Primary Health Care

evidence & practice
non-clinical interventions

Why you should read this article:
- To increase your awareness of the potential benefits of social prescribing in primary care
- To learn about a nurse-led social prescribing pilot project conducted in a general practice in South Devon
- To prompt you to consider setting up a social prescribing scheme in your work area

Social prescribing: a nurse-led pilot project in a general practice setting

Joyce Pickering and Kathryn Smyth

Key points

- *In social prescribing schemes, people are referred for non-clinical interventions to a range of services and groups in their local community*
- *Social prescribing aims to address the social and mental health issues that can have a detrimental effect on physical health*
- *There is no set model for social prescribing schemes, since the health needs of the population vary from one area to the next*
- *Social prescribing schemes should be designed to respond to local needs and use local resources*
- *Evidence from existing schemes indicates that social prescribing can improve health outcomes for people and reduce pressure on the NHS*
- *More robust and systematic evidence of the effectiveness of social prescribing is needed*

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Correspondence
joycepickering@nhs.net
[Q1: would you like to add a Twitter handle to your correspondence details?]

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None declared

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Abstract

Social prescribing is a mechanism for promoting health and well-being whereby people are referred for non-clinical interventions to a range of services and groups in their local community. In social prescribing schemes, healthcare professionals and/or link workers connect people with community groups and services that can support them with a broad range of emotional, social and practical needs, ultimately enabling them to take ownership of their health. This article describes the development, implementation and outcomes of a nurse-led social prescribing pilot project conducted in a general practice in South Devon. There is evidence that social prescribing can result in improved health and well-being, but more robust and systematic evidence of its effectiveness is needed. Qualitative outcome data were collected as part of the pilot project, adding to the evidence base showing the benefits of social prescribing.

Author details

Joyce Pickering, practice partner [Q3: should this say 'general practice nurse manager', as in the article itself?], Cricketfield Surgery, Newton Abbot, England; Kathryn Smyth, lecturer, School of Community Health and Midwifery, University of Central Lancashire, Preston, Lancashire, England [Q4: please note that the Queen's Nurse titles have been removed because it is our house style not to include titles in author details. Apologies for that.]

Keywords

behaviour change, clinical, community, diabetes, general practice, glycaemic control, health promotion, lifestyles, patient engagement, patients, practice nurses, professional, wellbeing

Social prescribing is a mechanism for promoting health and well-being whereby people are referred for non-clinical interventions to a range of services and groups in their local community. In social prescribing schemes, patients are often referred to a link worker, who performs a holistic assessment and then connects patients with appropriate community services and groups (NHS England 2021). Referrals of patients to a link worker are usually made by healthcare professionals working in primary care settings, such as GPs and practice nurses (Buck and Ewbank 2020) or pharmacists (NHS England 2021). The interventions are typically provided by voluntary and community sector organisations and include volunteering, artistic activities, group learning, gardening and sports (Buck and Ewbank 2020).

Social prescribing is not a new concept and has been used in the NHS since the 1990s (Buck and Ewbank 2020). However, interest in social prescribing has increased in the past decade. In the General Practice Forward View (NHS England 2016), social prescribing was identified as one of ten high-impact actions that would allow to free up GPs' time. In 2019, the NHS Long Term Plan described how social prescribing would increase the range of support available to patients and how link workers would become an integral part of the multidisciplinary team in primary care (NHS England 2019).

Social prescribing schemes aim to address the social and mental health issues that can have a detrimental effect on physical health, particularly in people with long-term conditions. The decision to refer a patient to a link worker is usually made by a healthcare professional after an assessment of the person's physical and mental health. Being referred to a link worker provides the person with an opportunity to discuss what matters to them in a safe place with someone who has time. The link worker can then connect the person with community groups and services that can support them with a broad range of emotional, social and practical needs, the ultimate aim being to preserve or improve physical health and psychological well-being. This is quite different from the conventional patient-clinician relationship and social prescribing is part of a general move away from the medical model towards a personalised model of care (NHS England 2020).

This article describes the development, implementation and outcomes of **a nurse-led social prescribing pilot project conducted in ????** [Q5: please indicate year(s)] by the first author of this article (JP), who is a general practice nurse manager in South Devon. In this pilot project, the role of link worker was undertaken by the project team, composed of JP and a senior healthcare support worker.

