



University of
Salford
MANCHESTER

Social prescribing : the whys, wherefores and implications for nurses & prescribers.

Howarth, ML and Donovan, H

10.12968/jprp.2019.1.2.94

Title	Social prescribing : the whys, wherefores and implications for nurses & prescribers.
Authors	Howarth, ML and Donovan, H
Type	Article
URL	This version is available at: http://usir.salford.ac.uk/id/eprint/49836/
Published Date	2019

USIR is a digital collection of the research output of the University of Salford. Where copyright permits, full text material held in the repository is made freely available online and can be read, downloaded and copied for non-commercial private study or research purposes. Please check the manuscript for any further copyright restrictions.

For more information, including our policy and submission procedure, please contact the Repository Team at: usir@salford.ac.uk.

Social Prescribing: The Whys, Wherefores and Implications for Nurses & Prescribers.

Dr Michelle Louise Howarth
Senior Lecturer in Nursing
University of Salford, School of Health and Society
m.l.howarth2@salford.ac.uk
0161 295 2873

Helen Donovan
Professional Lead for Public Health Nursing.
RCN
Cavendish Square
London

Key Phrases

Personalised Care
Social Prescribing
Prevention
Long Term Plan
Non-medical

Abstract:

This article discusses ‘social prescribing’ as a non-medical approach for nurse prescribers that can promote health and wellbeing within a personalised care context as part of the NHS Long Term Plan (DHS 2019). The concept of social prescribing and its origins will be described alongside common interventions and services. This article concludes with an exploration of how social prescribing can be used to compliment nurse prescribing to support personalised care.

Background: Current Health Challenges (2601 words without refs and abstract)

In 2017, the World Health Organisation declared that non-communicable diseases (NCD) such as type 2 diabetes, cardiovascular and respiratory disorders are a significant cause of death globally (WHO 2017). In the UK, estimated figures report that more than 800,000 people live with respiratory diseases such as COPD. Equally, those diagnosed with type 2 diabetes are estimated at 3.1 million, which creates challenges for a resource diluted NHS. Similar unprecedented demands are also observed through increasing numbers of people with dementia needing support. Consequently, there is need to understand how nurses can help prevent the onset of NCDs *and* enable those with long term conditions to self-manage. Hence, nursing involvement with self-care initiatives through national agendas such as personalised care is one which can both stem the increase of NCDs and empower those living with long term conditions. Social prescribing is a process that enables nurse prescribers to work with the individual to understand ‘what matters to them’ in order to create a ‘personalised prescription’.

Personalised Care

Personalised care has been described by NHSE as being that which focuses care on the needs of the person rather than the needs of the service. Based on ‘*what matters*’ to them, personalised care enables personal choice and control, dignity, health and well-being of the individual (DHSE 2019). The promotion of personalised care ultimately influences self-determination and self-directed care, typically through identifying an individual’s assets that will help them to achieve their person-centred goals. Personalised care is fundamental to the NHS Long Term Plan (DHS 2019) and is part of a wider comprehensive personalised care model designed to enable the delivery of better care that will promote both health and wellbeing. Typically delivered in partnership within ‘Primary Care Networks’ through which individuals and the community will be supported use assets (such as community groups, community forums and other group activities) it is envisaged that personalised care will help promote

wellbeing and resilience. Ultimately, individuals will be supported to work in partnership to enable shared decision and choice through personalised health and integrated budgets to empower them to take control of their health and wellbeing. Social prescribing is one aspect of the personalised care agenda that could be better embedded into nurse prescribing to facilitate shared decision making.

What is Social Prescribing?

Since the introduction of social prescribing in 2016, there has been an increased interest in how it can support people in the community with long term conditions and work to support public health measures to combat the increase in obesity levels, type 2 diabetes and coronary heart disease. Working with third sector organisations and the community to tackle some of the worst health and social inequalities was highlighted in Marmot (2010), and more latterly in the NHS Five Year Forward View (DH 2014) and has been identified as one of the 10 key priorities in the GP Forward View (2016) and reinforced in the NHSE Long Term Plan (DHS 2019). In November 2018, Matt Hancock’s statement at the National Social Prescribing conference advocated ‘*perspiration rather than Prozac*’ as an example of a non-medical approach that can promote the health and wellbeing of individuals. Social prescribing is an integral part of personalised care because it embraces non-medical and often non-traditional approaches to support both individuals and communities. Social prescribing is a process of enabling frontline staff to refer individuals to a link worker to provide them with a face to face wellbeing conversation during which they can learn about the possibilities and design their own personalised care. It presents an opportunity for nurse prescribers to engage in a wellbeing conversation and refer directly to a non-medical service. Social prescribing ‘interventions’ are typically located within the third sector; hence, voluntary organisations have a key role in the provision of a social prescribing ‘ecosystem’. One of the many benefits of social prescribing is the impact on A&E admissions, and it has been reported that social prescribing has helped reduce unnecessary GP visits and hospital appointments by an average of 28% (Polley et al 2018). Although there is currently no agreed single term used to describe social prescribing (Cook, Howarth & Wheeler 2018), historically, social prescribing has been recognised by some nurses as ‘community referral’ or ‘asset-based community development (ABCD) in which personalised care planning with the patient and family enabled appropriate goal setting. The principles of social prescribing are similar to ABCD and reflect the need a conversation between the person, link worker (or equivalent) around both the health and wellbeing needs. The process of social prescribing is based on 6 key principles that illustrate the need for collaborative systems, workforce, commissioning and appropriate outcome measures. See box 1:

