mah et al. 2022[4]) further reinforces the value of targeted interventions for socially vulnerable older adults on health outcomes. Based on 38 sources, this covered five areas of interventions from those focused on strengthening social and community context (offering regular social connection and interaction, support with goals and activities); those focused on neighbourhood and home environment (e.g. help with home hazards and repairs, falls/injury prevention, nutritional support, social worker access); those seeking to improve navigation of health and care services (e.g. patient navigators, medication help, communication with care providers, transport, post hospital care); interventions to promote education to older people and two interventions to support economic stability (help with benefits, paying for care). The evidence reviewed showed statistically significant (all $p<0.001$) positive influences on function (not specified), cognition, subjective health and hospital utilisation (emergency department visits or hospital admission). The evidence was mixed for use of non-hospital services and insufficient to determine effect on mortality.

In summary

Social vulnerability is an important dimension of poverty to consider in interventions. A common thread in these three papers was the importance of community connectedness through activities that offer social interaction and the provision of local services that support this such as education and the arts. The importance of wider infrastructure in enabling this such as better local transport links should be noted. Supporting socially vulnerable older people with home improvements around warmth, safety and repairs can also benefit health and wellbeing. Providing informal (peer) support with navigating health information and communicating with care providers may also be beneficial.

Barriers and enablers for social vulnerability interventions

Barriers	**Enablers**
Lack of a robust rural transport network prevents people getting support and going to activities.	Improving community transport partnerships in rural areas could alleviate social isolation.
Lack of access to digital hardware and rural broadband prevents people from	Investment in better rural broadband is also needed in these areas.

being able to access information, support and join online activities.	
Lack of training for peer mentors especially in the use of screening tools and technology may present a barrier for some older people to become mentors.	Peer mentors can support older people in their communities, with suitable training for the role. Clear referral pathways and capacity in the onward system would be needed for any system of peer support that included being able to refer.
Access to interventions to support social vulnerability in deprived areas may be lacking making it difficult for link workers to connect older people with social activities, home improvement help and financial support (grants/benefits).	

Implications for social prescribing and policy makers

- Link workers could refer older people to information and support with government grants for house insulation and new boilers (where applicable), and similarly to information about services offering home safety checks and improvements. Training and resources for link workers in these areas may be needed.
- Link workers need to consider ways to reach men in rural areas who find it harder to seek help for the challenges they face; different ways to offer help may be needed.
- Link workers and health coaches could help identify more resilient older people in their communities for training as peer supporters, and/or establish a peer buddy system for those with similar health goals and needs.
- Training for link workers specifically in the aspects of poverty covered by this review to support vulnerable older adults referred to social prescribing services.
- Investment in community rural transport partnerships is needed to improve access to beneficial community events and services and improve social connections among older, rural populations. Similarly, boosting investment in rural broadband could better connect communities in rural areas.

- Expansion of interventions across the range of older people's needs from social, to home environment/safety, to health services and prevention, and financial help has potential to improve wellbeing in older people.

Recommendations

The analysis in this rapid scoping report has identified some overarching themes available in the research literature that relate to supporting older people experiencing different elements of poverty. Many of these themes are anchored in the fact that being without enough of something, whether it is food, heating, money, or digital access, is usually the result of other serious situations that are unresolved in a person's life. Similarly, the impact of poverty is far reaching on a person - it particularly affects their physical and mental health, and increases their likelihood of being depressed, lonely, isolated and lacking confidence or knowledge on how to improve their situation on their own. Therefore, supporting people in poverty requires a holistic approach rather than trying to plug a gap in one area of their life. Social prescribing as a holistic and personalised approach to support people, is therefore well suited to provide the support required for older people in poverty. Further evidence regarding the social welfare legal advice aspects of social prescribing is also available from NHSE [25].

Below are some implications of the data that seek to inform policy makers, commissioners and funders of services supporting older people:

1. A multidisciplinary and locally coordinated approach is needed to ensure that all services and professionals in a locality are able to work together to provide the support an older person needs who is in poverty. This includes crisis management to provide immediate basic survival needs e.g. food and heating, as well as a longer term approach to continuous engagement to identify and address the causes and effects of poverty for that person. For the recently introduced setup of Integrated Care Boards, this means personalised care for older people is much more than just identifying those at risk of frailty and more long-term commissioning of VCFSE organisations and services needed to support food, energy, digital, social and financial aspects of a person's life. Very early evidence points to the potential of this coordinated and community based approach to reduce demand on health services and this should be researched further. Furthermore several poverty related issues could be addressed concurrently by one activity e.g., support to manage food security issues provided at a hub that provides digital access support and social interaction. New learning from the recent warm spaces initiatives could be built upon.