Rationale for social prescribing

Approximately 20% of patients consult their GP for what is predominantly a social issue (Polley et al 2017a). Over 75% of GPs report that they see, each day, between one and five patients who experience loneliness (Campaign to End Loneliness 2013, Steadman et al 2017). Valtorta et al (2016) found that a lack of social relationships was associated with an increased risk of developing coronary heart disease and stroke. Addressing social issues such as loneliness and isolation could therefore play an important role in the prevention of long-term conditions.

Social prescribing is not simply about attempting to ease the pressure on general practice, but also about ensuring that each person receives support from those who are best placed to meet their physical, emotional and social needs. With increased demand for health and social care, it is important that resources are used efficiently. Evidence from existing social prescribing schemes indicates that social prescribing can improve health outcomes for people – enhancing quality of life, improving mental and emotional well-being, and alleviating depression and anxiety – and reduce pressure on the NHS. Research has shown that social prescribing schemes could result in an average 28% reduction in the number of GP consultations and an average 24% reduction in the number of emergency department attendances (Polley et al 2017a).

Several models of social prescribing are emerging in England and it is likely that more will develop over the next few years, as the comprehensive model for personalised care, which aims to make personalised care 'business as usual' across the NHS in England (NHS England 2020), becomes embedded in clinical practice. There is no set model for social prescribing schemes, since the health needs of the population vary from one area to the next. Social prescribing schemes should be designed to respond to local needs and use local resources. While there are some excellent examples of social prescribing schemes, such as that described by Spencer (2017), there are wide variations in the implementation of social prescribing schemes nationally.

Figure 1 shows the NHS England model for social prescribing (NHS England 2020), outlining the main features of an optimal social prescribing model.

Figure 1. NHS England model for social prescribing

Adapted from NHS England (2020)

Project development

Background

The idea for the pilot project emerged from JP's clinical role in supporting patients with long-term conditions, particularly those with type 2 diabetes. JP found that some patients were able to understand the importance of blood glucose monitoring and adhere to recommended lifestyle changes, but that others struggled to find the motivation, or were not able, to make such changes. At JP's practicse, patients with type 2 diabetes are offered a referral to the local 'diabetes group education' service, which provides evidence-based education and advice. However, a review of the practice's patient list showed that, while around 50% of patients with type 2 diabetes would agree to be referred, only half of those referred would actually attend the education sessions. Informal conversations, during clinical consultations, with patients who had been referred but had not attended the group education sessions revealed a variety of reasons for not attending, including a reluctance to participate in group sessions, a lack of confidence, a fear of the unknown and, for some, a lack of transport.

A further review of the practice's patient list showed that the practice's population of older people was increasing and that some of these older people lived in remote locations. South Devon is popular with people looking for a peaceful place to retire to and **has seen an increase in its population of older people, which is larger than the national average (Public Health England 2018)** [Q6: the PHE document cited here does not appear to include comparisons between different regions in England. Please provide a reference citation that covers this statement]. As they age, older people are at increased risk of becoming isolated and may find it increasingly challenging to access healthcare and other services, especially after their partner has died (Courtin and Knapp 2017).

These reviews of the practice's patient list and conversations with patients suggested that there were many patients registered at the practice who would potentially benefit from social prescribing.

Planning

Several well established services and groups providing social prescribing interventions already existed in the locality, but there was no cohesive referral system in place to enable straightforward access to these services for patients. Many patients also lacked the confidence to access these services. This was therefore an area where improved collaboration and communication would potentially enhance patient care. The idea was that the pilot project would be nurse-led and based at the practice, so that patients would receive support in a familiar environment from staff they knew. The role of the link worker would be performed by the two staff members in the project team – JP and a senior healthcare support worker. This was designed to remove the anxiety and lack of confidence experienced by patients when referred to external services. Ultimately, the goal was to give patients the confidence and ability to take ownership of their health and long-term condition.

During the planning phase, it was important to avoid duplicating similar already existing social prescribing schemes. The cost of the pilot project had to be calculated. The planning required researching social prescribing, engaging with local stakeholders, identifying important contacts and determining a realistic time frame. Taking the time to visit local social prescribing services proved helpful in obtaining information on what was available locally and learning what communication methods worked best. JP set up a plan for the project demonstrating that it would address an unmet need and potentially enhance patient care.