Box 1: NHSE Principles of Social Prescribing.

- Easy referral from all local agencies
- Collaborative commissioning and partnership working
- Workforce development
- Common outcomes framework
- Support for community groups
- Creating a tailored ‘what matters to me’ plan.

This process is underpinned by the role of the link worker who is responsible for liaising with the primary care network team and local community connector schemes. Nurse prescribers need to be aware of the role of the link worker and/or community connector to ensure patients are referred appropriately based on what matters to the individual. Thus, social prescribing facilitates the personalised care approach that can complement and strengthen existing nurse prescribing principles, practices and competencies.

Social Prescribing & Nursing Practice.

Arguably, social prescribing has been a part of ‘community referral’ for the past 2 decades, during which time, nurse prescribers have promoted wellbeing and health through key public health messages. For example, ‘health promotion, prevention of ill health and health protection (for more information see the RCN Public Health pages at <https://www.rcn.org.uk/clinical-topics/public-health>). Predicated on the premise that “*Improving public health should be seen as part of all nursing and midwifery roles*”, the RCN encourages nurses to minimise the impact of illness through promoting health and by supporting people to self-manage and function at home, work and leisure (RCN 2018). As such, nurse prescribers need to consider both the population and individual needs and view social prescribing as part of the wider personalised care agenda that embraces ‘*what matters to me*’ to empower individuals to take control of their health. The emphasis here is the need to support individuals and communities to adopt healthier, more active lifestyles through empowering the population through key messages, strategies and at a local level and through social prescribing. Promoting the ‘everyone active’ messages and opportunities to achieve this for everyone could be widely promoted through wellbeing conversations and through referral to socially prescribed interventions.

Models of Social Prescribing:

The past two decades has observed a significant rise in the number of social prescribing models and services. Some, such as Howarth, Gibbons & Lythgoe (2018) argue that the array of models maybe as a result of several influencing factors predicated on the wider determinants of health originally highlighted in the Marmot Report (2010). Policies since Marmot have explicated the need to provide more holistic, person centred approaches that help tackle the cause of ill health through understanding wellbeing and the non-medical solutions that can help reduce pressures on GPs and the NHS (Kimberlee 2015, Polley et al 2017). Non-medical approaches include a range of ‘interventions’ typically provided by the Voluntary, Community and Social Enterprise Sector (VCSE) and other third sector organisations (charities). You may recall the introduction of ‘weight watchers on prescription’, or the advent of ‘exercise on prescription’, both of which were employed to help people develop healthier lifestyle choices to stave off obesity and subsequent NCD’s. However, since the advent of social prescribing in 2016, the NHSE refer to three distinct models of social prescribing (see box 2)

Box 2: NHSE Models of Social Prescribing.

1. Referral to a commissioned ‘one-stop connector service’,
2. The involvement of ‘Collaborative Practices: GP surgeries as community ‘hubs’, invite citizens in to work collaboratively, as ‘health champions’, ‘In-house ‘community link workers/ navigators’ – employed by GP Practices and,
3. ‘Active Signposting: ‘Care Navigators’ in GP practices, having different conversations with patients, signposting them to community support, as well as pharmacy, physiotherapists and care providers.

The emergence of social prescribing since the NHS Five Year Forward has been captured in the literature, and more recently, Kimberlee (2015) described 4 models of social prescribing see box 3:

Box 3: Kimberlee’s Typology of Social Prescribing Models

- **Signposting:** which refers to a very basic referral with limited relationships between the individual, organisation and little to no follow up

- **Social Prescribing Lite:** relates to Community or Primary care-programmes referring people for specific objectives, for example, referring someone with a weight problem for weight watchers programme
- **Social Prescribing Medium:** Typically involves a wellbeing conversation based on a good relationships both with patients and VCSE sector. The support offered remains directed to specific behaviours or objectives
- **Holistic:** A holistic system operates around the individual whereby systems within primary, secondary and third sector are able to communicate, have established partnerships to support the individual.

