The Role of Social Prescribing Link Workers in Reducing Health Inequalities

(Individual and community level)

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This document has been informed by the National Association of Link Workers UK roadshows, dedicated Twitter Link Worker chats, and round table discussions with key stakeholders carried out throughout 2021.

It has been peer-reviewed by the people on page 11.

It provides clarity and helpful guidance to Social Prescribing Link Workers, employers, and Health Inequalities strategies.

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FOREWORD

Social Prescribing Link Workers are leading a ground-breaking innovation that allows the NHS to deliver 360° care to meets the needs of the local population, whether it be a reduction in health inequalities, an improvement in mental health and quality of life, an increase in the NHS workforce capacity, or join up care.

Owing to the ever-increasing NHS workforce pressures, increased public demand for 360° care, health inequalities and mental health crises, all stakeholders need to understand the absolute necessity for the role of Social Prescribing Link Workers (SPLW) in reducing health inequalities.

The "Social Prescribing Link Worker intervention" is a "cure" and they provide the link between the community, NHS, and policy makers. We must utilise their knowledge to inform intelligence and service provision nationally and locally, empower them with the resources they need to drive systems change, recruit more across the entire health and social care landscape, and deliver all-doors access to Social Prescribing Link Workers.

I would like to thank our members whose intelligence informed this document and the peer review group, Zoe Dunster, Marie Adams, Jane Soothill, Sara Godoli, Faith Walkwell, Monica Boulton, and Kelly Austin, for their timely contributions.

This document will helpfully provide clarity and helpfully guide Social Prescribing Link Workers, employers, commissioners and Health Inequalities strategies.

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INTRODUCTION

Social Prescribing Link Workers (SPLW) are new members of the NHS workforce. The role of the SPLW is defined by some quarters as "connecting people to wider community support that can help improve their health and well-being". This definition is too narrow in scope and only defines the community connecting aspect of their role. It doesn't reflect the full scope of their role and impact in practice. In this document, we demonstrate how their role is beyond this narrow definition and the role they play in reducing health inequalities and improving health outcomes.

Social Prescribing Link Workers are frontline non-clinical health professionals working at an individual and community level. They are part of the Multi-Disciplinary Team (MDT) delivering personalised care to people, enabling them to take control of their health and well-being. They make observations around how to improve the individual's physical and mental health, looking at it from the social, cultural, economic, and environmental circumstances in which they live - in other words, from the viewpoint of the wider and social determinants of health points of view and seek to address what matters to the person holistically through time to talk and shared decision making. They empower people to create personalised action plan to achieve the goals they have set for themselves, without feeling overwhelmed and enable them to achieve them.

The collaborative approach, which underpins SPLW's interactions, naturally empowers people and fosters independence and resilience. The specific perspective from which SPLW look at people's health - namely the wider social determinants of health - naturally highlights barriers to health and well-being responsible for health inequalities.

Aiming to improve the mental and physical well-being of the population they serve, SPLW facilitates access to support to meet identified needs. They connect and link people to the right support and interventions. They may also help set up new support and interventions to fill gaps in service provision.

Many GPs are facing an impossible task: with only a short appointment slot to assess and address the needs of the patient in front of them. Understandably, the immediate presenting medical complaint takes priority. The Link Worker social model of health can support GPs in providing holistic care to meet people's needs. The COVID-19 pandemic has exposed and increased health and social inequalities and, therefore, increased pressure on the NHS.

A holistic approach to health is needed to pay equal attention to medical and socio-economic factors, with Social Prescribing Link Workers playing a vital role in improving health outcomes.

With sufficient resources allocated and numbers of SPLW working alongside primary care and community services, they can relieve the burden of care, effectively utilise limited resources, and improve health outcomes, positively impacting marginalised individuals and communities. We endeavour for all stakeholders to understand their role in reducing health inequalities - Health Improvement, Integrated Care, Community Integration, and Equitable access.
THE ROLE OF SOCIAL PRESCRIBING LINK WORKERS IN REDUCING HEALTH INEQUALITIES
1. HEALTH IMPROVEMENT

Managing ill health

Many GPs are facing an impossible task: with only a short appointment slot to assess and address the patient's health in front. Understandably, the immediate presenting medical complaint takes priority in scenarios where the clinician rarely is afforded time to adequately address any non-medical causes of illness. The SPLW supports the GP by uncovering and addressing the non-medical concerns of the patient.

Case study 1:
Mr. A is a 49-year-old male presenting to a busy GP surgery with a suspected chest infection. He has never smoked. He has previously presented with several respiratory issues in the last year. These have all cleared with a short course of oral antibiotics, and he is otherwise completely well between episodes. Dr. B is seeing Mr. A for the first time. She prescribes another course of antibiotics and decides that if he presents again, she will refer him to Respiratory Outpatients for specialist investigation. She also refers to the SPLW as the patient raised issues around feeling isolated and having low moods.

