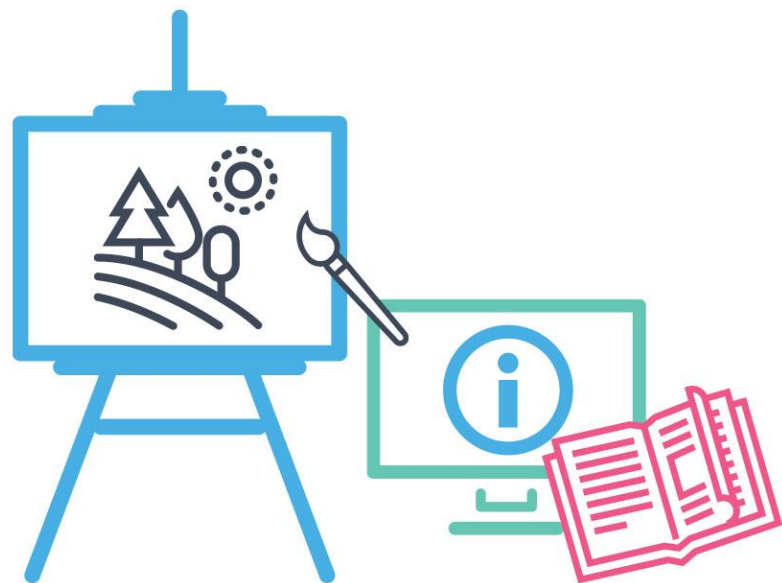


National
Academy
for Social
Prescribing

How to use social prescribing to support Population Health Management

A guide for Integrated Care Systems

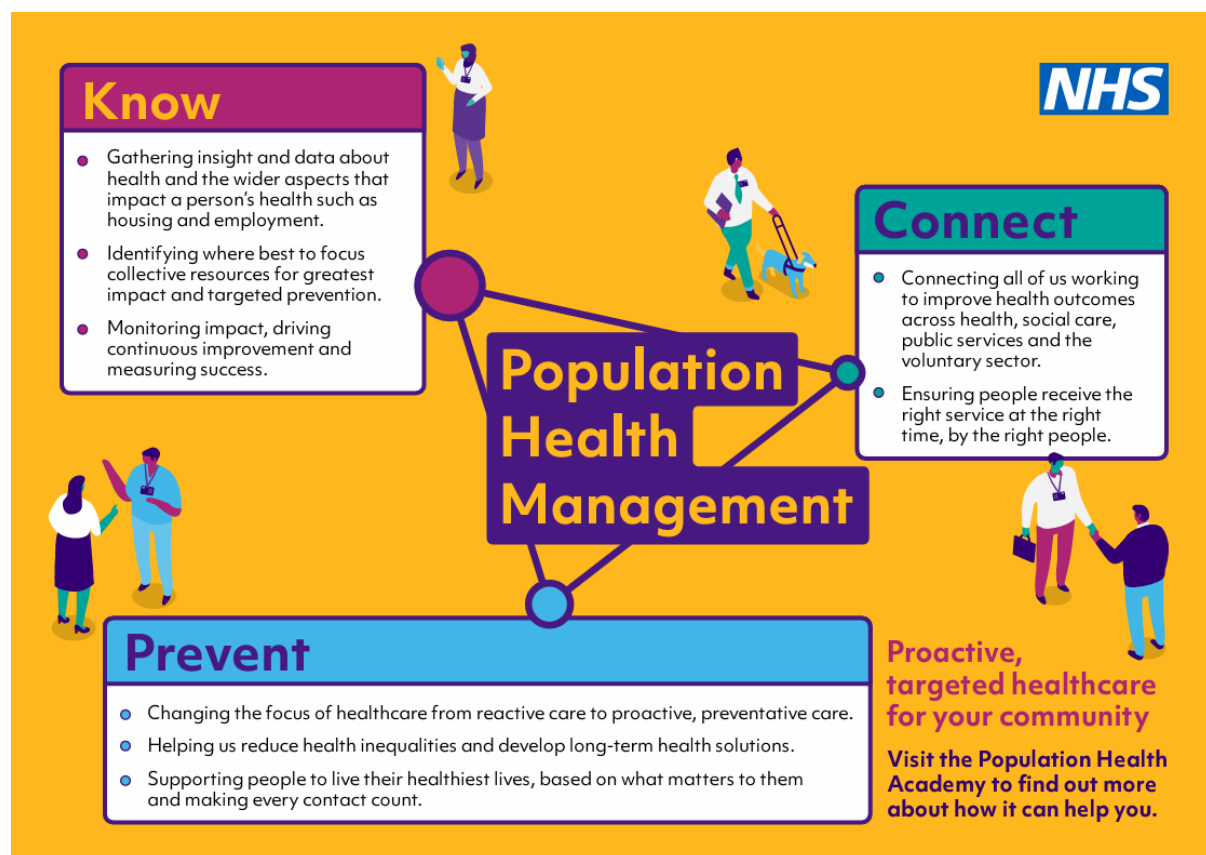


Population Health Management is an evidence-based approach to reducing health inequalities