Nurse prescribers can be involved in a range of models and refer people to receive or attend services within the third sector.

Effectiveness of Social Prescribing?

The range of models has led to a diverse evidence base that details and describes the different systems, processes and outcomes. Recent reviews by Polley (2017) and others highlight the impact of social prescriptions on communities, groups and services, however, the evidence base for social prescribing is sporadic, and lacks experimental methodologies as aspired such as RCTs or quantitative systematic reviews. Moreover, the diverse interventions and lack of standardised approach led Bickerdike et al (2017) to conclude that the ‘*current evidence fails to provide sufficient detail to judge either success or value for money*’. That said, Polley et al (2017) argue that social prescribing is valued by both practitioners and patients and longitudinal research is needed to demonstrate the impact on services over time. Moreover, NHSE has attempted to provide an outcomes framework to support social prescribing – and used wide ranging parameters to enable scope of practice to emerge. Whilst the evidence base lacks causality, there is now an acceptance that social prescribing works – but how and why requires further research. In addition, there is a number of studies that have evaluated the impact of specific activities on populations – for example therapeutic horticulture on social inclusion, exercise for mental wellbeing and arts based therapies to promote connectedness. A range of services or ‘interventions’ currently exist within the VSCE and, depending on the wellbeing conversation and assessment, can be suitable for a number of populations.

Socially Prescribed Services.

Socially prescribed activities can include arts based approaches, green care, nature based activities and exercise such as walking or yoga (see for example, the RCN’s pages below). Typically, an individual can be referred by a nurse prescriber, directly to an intervention or via the link worker or to community groups that provide one or more of these activities. For example, a socially isolated older person could be referred to a gardening group to help reduce the likelihood of social isolation, prevent unnecessary GP appointments and promote a sense of wellbeing through engagement with nature. Nurse prescribers can refer to a link worker or directly to such schemes.

RCN: Case studies

<https://www.rcn.org.uk/clinical-topics/public-health/the-role-of-nursing-staff-in-public-health>

Arts based Approaches

Arts based approaches can include taking part in creating activities such as painting, sculpture or other crafts – or attendance at an arts workshop and using dance to help people with dementia can help reduce anxiety and agitation (Beard 2011). Equally, Roe et al (2016) report that engagement in cultural and creative arts improves self-confidence and can influence provides opportunities for older people to socially connect.

Nature Based Activities

Nature Based Activities have been defined as ‘*an intervention with the aim to treat, hasten recovery, and/or rehabilitate patients with a disease or a condition of ill health, with the fundamental principle that the therapy involves plants, natural materials, and/or outdoor environment, without any therapeutic involvement of extra human mammals or other living creatures*’ (Annerstedt & Währborg 2011). For example, nature-based activities can help to improve anxiety (Gonzalaz et al. 2011), general health (Wood et al. 2016), heart rate (Wichrowski 2005) & reduce social isolation (Howarth et al. 2016). In 2019, DEFRA is working with the Department for Education to support access to green spaces for children, young people and those with mental health problems as part of the ‘Year of the Environment’. This is a unique opportunity for nurse prescribers to be aware of and prescribe some of the many nature based opportunities.

Green Care

Whilst nature based activities offer health and wellbeing benefits generally, for example walking the dog, strolling through the park, Green Care provides a more structured approach using the natural environment and has been defined as “*nature-based therapy or treatment interventions – specifically designed, structured and facilitated for individuals with a defined need*”. Moreover, Maxwell & Lovell ‘s (2017) review reported a direct link between exposure to, and involvement with nature and improved health and wellbeing for communities and individuals.

The Future of Social Prescribing.

In the UK, the government has set a series of ambitious targets that will support all local health and care systems to implement social prescribing connector schemes across the whole country by 2023. The NHS Long Term Plan (DHS 2019) predicts that within five years “*over 2.5 million more people will benefit from social prescribing*”, within a personalised approach that will provide support for people to manage their own health through partnerships with the voluntary sector and patient groups. The comprehensive personalised care model will be implemented across England, and it is envisaged that a universal social prescribing national offer will be available in all GP practices (DHS 2019). This includes understanding existing social prescribing connector schemes, publishing a national Common Outcomes Framework, piloting accredited learning programmes for link workers. These targets are not exhaustive and reflect the ambitions of the NHSE and Government to support social prescribing across the NHS, primary, secondary and third care sectors.