The SPLW has access to the 'whole' person over a longer period. As a non-medical professional, the nature of the interaction between the individual and the SPLW focuses not only on the physical symptoms of their illness but also on the wider social determinants of health that might contribute to those symptoms. With the opportunity to discuss these in greater depth, the SPLW can uncover the non-medical determinants of illness by looking at the wider social context within which the individual lives and consequently additional contributing factors to ill health, and the individual context in which illness occurs, supporting patients to access the appropriate health and social care interventions.

Case study 1 continued:
The SPLW visits Mr. A at his home in a social housing block. Mr. A says he is feeling improved after antibiotics. Mr. A apologises for the damp and mould in his living room. He had not mentioned this to the GP as he didn't know it could have been related and didn't think this was her responsibility in any case. The SPLW contacts the responsible persons at the council and explains the situation. The damp and mould are fixed, a referral is made to address his fuel poverty, he is connected to a local group men's group where he has made some friends. Mr. A has no further respiratory issues and needs no further investigation.

In this case study, the GP can address the medical issue appropriately while the SPLW addresses the root cause, preventing ongoing health concerns and additional visits to GP, saving the patient from unnecessary investigations and treatment, and saving NHS time and resources. Mr A is empowered and aware of the menu of support available to him and how to get support and is in control of his health and well-being.
1. HEALTH IMPROVEMENT

Preventing ill health

As seen in Case study 1 above, short consultations limit GPs from having enough time to dedicate to non-medical issues. Any medical issue will likely take priority in a consultation slot that does not allow for exploring complex contributing factors. A collaborative exploration of ill health complex contributing factors takes time, resources, and a different set of skills. Further, we have a chronic shortage of GPs. When GP's do identify and recommend alternative preventative health interventions, it still takes an additional interaction with a SPLW for the recommendation to become a reality, as seen in Case Study 2 below.

Case study 2:
Mrs. C is a 55-year-old woman with a BMI of 30. She presents to her GP for a check-up after previously starting treatment for essential hypertension. Her blood pressure is now 124/70, and she is otherwise well. Dr. D discusses the importance of adhering to medication and briefly discusses lifestyle changes such as weight loss, exercise, and dietary changes. Dr. D suggests joining a gym or an exercise class, which she didn’t.

In this scenario, the SPLW works alongside the primary care team to explore the patient’s background and context, resulting in personal, appealing, and sustainable interventions.

Case study 2 continued:
Six months later, Mrs. C returns for a routine follow-up with Dr. D. Her weight is unchanged, and her blood pressure is borderline high. Dr. D refers her to the SPLW, who visits Mrs. C and spends some time talking to her. Consultation with the SPLW reveals that Mrs. C felt unmotivated to attend the gym, as she felt this was a space for younger, fitter people and felt embarrassed to exercise in a public space. She tried jogging, but this hurt her knees. The SPLW can recommend a walking program to Mrs. C, who didn’t know this was an option. Mrs. C feels comfortable doing this in public. The SPLW attends the first group with her, as she was feeling nervous. She is supported by the SPLW, empowered, and newly motivated, she feels comfortable doing this on her own, and she loses 10kg over the following months, and her blood pressure remains stable on one medication.

The SPLW can identify with the individual concerned about the barriers preventing her from following the GP’s suggestions and collaboratively working out alternative solutions. A personalized care plan is co-produced.

By uncovering the individual factors responsible for health and finding the unique motivations and incentives for the individual, the SPLW helps the individual to co-produce a personalized plan. This strengths-based approach facilitates the patient to activate their assets and take control of their own health and well-being. The SPLW can support the individual in their behaviour change over time. The result avoids unnecessary medical and pharmaceutical intervention and takes charge of their narrative.
2. INTEGRATED CARE

SPLW play a necessary role within Primary Care. Social Prescribing meaningfully embedded within Primary Care opens new opportunities for Public Health and Healthcare to become more person and community centred. Social Prescribing bedrock is the recognition that the context of people's lives determines their health. By identifying barriers to health SP addresses issues of social justice and health inequalities.

This is a broad remit, and the SPLW works with a variety of professionals, local agencies, and partners such as local authorities, emergency services, welfare providers, primary and secondary care, and voluntary/community groups to identify people and areas of need.

SPLW operates holistically and proactively, identifying socio-economic and environmental factors that determine health and prevent illness resulting from injustice and inequality. SPLW not only advocates for their patients and communities but empowers them to enact positive changes at an individual and community level for their health and well-being.

