



# Connecting communities and healthcare:

Making social prescribing work for everyone

Insights and examples from the community and voluntary sector



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# Foreword

Our health and wellbeing is more than just a medical issue. Social, environmental and economic factors all play a part and importantly, contribute to health inequalities - the “avoidable and unfair differences between groups of people or communities.”<sup>1</sup>

Experiences like social isolation and loneliness, stress, discrimination, trauma and neglect, being a carer or living in poverty play a contributing role,<sup>2,3</sup> in many physical and mental health conditions. As do lifestyle factors like diet and exercise, smoking, drinking or drug use.<sup>4</sup>

Social prescribing can't resolve underlying inequalities, but its advocates say it's a holistic and personalised way to address symptoms through non-medical support that complements conventional health treatments like medication. They also suggest it has a role in reducing pressures on the NHS: around 20% of GP visits are for non-medical reasons.<sup>5</sup>

There is a growing drive to embed social prescribing across the UK and to make it accessible and impactful for more people. But we know there's a lack of good quality research to show its efficacy and meet the exacting evidence requirements of health professionals.

In this paper, we describe what we've learnt from our grant holders who are piloting or scaling social prescribing, or who provide services as part of existing schemes.

We don't have all the answers but set out the learning we've gathered to date which highlights the need for the below.

- A systematic approach to funding that nurtures and enables collaboration between statutory and community providers and ensures that money reaches all parts of the system, so the volume of demand is not simply transferred from health care to the voluntary sector.
- Link workers with a blend of experience, knowledge and personal qualities to adeptly support individuals in need while also influencing key stakeholders at strategic and system-wide level.
- Effectively supporting key staff through supervision, peer support, remuneration and the resources to avoid burn out and overload.
- The importance of intentionally generating, gathering and sharing evidence of all kinds, which demonstrates the benefits and impact of social prescribing on people, community organisations and the health and social care system.

Here we share experiences and stories from across The National Lottery Community Fund. We offer useful messages and inspiration for anyone thinking of designing, improving or expanding social prescribing schemes.

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# 1. Introduction

Social prescribing is a way to support people's wellbeing and quality of life while reducing pressure on the NHS. It links patients with physical or mental health conditions, or people who may be lonely, isolated or experiencing stress for example, to community based activities, rather than simply prescribing them medicine.



Digital Buddies

It has been described as part of a shift away from traditional top-down models of care through General Practitioners (GP) and hospitals to a more networked, non-medical and person-centred approach. This can mean offering anything from physical and social activities, like walking groups, dance classes, reading groups, healthy eating lessons and mindfulness courses, to peer support or advice on debt or benefits.

It works by considering the issues that may be contributing to people's symptoms, and without defining the person by their condition. Compared to traditional medical interventions, social prescribing focuses on wellness, instead of illness. It explores what matters to people, not what's the matter with them and aims to address problems that may be caused by social, environmental and economic factors, like debt or loneliness.

There are many different models for social prescribing, and, "it is important to conceptualise [it] not as an intervention, but as a system."<sup>6</sup> Most have three key elements.

- **Referral:** A GP, nurse or other health professional refers the patient to, typically, a link worker. Referrals can also be made by pharmacists, social

care or local authority staff, and by other voluntary and community sector (VCS) services. Many schemes welcome referrals from community outreach and engagement workers too, and self-referrals and recommendations from family and friends may also be possible. The referral recognises that someone has underlying issues and would benefit from a different kind of intervention in addition to, or instead of, medical treatment.

- **Prescription:** Working with the patient, the link worker identifies activities or services that can improve their health, wellbeing or personal situation. This is more than just signposting. There is a genuine partnership between the individual and the link worker: building rapport, exploring interests and barriers, and connecting patients with activities and services that build on their potential.
- **Activities:** The individual takes part in "prescribed" activities and services, mostly provided by the local VCS. These vary from one-off activities and individual support to open ended specialist support services.<sup>7</sup>

UK governments, health services and local authorities recognise that social prescribing has the potential to make better use of resources and influence the reorganisation of local services. In May 2018, the **Royal College of General Practitioners** called on government to promote social prescribing. They recommended that every GP surgery should have access to a dedicated link worker and social prescribing scheme.<sup>8</sup> It also plays a key part in the ambitious **personalised care**<sup>9</sup> agenda of the NHS, which is focused on giving people choice and control over the way their care is planned and delivered.