“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. [NHS England states](#) that Integrated Care Boards should use a range of data and the information within relevant [Joint Strategic](#)

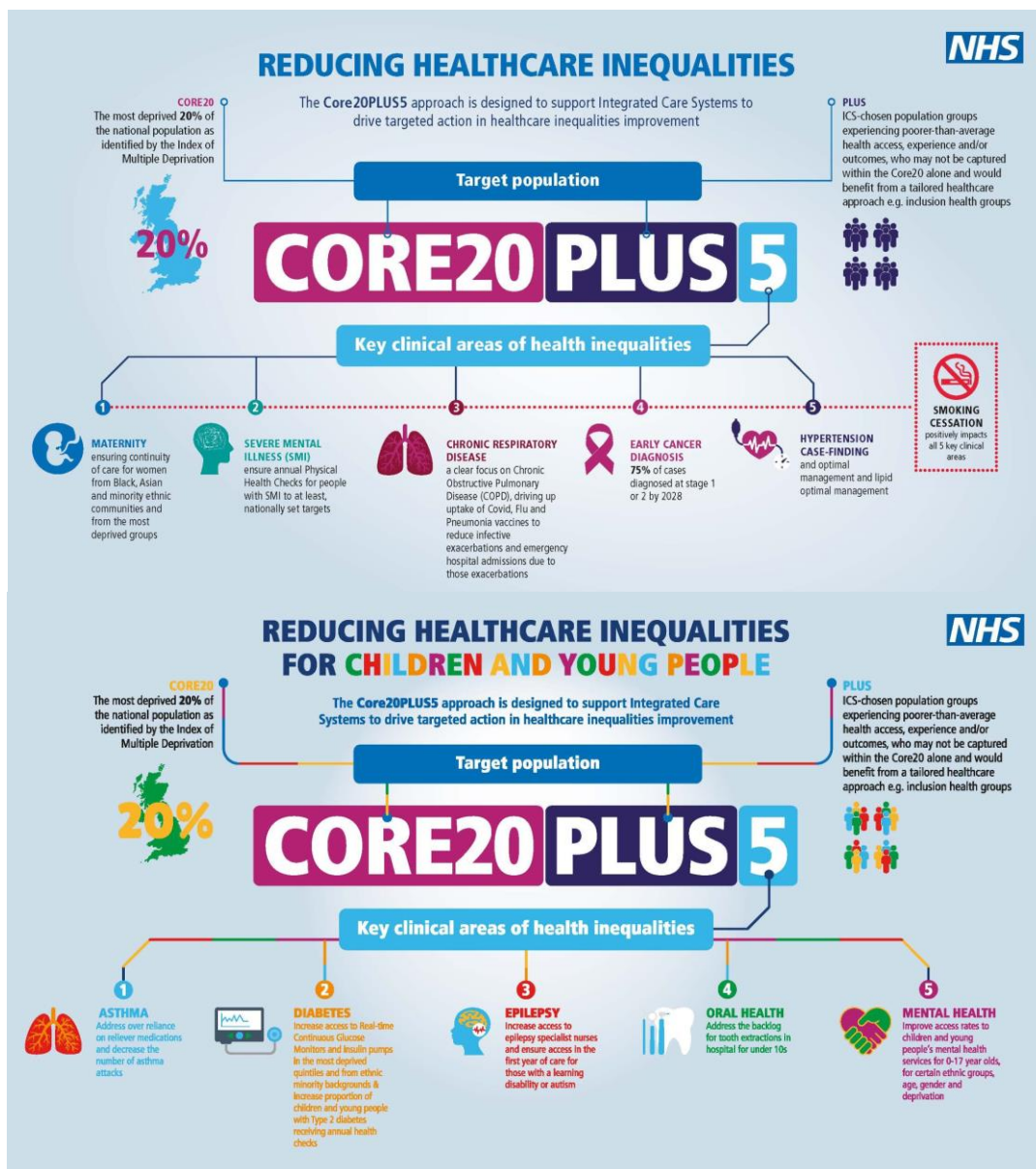
[Needs Assessments](#) to understand healthcare inequalities as a basis for reducing them.