Case study 3:
SPLW attends Frailty MDT meeting and raises concern about Ms. D who had mobility issues. The initial reason for the referral to SPLW was loneliness. Upon a home visit, he identified D's multiple needs both medical and social, and raised this at the Frailty MDT meeting which activated MDT approach:

Division of labour shared between the district nursing team, community matrons and GPs, and patient identified as housebound and added to the chronic disease registers that had otherwise kept her off the GP radar. Practice Frailty Lead GP undertaking a comprehensive review of her treatment, and treatment of her cardiac and renal failure. Treatment escalation planning and ReSPECT conversations in progress. Dementia diagnosis in process and conversations surrounding support for her ongoing

Much of this work has been done without adding lots of additional work and investigations for her own named GP, by utilising and sharing existing information. This is a perfect example of true MDT working with SPLW and the impact it has.
3. COMMUNITY INTEGRATION

Community Development

Empowering communities is a sustainable way to achieve better overall health outcomes on a large scale. Some individuals are unlikely to directly control many determinants of health. Many of those determinants need addressing at the community level. SPLWs play a vital role in giving people a voice and highlighting social injustice and health inequalities in their specific local and social context.

The SPLW has a unique understanding of their community that facilitates ground-up solutions that develop pre-existing strengths and assets.

Community intelligence

SPLWs success lies in their knowledge and affinity to the communities they serve. During the COVID-19 pandemic, SPLWs were uniquely placed to work proactively with vulnerable people and respond to the community's needs quicker than some statutory establishments. SPLWs have been more critical than ever in ensuring continuity of care and support for some marginalised communities. Giving people time to talk on broad issues gives the SPLW a ground-level understanding of the person's health and needs. This allows them to identify the right services and support that the community needs, gaps in provision, or barriers to access (see below). This intelligence can be used to develop an evidence base and influence strategy and policy locally and nationally.

If by community we can also identify various social locations shared in different combinations by many Social Prescribing clients, such as LGBTQ+ community, people with a history of childhood trauma, mental health issues over many years, isolation, not been fit for work, benefit claiming, this case study can illustrate with a very gentle narrative how Social Prescribing can offer continuity of care and support by filling the existing gaps.

A SPLW can refer someone to the right service to help with PIP filling forms, yet as below, the contact with such organisation has been possible because of the Social Prescribing "intervention" (because of the collaborative work with clients). Therefore the "Social Prescribing Link Worker intervention" itself is the "cure".

Case study 4:
A is a woman in her late 30's. When introducing herself, she mentioned childhood trauma and many years of struggling with mental health issues and social anxiety, increased by the Covid-19 situation. This makes it difficult for her to leave the flat and meet anyone, even through Zoom.
Community Intelligence

Case study 4 Continued

She is on several medications and is concerned that her physical health will suffer because of it. Over many years, she was told her presentation was not complex enough to be referred to any specialist service. The only support she could get from the GP has been a medication review. She feels as if she has tried everything, but nothing has worked. A is struggling with her PIP application which requires her to go through her whole medical records: she said that reading her mental health history is discouraging and makes her feel hopeless.

During the first session, going through different activities offered by the council, she always highlights the risks and the possible failures related to pursuing new projects. She said she might be interested in writing classes and some activities within the LGBT community, but she did not feel ready yet.

During the sessions, her camera was always close to her face, which the link worker could hardly see in full. However, she was there, on time, week after week, laughing at shared jokes, engaging, listening, and caring.

The SPLW pointed out that she was challenging herself and succeeding in taking a commitment with the sessions and meeting a new person. She agreed, accepted this, and literally patted her back to congratulate herself, which was a significant gesture in their collaborative work.

A said that she feared taking steps such as counselling or other longer-term projects as she felt that another failure could send her back to a very dark place of despair, compromising her will to keep going, to keep living. Their shared keyword to guide their work together became baby steps.

They agreed that Social Prescribing is that support that fills the gaps other services cannot address. As A described it: collaborate to discover what little things can make you feel better and can be achieved with a sustainable effort.

Step by step, with a gentle poking from the SPLW, A managed to have an interview with an organization in the community which could help her with her PIP application, and, right before the eighth and last session with the SPLW, joined her first Zoom class.

The last session looked like a ray of sunshine. She had her first Zoom class right before. The camera was wider, and her face was fully visible and looking proud. She also reached another important goal: plan to get out of her flat, even if for a few hours. Her brother agreed to pick her up from her flat over the weekend, with his new puppy she is excited to meet. She has committed to meeting up again in three months for a review.
4. EQUITABLE ACCESS

The Social Prescribing Link Worker model is underpinned by an inclusive approach that ensures equitable access to healthcare services and support for underserved groups, communities, and individuals. As flexible, mobile individuals working closely with their respective communities, the SPLW can empower people to tackle social determinants of health that the NHS cannot traditionally reach.

In this capacity, the SPLW can identify and remove barriers to care alone or helped by a clinician if appropriate. In one case study in the Wirral, a telephonic intervention made by SPLW identified barriers to attending smear tests and markedly increased the uptake of cervical smears in a group of women over 40.

Considering further that in the UK, cervical cancer rates are drastically higher in the most deprived quintiles, interventions of SPLW that ensure and facilitate access to health services can significantly improve health outcomes for underserved and underrepresented communities.
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