Charities and community organisations play a vital role in social prescribing. Local voluntary groups run many of the prescribed activities, while VCS organisations often provide the link worker or prescriber function. Social prescribing offers opportunities for the VCS to reach new people and promote a holistic way of working that looks at the whole person rather than only at their symptoms. However, it presents a challenge for funding and resourcing by creating increased demand for services.

At The National Lottery Community Fund, we have seen a year-on-year increase in the number of applications and successful grants for social prescribing. We have invested over £60 million over the last five years,<sup>10</sup> to support and enable link workers, pilot new approaches and VCS-led activities and services that underpin social prescribing.

Our funding has also supported the VCS to capture evidence about its benefits. For example, a number of pilots are developing technology to improve links between the health system, link workers and service/activity providers.

This paper focuses on practical, day to day learning which may be useful for those who are thinking of designing new social prescribing schemes or expanding or improving existing ones. We'll also examine some of the wider system challenges and offer examples of solutions our grant holders are developing and testing.



HAPANI

## 2. Fulfilling potential and addressing a need

Our health system is under great strain. NHS England's annual patient survey found that the number of people waiting a week to see their GP has almost doubled in the last six years (from 13% in 2012 to 24% in 2018).<sup>11</sup> A survey in Wales found that two out of five people find it difficult to make a convenient GP appointment; this proportion has increased from 33% in 2012-13 to 42% in 2018-19.<sup>12</sup>

At the same time, many people are seeing their GP for issues that don't require medical solutions, or that have an underlying social or non-medical need. As a nation we are also living longer, which means that more people will experience poor health for longer<sup>13</sup> and this too increases pressure on health and social care.

The **Social Prescribing Network (SP Network)**<sup>14</sup> brings together health professionals, researchers, commissioners, funders, practitioners, patients and the VCS. They estimate that as many as one in five patients consult their GP for a social, rather than medical, problem.<sup>15</sup> This could be loneliness or stress, mild mental health issues, anxiety or depression – conditions where non-medical interventions could offer a good or even better treatment option than drugs. Other issues such as debt, housing or relationship worries can affect health and wellbeing, leading to

frequent repeat visits to GPs or emergency medical services.<sup>16</sup> The **Low Commission** reported that 15% of GP visits were for issues that require social welfare advice or support, rather than a medical intervention.<sup>17</sup>

Social prescribing aims to respond to these challenges. Many medical professionals want to do better for their patients. They want to provide alternative solutions and give patients more choice and control in improving their health. At the same time the VCS offers a broad range of activities and services which have the potential to improve quality of life, support health and wellbeing, and reduce the need for medical intervention.

### Different terms, shared goals

Social prescribing isn't new. There are around 100 local schemes in the UK today. Most were set up over the past decade<sup>18</sup> but the first of them date back to the 1980s.<sup>19</sup>

Health and community led schemes tend to use different terminology. Social prescribing is widely used by the health sector, along with community referral and non-traditional providers, to describe a range of non-medical options available to healthcare professionals.<sup>20</sup>

Some feel that the term social prescribing is too rooted in the health sector, and that talking about a prescription might constrain what the service can provide. They prefer a more community based language: alongside link workers (which we use in this paper), they use terms like community connectors and community care coordinators.<sup>21</sup> For others, the direct reference and link to the health sector, such as seeing a link worker located in a GP practice, adds credibility.

Regardless of terminology, all these schemes share the ultimate aim of connecting healthcare and community interventions to improve people's wellbeing in a person-centred way.