Funding

Funding was obtained through an initiative developed in the wake of NHS England's Ten Point Action Plan for General Practice Nursing (NHS England 2017). JP attended a leadership programme that was funded by one of these initiatives. On completion of the leadership programme, there was the opportunity to propose a project and business plan, which were submitted to a panel. The panel decided that the proposed project had the potential to enhance patient care and funding was therefore granted.

Project implementation

Preparation

Once the project had been approved and funding obtained, implementation started with a six-month preparation phase. To prepare themselves to take on the role of link worker, JP and the senior healthcare support worker underwent health coaching training. The senior healthcare support worker also attended a local course on how to overcome problems effectively, designed to support people to better understand and manage their long-term condition. The project team also compiled a directory of local social prescribing services and local evidence-based online resources. One of the clinical rooms at the practice was redecorated, fitted with comfortable chairs and renamed the 'well-being room' to make the environment less clinical for patients.

Not everyone at the practice was familiar with social prescribing. It was therefore important to inform staff across all practice departments so that the message communicated to patients would be consistent. JP presented the project to staff and patients during an open evening talk and provided staff with regular updates. Patient participation groups, which have an important role in the practice, were enlisted to support the project, notably by assisting with its promotion. This collaborative working strengthened the project, providing valuable advice and networking opportunities. The project team also established relationships with further voluntary groups in the locality.

Delivery

In ???? ???? [Q7: please indicate month + year], once preparations had been completed, the project started, led by the senior healthcare support worker. A total of 14 half-hour social prescribing sessions per week were available to patients. During clinical consultations, JP identified patients with ongoing health concerns who would potentially benefit from social prescribing. Those who agreed to participate were offered up to 12 social prescribing sessions. The sessions were patient-led, with coaching from the healthcare support worker and input from JP as required. The aim was to support patients to make lifestyle changes that would benefit their health and well-being. This was a fluid process tailored to the needs of each individual. Signposting to other services was incorporated but was a minor component of the sessions.

The frequency of appointments depended on the patient; for example, they could attend weekly or fortnightly. Some patients did not want or need to attend 12 sessions so attended a smaller number of sessions. Appointments for the social prescribing sessions were clearly identified as such on the internal clinical system. Initially, only GPs and nurses could refer patients to the service, after having assessed them, to ensure the appropriate use of appointments.

The pilot project focused on supporting:

» Patients with type 2 diabetes.
» Patients with non-diabetic hyperglycaemia.
» Patients with low-level mental health issues such as mild depression or low mood.
» Socially isolated patients.
» Patients experiencing **weight loss** [Q8: excluding weight loss caused by a health condition, presumably? This needs to be specified. Please also confirm that you do mean weight loss, not weight gain].
» Patients with long-term conditions, such as chronic obstructive pulmonary disease and cardiovascular disease, who needed extra support in managing their condition.

The project was piloted over a six-month period from ???? ???? to ???? ???? [Q9: could you please indicate months and year(s)?]. A total of 36 patients took part in the pilot, including 28 who had either type 2 diabetes or non-diabetic hyperglycaemia.

Project outcomes

Data collection

A robust evaluation of the project was a condition for obtaining funding. Support with data collection was obtained from local **research doctors** [Q10: do you mean researchers who have a doctorate? Or doctors involved in research?]. Data relating to social

prescribing tend to be subjective, but objective data were required to evaluate the project, so a quantitative approach to data collection was needed.

A spreadsheet was used to collect important information, including:

» Patients' reason for attending the sessions.
» Number of patients who missed sessions.
» Intentional weight loss achieved at the end of the patient's sessions.
» Blood pressure reduction achieved at the end of the patient's sessions.
» HbA1c (glycated haemoglobin) levels at the start and end of the patient's sessions.
» **Alcohol consumption** [Q11: when? At the start and at the end?].
» Mood and well-being, **recorded using subjective information** [Q12; recorded how? What sort of subjective information? Please explain].
» Feedback from patients.
» Feedback from GPs.
» Feedback from other members of the practice team, clinical and non-clinical.