Implications for Nurse Prescribers

Nurses who prescribe have a unique opportunity to build on these approaches and reduce the craving for potentially unnecessary pharmacology interventions. According to the Royal Pharmaceutical Society Competency Framework for all Prescribers (2016) prescribers need to consider both ‘*non-pharmacological and pharmacological approaches to modifying disease and promoting health*’ (pg 10). This includes a range of non-medical interventions that could be socially prescribed. For example, taking a walk outdoors could help alleviate feelings of social isolation (Durcan & Bell 2015) and physical exercise working on an allotment can help release myokines and reduce inflammation that causes a range of chronic diseases (Cook, Howarth & Wheeler 2018). Now is the time for nurse prescribers to consider how to further embed social prescribing as a method to promote wellbeing. As Virginia Henderson (1987) quoted, we need to ‘get inside the skin of our patient’s to truly understand what their strengths rather than their needs are so that nurse prescribers can offer a personalised approach that embeds more than medicine. Hence, understanding our patients needs at the forefront of practice – and the last bastions of person centred care.

Conclusion:

Social prescribing an integral part of the personalised care agenda moving away from the medical dominance to one that is person, rather than patient centred. In doing so, the NHS rhetoric of the past 10 years to empower primary care to support the need of more complex needs has come to fruition, and within it, an ambition to ensure that all people in the community are enabled through asset based approaches to non-medical, socially prescribed solutions to promote wellbeing. Nurse prescribers are in a unique position to ensure that social prescription is fully embedded into the NMP programme to meet the changing needs of the population.

References:

Annersted, M. & Wahrborg, P. (2011) Nature-Assisted Therapy: Systematic Review Of Controlled And Observational Studies. *Scandinavian Journal Of Public Health*, 39: 371-388

Beard RL. (2011) Art therapies and dementia care: A systematic review. *Dementia*: 11(5) 633–656

Bickerdike, L., Booth, A., Wilson, P. M., Farley, K. And Wight, K. (2017) Social Prescribing: Less Rhetoric And More Reality. A Systematic Review Of The Evidence, *Bmj Open*, 7 (4): 1-17

Brandling, J., & House, W. (2007). *Investigation into the Feasibility of a Social Prescribing Service in Primary Care: A pilot project*. Bath: University of Bath and Bath and North East Somerset NHS Primary Care Trust.

Cook, P.A., Howarth, M., Wheater C.P. (in press) Biodiversity and health in the face of climate change—Implications for public health. In: *Biodiversity and Health in the face of Climate Change* Ed: Marselle, M.R. et al. Springer.

Durcan D., Bell R. (2015) Local action on health inequalities Reducing social isolation across the life course. PHE. London.

NHS (2016) General Practice Forward View. HMSO: London

NHS (2019) The Long Term Plan. HMSO: London.

Gonzalez, M.T., Hartig, T., Patil, G.G., Martinsen, E.W. and Kirkevold, M. (2010), Therapeutic horticulture in clinical depression: a prospective study of active components” *Journal of Advanced Nursing* ., Vol. 66 No. 9, pp. 2002-13.

Howarth, M. L., Mcquarrie, C., Withnell, N. & Smith, E. (2016) The Influence Of herapeutic Horticulture On Social Integration. *Journal Of Public Mental Health*, 15: 136-140

Howarth M, Gibbons A, Lythgoe A (2018) Evaluation of Social Prescribing Across Greater Manchester. University of Salford (awaiting ISBN)

Kimberlee, R. (2015). What is social prescribing? *Advances in Social Sciences Research Journal*, 2(1), 102–110. <https://doi.org/10.14738/assrj.21.808>

Maxwell S, Lovell, R (2017) “Evidence Statement on the Links between Natural Environments and Human Health” London: Department for Environment, Food and Rural Affairs.

NHS England (2014) Five Year Forward View . Available online: [www.england.nhs.uk/ wp-content/uploads/2014/10/5yfv-we](http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-we)

Polley M., Bertotti M., Kimberlee R., Pilkington K., Refsum C. (2017) A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications. University of Westminster Publication.

Roe B, McCormick S., Lucas T., Gallagher W., Winn A., Elkin S. (2016) Coffee, Cake & Culture: Evaluation of an art for health programme for older people in the community. *Dementia*. Vol. 15(4) 539–559.

Royal Pharmaceutical Society (2016) A Competency Framework for all Prescribers. RPS. London.

Wichrowski, M., Whiteson, J., Haas, F., Mola, A., Rey, M.J., (2005) Effects Of Horticultural Therapy On Mood And Heart Rate In Patients Participating In An Inpatient Cardiopulmonary Rehabilitation Program. *J. Cardiopulm. Rehabil. Prev.* 25: 270 –274

Wood, C. J., Pretty, J. & Griffin, M. (2016) A Case-Control Study Of The Health And Well-Being Benefits Of Allotment Gardening. *Journal Of Public Health*, 38: 336 – 344*

World Health Organisation Global Health Observatory (2017) NCD Mortality and Morbidity [Online] Available at: http://www.who.int/gho/ncd/mortality_morbidity/en/ [Accessed 14 September 2017]