## From practice to policy

UK governments are supportive of social prescribing. **Taking Wales Forward 2016 –2021** identifies social prescribing as a priority for mental health treatment.<sup>22</sup> In October 2018, the Welsh Government announced funding of £1.3 million for **Mind** and the **British Red Cross** to pilot social prescribing for mental health.<sup>23</sup>

In Northern Ireland, the **Draft Government Programme** highlights the importance of the health and social care sector working together with the VCS to promote active, healthy lives.<sup>24</sup> Integrated Care Partnerships are developing a range of initiatives to transform health and social care, including social prescribing schemes.<sup>25</sup>

The Scottish Government fund **Community Link working** - a programme to recruit 250 link workers by 2021, who will be based in GP surgeries.

In England, the government has **funded 23 schemes** to build evidence, share lessons and expand successful practices<sup>26</sup> and the **Loneliness Strategy for England** made the commitment that by 2023 all GPs in

England will be able to refer patients to social prescribing connector schemes.<sup>27</sup>

NHS England has a national clinical champion for social prescribing and around half of all Clinical Commissioning Groups (CCGs) in England are currently investing in social prescribing.<sup>28</sup> The Department of Health and Social Care's **Prevention is better than cure** vision stated that social prescribing can, "change the mindset from condition management to health creation".<sup>29</sup> The **NHS Long Term Plan of 2019** sets out a commitment that within five years, "over 2.5 million more people will benefit from 'social prescribing', a personal health budget, and new support for managing their own health in partnership with patients' groups and the voluntary sector."<sup>30</sup> They are currently producing a common outcomes framework, designed to support measurement and add to the evidence.

The future strategy for the GP service, **General Practice Forward View** of 2016, specially mentions social prescribing and working with the VCS to reduce pressure on GP services.<sup>31</sup>



Ageing Better Conference

The **Local Government Association** report **Just What the Doctor Ordered**<sup>32</sup> identifies three potential roles for councils regarding social prescribing:

- playing a role in health and wellbeing boards, which can engage the voluntary and health sectors in social prescribing schemes
- directly funding or providing social prescribing
- running local schemes under their public health responsibilities.

## Does it work?

There is much optimism that social prescribing can offer a range of benefits, and some individual studies<sup>33, 34, 35</sup> have linked it to a reduction in the use of NHS services; improvements in anxiety and feelings about general health and quality of life; as well as high levels of satisfaction from patients, professionals and commissioners. A recent survey of GPs carried out by the Royal College of General Practitioners found that 59% of family doctors think that social prescribing can help reduce workload.<sup>36</sup>

However, it's widely acknowledged that there is a lack of robust and systematic evidence to make bold or confident claims about the impact and effectiveness of social prescribing.<sup>37</sup> In 2016 a systematic evidence review found, "little convincing evidence for either effectiveness or value for money."<sup>38</sup> Others acknowledge the, "difficulties in conceptualising what social prescribing is and what good evidence for a complex service might look like."<sup>39</sup> The Kings Fund has pointed out that, "Many studies are small scale, do not have a control group, focus on progress rather than outcomes, or relate to individual interventions rather than the social prescribing model. Much of the evidence available is qualitative and relies on self-reported outcomes."<sup>40</sup>

There are also difficulties in bringing together the different types of qualitative evidence to help commissioners and medical staff make funding decisions.<sup>41</sup> Together with perceived weaknesses in the available quantitative evidence about costs, this can hamper efforts to roll out social prescribing.

Addressing these evidence gaps is an important priority and in **section four** of this report we offer suggestions as to how our grant holders are addressing these challenges.



Recycled Teenagers



### 3. Our learning on social prescribing practice

Establish good relationships with GPs and other referrers	Link workers are the heart of social prescribing: look after them
People are more than just patients	Activities people want to do and services that meet their needs

#### Practical advice on establishing good relationships with GPs and other referrers

A steady flow of appropriate referrals is vital for sustainable services. That means establishing trust and good working relationships with referring agencies, alongside ensuring clarity and understanding of exactly what's on offer. Here is our learning for VCS service providers on how to build an active network of referral partners and how to work effectively together.