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 giving personalised care and routes into long-lasting support.

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

Note that in this resource we will refer to “social prescribing link workers”. We recognise that, in reality, people fulfilling this role go by many different job titles, have many different employers and are funded by many different funders and commissioners: we intend to cover the function as broadly defined above and the content of this resource is intended to be widely applicable.

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 Integrated Care Systems to consider

Access to social prescribing

Think ‘no wrong door’ to get the best from social prescribing.

Social prescribing is now well-established in primary care, but that means that population groups that don’t tend to access primary care are less likely to benefit from social prescribing.

- What do you know about population groups who are currently less likely to be offered or to take up social prescribing? Where do they come into contact with the health and care system? Who can you work with, internally and externally, to discover the full picture?
- How can you build in social prescribing across all parts of your system, so that it reaches the maximum number of patients, and particularly those who are most likely to benefit from it?
- How can you make sure that, however patients are referred to social prescribing, they receive a high-quality offer?

See our [Green social prescribing programme](#) for example on integrating with mental health pathways, our [case study on perioperative ‘waiting well’](#) and our [case study on social prescribing within hospital discharge pathways](#).

Develop your data and intelligence

Social prescribing is a complex intervention sitting within a complex system and you will need to consider lots of different strands of information to understand it.

- Work with your population health management team to identify health and healthcare inequalities that social prescribing could help to address. Consider population groups defined by characteristics (including multiple, intersectional ones) as well as by health conditions and needs.
- Think about who is missing from your data too: groups that are transient or that don’t tend to register for healthcare, such as migrants and those in insecure housing. Where can you get the community intelligence to supplement your data? What do you know about their needs, either directly or via an expert third party? How could social prescribing help them? Social prescribing link workers and activity providers are likely to be a good source of information here, often detecting issues before they emerge in the data.
- Think about equity when reviewing and evaluating your existing social prescribing services. Who is and isn’t accessing them? Are they having the same quality of experience? Are they seeing the same outcomes? The NIHR Applied Research Collaboration North West Coast has produced [some tips](#) on this.
- You will need good data on the reach and impact of any new or pilot social prescribing models so that you can continue to improve them and target further. How can you implement the [Social Prescribing Information Standard](#)? How can you link information about your social prescribing

services back to health and care datasets so that you can evaluate their impact? How can you combine quantitative data with patient stories?

See our case studies on [developing an understanding of health-related social needs in Slough](#), [supporting the LGBTQ+ community through social prescribing](#) and [using link worker intelligence to develop new responses to need in Walsall](#).

NHS England has published a [social prescribing migrant health guide](#).

Co-design equitable models of social prescribing

If not carefully designed, there is a risk that social prescribing services and activities can unintentionally reinforce inequalities. To avoid this happening, you need to design them with the people they are intended for.

- Co-design takes time. Start the process early and give resource to it, both within your commissioning teams and for the providers, groups and people who participate in it. Find out what matters to them, and act on it.
- Build a common understanding of what you are trying to achieve and what is social prescribing's role in achieving those objectives. You may have an existing prevention or wellbeing framework that can provide the structure for this.
- Consider all the contributing factors that could reinforce inequalities, and how you could mitigate them in your service design. For example, access to green spaces in urban areas, transport costs, cultural differences in what is attractive or acceptable activity, the accessibility of digital tools.
- Don't forget to include all sections of your workforce in co-design: the link workers are just one part of the process, and NHS-employed link workers are just one of many forms of social prescribing. To make the most of social prescribing, all members of the multi-disciplinary team, clinical and non-clinical, and the wider sector of voluntary, community and social enterprise organisations, will need pathways that work for them and feedback about its value for the patient.
- Work with your delivery partners and activity providers to ensure that you don't create gaps between services which disadvantaged groups will find harder to navigate.