Findings

Quantitative data collection over the six-month pilot period demonstrated that:

» **81% of patients** [Q13: among all 36 patients or only those who were overweight?] **had successfully lost weight, of whom:**
  – **53% had lost 1-5% of their total body weight.**
  – **28% had lost 5-10% of their total body weight.**
» **6% had gained weight** [Q14: among all 36 patients or only those who were underweight?].
» **6% had seen their weight remain static** [Q15: among all 36 patients or only those who had a normal weight?]**.**
[Q16: among the 36 patients who took part, presumably, some needed to lose weight and some needed to gain weight (and maybe some did not need to lose or gain weight at all). This makes the above percentages confusing, because we don't know whether they show a positive or a negative outcome. Could you please clarify?]
» One patient was able to cease antihypertensive treatment as a result of the weight loss they had achieved.
» In the 28 patients with type 2 diabetes or non-diabetic hyperglycaemia, there had been a 18% average reduction in HbA1c levels.
» 8% of patients had missed sessions.

Patients' feedback about the project included, for example:

» 'I feel empowered.'
» 'For the first time in many months I feel back in control of my health.'
» 'I feel less isolated.'
» 'Increasing exercise motivated me to make other lifestyle changes.'

Discussion

Measuring HbA1c levels was one of the main objective ways of evaluating the effects of the social prescribing pilot project on patients with diabetes or non-diabetic hyperglycaemia. The outcome of an 18% average reduction in HbA1c levels far exceeded expectations. It represents a significant improvement in glycaemic control, **which can be challenging to achieve even with an increase in patients' medicines** [Q17: could you please provide a reference citation backing up this statement?].

The project has demonstrated sufficiently positive outcomes for the GP partners at the practice to agree to fund it on an ongoing basis. They have agreed to look at how the project could be developed to include other patient groups. Furthermore, they have agreed to examine the option of group consultations providing both clinical and social support to patients who require ongoing assistance. The local clinical commissioning group is investigating how the social prescribing project could be rolled out more widely to support patients with long-term conditions.

The COVID-19 pandemic has led to new ways of managing and delivering services in general practice. It was essential to maintain, throughout the pandemic, the provision of social prescribing, since the pandemic would have exacerbated social isolation and

loneliness, particularly in vulnerable groups. **The social prescribing project was quickly adapted and moved to remote consultations** [Q18: was that during the pilot or afterwards?], enabling the team to continue supporting patients.

Social prescribing is an important element of the NHS Long Term Plan (NHS England 2019). The fact that every primary care network has a social prescribing link worker opens up opportunities of new ways of working with patients to improve their health and well-being. A variety of social prescribing schemes have been developed across the country and this is likely to continue. There are wide differences in general practice patient demographics across the UK, so general practices will require different types of social prescribing services according to the needs of patients in their area.

There is evidence that social prescribing can result in improved health and well-being, but more robust and systematic evidence of its effectiveness is needed (NHS England 2020). Well-being is challenging to measure and healthcare professionals who implement or lead social prescribing schemes are encouraged to evaluate these schemes by collecting quantitative data. The Making Sense of Social Prescribing guide (Polley et al 2017b) provides advice on how to evaluate a social prescribing scheme as well as a checklist of things to consider when setting up such a scheme. The Personalised Care: Social Prescribing and Community-based Support guide (NHS England 2020) provides a common outcomes framework that enables social prescribing schemes to capture core data, with a view to develop a consistent evidence base.

Conclusion

Social prescribing is not a new concept, but interest in social prescribing has increased in the past decade and is an important element of the NHS Long Term Plan. There is evidence that social prescribing can improve health and well-being, but more robust and systematic evidence of its effectiveness is needed. The piloting of a nurse-led social prescribing project in a general practice in South Devon had positive effects on the physical health of participating patients, in particular a notable reduction in HbA1c levels among patients with type 2 diabetes or non-diabetic hyperglycaemia. It is recommended that general practices who are considering the use of social prescribing tailor their social prescribing scheme to the needs of the local population and ensure they evaluate the scheme by collecting quantitative data.

FURTHER RESOURCES

Royal College of Nursing
rcn.org.uk/clinical-topics/public-health/self-care/social-prescribing

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