##### 1. Be proactive, get out and about, and take time to build relationships

Most referrals tend to come via GPs. But in our grant holders' experience, relying on this route has meant some schemes struggled to find enough patients. **Ageing Better** projects, which offer services to prevent loneliness for the over 50s, now aim for a mix of referral partners to ensure a constant flow of people. Working with partners that include adult health and social care, other local VCS organisations, and encouraging referrals from friends/

family, and self-referrals has been more successful in identifying isolated and lonely clients than working with GPs and pharmacists alone.

You can expand your network by talking to a range of local organisations and residents. This could be through attending events run by local VCS support organisations or joining targeted networks run by larger charities such as Age UK or Mind. You can market your services directly to patients by advertising in local newsletters and newspapers, running open days, and organising taster sessions of activities at local community events.

The exact mix of referrers may depend on the target group, or the issue your scheme is trying to address. Social prescribing to tackle isolation in older people will need a different range of referral partners than schemes that work to improve mental health in the whole population.

You can build good relationships with key healthcare partners by taking the time to visit pharmacists and nurses at their practices, and meeting with Clinical Commissioning Groups (CCGs) and groups of local GP practices. You could focus on practice managers who meet with colleagues from other surgeries, speak to

### **Being proactive pays off**

The Bogside and Brandywell Health Forum has a three year grant of £3.1 million to support social prescribing in 15 locations across Northern Ireland and Scotland.

Their partners in Derry found that it takes around 12 months to build trust with GPs. Investing time in attending monthly practice meetings, regional boards and commissioning groups, as well as building individual relationships were all helpful. In particular, working with a small number of standard bearer doctors in each practice or area was successful,<sup>42</sup> as GPs telling their peers about social prescribing was most effective in demonstrating its benefits.

[twitter.com/SPRINGSocialPre](https://twitter.com/SPRINGSocialPre)

patient engagement panels, or advertise your services through the local CCG. Many areas will have a lead GP for specific themes, so find and engage the most relevant for social prescribing.

GPs have many demands on their time and attention, with other services trying to gain their attention and business too. That's why it's important to remember the power of influence and word of mouth: once one GP is championing the service, you can reach their colleagues too.

You can consider locating link workers in GP surgeries, or training non-medical frontline staff. Some surgeries which refer to the [Valley Steps](#) project in Wales have trained practice receptionists to signpost and refer patients to wellbeing and mental health courses.

## **2. Be explicit with your partners about what you can and can't offer**

Referrals to services must be appropriate and at a level that's sustainable. It helps if you are clear about any limits to the support you can offer, so be upfront and honest about your capability and capacity. This helps to manage expectations for everyone.

For example, if capacity is an issue, think about how you will manage waiting lists for activities or services. Some social prescribers specify a set number of link worker sessions, while others are more open-ended. There must be a balance between individual need and the available budget or capacity of your organisation and your link worker(s).

Some of our grant holders told us that they received referrals where people's situations were too complex for them to manage, so they needed to go back and clarify the scope and remit of their service with their referral partners. Others had to find other services to pass more complex cases on to.<sup>43</sup>

### 3. Share your successes

All parties - referrers, the link organisation and activity providers - have to make social prescribing work for them. Some GPs have questioned the time and expense required to set up social prescribing, given the perceived weakness of existing evidence.<sup>44</sup> Being proactive about showing the benefits, using clear and accessible language, and setting out what you can do for the referral organisation and their users is important.

GPs need to trust that the social prescribing services are sustainable and have secure funding. A GP who refers into the **Brightlife Cheshire** project explains, “the worst thing to happen would be to give a patient a phone number, for it to no longer be working”.<sup>45</sup>

Checking in regularly, sharing successes and giving regular feedback about the impact of services on individuals helps build trust and maintain engagement. It can also unlock useful insights into how to continuously improve the service.