2. Many older people may be hiding their poverty related issues due to the embarrassment and the social stigma they perceive. There are several groups of people identified in the literature whom this applies to: those with gambling problems; women aged 55-64 years who are most likely to have suffered domestic abuse and coercive control, vulnerable older adults, and/or older adults without digital access or with mobility issues. These groups are not exhaustive and localities could be identifying their target groups of people who are least likely to admit to their issues and develop

approaches to actively find, engage and support these people. This again requires a locally joined up approach to allow intelligence sharing opportunities.

3. As many older people are suffering in silence due to stigma, shame and embarrassment, it is crucial that professionals such as social prescribing link works, care coordinators and other professionals are compassionate in their interactions, and put developing the trust of the older person at the heart of their interaction. This may take several visits with a social prescribing link worker for instance and therefore the number of visits allocated per person needs to account for this, when services are being designed and commissioned. As the pressure in the health and social care sector is at crisis point, professionals such as social prescribing link workers may be asked to limit the number of times they see a person or to shorten the appointment times. This is short-sighted decision making and fundamentally acts against all the evidence which has identified the importance of building a relationship with a person to identify root causes of issues. The investment in developing the relationship with a person will inevitably pay off by being able to address root causes of issues and improve the physical and mental health of the older person. The economic impact of this approach is being examined currently.

4. All professionals such as social prescribing link workers, care coordinators and other health, social care and VCSE organisations should be trained on the 'hidden' people who are most likely to be hiding poverty related issues. Similarly the training needs to highlight the prevalence of stigma and shame in the older generation and provide professionals such as social prescribing link workers the confidence on how to open up and navigate these delicate conversations.

5. Some older people may experience more confusion with complex information, and may not always remember what had been said previously, therefore this needs accommodating when interacting with an older person. This is a good opportunity to co-design community activities, support services and apps with older people, to identify issues and solutions, and make the offers more accessible and effective for older people. This can also identify gaps in current service and support provision.

6. Peer volunteers and peer mentors have been noted in several sections of this review as beneficial for activities providing support for older people. It is important to therefore actively encourage older people who are capable of this voluntary role to take it up. Appropriate support and training is needed, but data shows that the volunteers value their role and being able to support their peers. Link workers and health coaches may play a valuable role in identifying prospective peer volunteers.

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Appendix 1

Call out for grey literature and existing initiatives and interventions for older people

The message was sent from the NASP Evidence Collaborative to around 300 recipients who are interested in social prescribing evidence globally, to the Social Prescribing Network with approximately 3000 members, and to the NHS England & Improvement Futures forum.

Rapid scoping review on older people, poverty and social prescribing

We are currently working with the National Academy of Social Prescribing (NASP) International Evidence Collaborative to support their new project that we hope our growing community can contribute to.

Some of NASP's International Evidence Collaborative are helping us conduct a rapid scoping review on older people, poverty and the role of social prescribing. If you have published a report, an evaluation or have data you can share with us on this topic - either from a social prescribing scheme, or as an activity provider, please fill in this brief form.

The review submission period, in partnership with Independent Age will end on the 17th of November so please share this email with your colleagues so we can reach as many people working in this area as possible. If you would also like to Tweet about the review, here is a template you can use for ease.

Involved with #SocialPrescribing, #OlderPeople and #Poverty? Help @NASPTweets gather evidence for their rapid scoping review by filling in the short form with your information https://tinyurl.com/mvptujec

The Grey call-out link on Microsoft Forms consisted of the following questions:

Older people and poverty alleviation: Understanding what works.

The National Academy for Social Prescribing (Academic Evidence Collaborative), in partnership with Independent Age, are gathering evidence regarding strategies, programmes, schemes and/or activities that support older people facing issues with poverty, financial wellbeing, debt, benefits, social, legal or welfare issues; this could include the use of food banks, warm hubs, welfare or other support or advice.

Please respond to the below short call for evidence to share your work on this topic. Thank you.

1. Name of your organisation

2. Your role

3. Details of your work (200 words)

4. How long has this programme or scheme been running?

5. Relevant weblinks (please provide links to any reports or other information)

6.Contact (please provide your name and email address if you are willing to be contacted by somebody from the National Academy for Social Prescribing or Independent Age).