See our [case study on coproducing a positive activities fund for people with multiple disadvantage in Sheffield](#) and overcoming barriers to accessing nature-based social prescribing in our [Green social prescribing programme](#).

Invest in community assets and activities

Social prescribing requires a whole-system approach.

Many social prescribing activities are now running at maximum capacity, and do not have scope to do the additional work required to reach and support more disadvantaged groups.

- Think creatively about how you can invest in social prescribing activities and community assets. Some areas have piloted [community chests](#) of pooled funding. NASP is scoping potential models for larger-scaled Shared Investment Funds (read more in [The future of social prescribing in England](#)).

- Some people suffering from health inequalities require additional support to access and participate in social prescribing activities. Personal health budgets are one means to do this. How can you ensure that link workers and activity providers feel confident supporting people to apply for and use them?
- Another way to offer enhanced support is through additional roles such as ‘buddies’ and ‘connectors’ and through making good use of existing community hubs and infrastructure. Again, this should be co-designed and adequately resourced.
- A major area of need is financial security and wellbeing. Social welfare advice, financial advice and legal advice are specialist areas and services providing them are hugely oversubscribed. [Bromley by Bow Insights](#) has produced some case studies on how some areas of London are improving access.

See [our webinar on buddying schemes](#) in the nature and heritage sectors.

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](#)
- [Supporting the LGBTQ+ community in Brighton and Hove through social prescribing](#)
- [Perioperative ‘waiting well’ pilot in North East and North Cumbria](#)
- [Creating the culture for social prescribing to thrive in Walsall](#)
- [Link workers within hospital discharge teams in Warrington and Halton](#)
- [Coproducting positive activities for people experiencing multiple disadvantage in Sheffield](#)
- Tower Hamlets Health Spot project has cross-trained youth workers to act as [specialist social prescribing link workers](#) (see p27 of guide)
- The pilot sites in the Green Social Prescribing test and learn programme were successful in reaching and engaging people with mental health needs. [Read more about it and access the toolkit and evaluation](#) on the NASP website, and [contact our team](#) if you would like support in implementing this in your area.

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.
- Watch our [webinar](#) on social prescribing and health inequalities.
- Use the learning toolkit from the [Green Social Prescribing test and learning programme](#)
- See our [guide to co-designing social prescribing initiatives with older people](#)
- Browse our [innovation hub](#) for examples of creative ways of using social prescribing to address a range of needs
- [Read the evidence](#) on social prescribing, including our reviews of:
 - [How social prescribing can support older people in poverty](#)
 - [Who is and isn't being referred to social prescribing](#)
 - [The accessibility of social prescribing schemes in England to people from Black, Asian and ethnically diverse population groups](#).

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
- [Creative health in the context of health inequalities](#) at Creative Health Toolkit
- [A strategy for wellbeing and heritage](#) at Historic England
- [Out of bounds: Equity in access to urban nature](#) at Groundwork
- [Addressing health inequalities through sport and physical activity](#) at Sport England
- [Health inequalities, population health and proactive prescribing](#) at Transformation Partners in Health and Care
- [Community chests for social prescribing](#) at Transformation Partners in Health and Care
- [Inclusive social prescribing](#) at Faith Action
- [Building Bridges: Social prescribing for people with learning disabilities and autistic people](#) at National Development Team for Inclusion
- [Tips for evaluating your social prescribing service with an equity lens](#) at NIHR Applied Research Collaboration North West Coast

- [Resources and funding to reduce health inequalities](#) at Healthcare Financial Management Association
- [Inclusion health framework](#) at NHS England
- [Working in partnership with people and communities](#) at NHS England
- [Keep it local for better health: How Integrated Care Systems can unlock the power of community](#) at Locality
- [Population Health Academy](#) on FutureNHS includes many case studies involving social prescribing as part of a population health management response (registration required)
- [Improving population health on the frontline](#) - Jane's story on YouTube
- [Transforming health and wellbeing services through population health management](#) at NHS Confederation

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

Get in touch

socialprescribingacademy.org.uk

 @NASPTweets

 @NASP_insta