### 4. Break down IT and technical barriers

Many charities struggle to find a way to access GP patient management databases to identify potential beneficiaries. There are a number of different systems in use, as well as concerns around patient confidentiality, safeguarding and GDPR.

A pilot scheme in London, **East Merton Social Prescribing Project**, based a social prescribing co-ordinator in a medical practice and concluded that early access to patient’s care management system was an important success factor. It allowed link workers to both book patient appointments efficiently and understand the patient’s circumstances.<sup>46</sup> Employing the link worker within the clinical system with a fixed or honorary contract can be a helpful way around the barriers.

Another option is to link into the technology used by health professionals. For example, the Bogside and Brandywell Health Forum projects’ IT system integrates with the GPs’ patient management system, **EMIS**.<sup>47</sup> This means that GPs can see the option of social prescribing or referring to a link worker alongside other treatment choices. This approach helps with measuring outcomes too.

### 5. Make referring as simple as possible

Making a referral should be as simple as possible, which is why co-locating link workers within easy reach of other local services, such as GP surgeries and VCS hubs is a common approach amongst our grant holders. Some also link with schemes that visit people in their homes or extend their own service to home visits. In Leeds, **Feel Good Factor** visits vulnerable older people at home, making it easier to assess their level of isolation or support needs, such as home improvements or a benefits check. Referrals come from GPs and others, and workers link older people to specialist support.

Cutting down on bureaucracy is also important, especially when working with vulnerable people. If you need signup forms, keep them as brief and simple as possible (for example, sticking to basic contact details). Because projects in the Bogside and Brandywell Health Forum scheme are linked in to GP IT systems the necessary forms can be pre-populated with key details to avoid patients and staff repeating the same information multiple times.<sup>48</sup>

# Link workers at the heart of social prescribing: look after them

The link worker role is an essential and challenging position, requiring a range of skills, experience and local knowledge:

## 1. The right people with the right skillset

In our grant holders' experience, specific formal qualifications matter less than experience of, and commitment to, supporting people in a person-centred way. Link workers must be effective at a one to one level with the people they directly support and able to act strategically and operationally with health and care partners and other VCS organisations.

They need up to date knowledge of what's on offer from the local VCS, how it functions and its connections, as well as a real understanding of the needs of the community.

Good link workers come from a range of backgrounds. Some have been social workers, while others come from the VCS, where they have provided support or advice. The key skills and qualities are listening, patience and empathy.<sup>49</sup> As a link worker at the **Brightlife Cheshire** pilot explained, "If you can't listen, or you don't like people, then it's not going to work. But just being able to be supportive and empathise.... just being yourself... If you go in and you're not who you are then it shows".<sup>50</sup>

Link workers who are well rooted in a community may be quicker to establish trust. Local understanding and knowledge of the challenges faced by patients makes it easier to navigate the barriers to support.

For the **Time to Shine** project in Leeds, link workers are now seen as equal partners by other parts of the health and social care system. Joint working, for example through integrated neighbourhood team meetings, has really helped build relationships and referrals. This has been important for link worker's own satisfaction, meaning that they are working with the system and not against it.<sup>51</sup>



Shettleston Community Growing Project

## Removing barriers in Leeds

Mr P is in his 80s and lives alone. He has multiple long-term conditions including chronic obstructive pulmonary disease (COPD) and needs 24-hour oxygen therapy. Each oxygen canister lasts three hours, making it hard for him to really get out of his flat. He had stopped going to the activities he enjoys and had become isolated and anxious.

He was referred to a wellbeing coordinator at **Time to Shine** and together they discussed how he could benefit from support for his emotional wellbeing, to increase his social connections and remove some of the practical barriers to getting out and about.

He missed taking part in his local men's social group, but could no longer attend, as the sessions lasted longer than his oxygen canister. The project worker contacted the group and arranged for its driver and minibus to pick him up, with an extra canister,

which he can change himself. He's now able to attend the group again every Saturday.

Through a benefits assessment, the coordinator helped Mr P to access extra financial support and the home visit also highlighted the opportunity to make some improvements to his flat. The local care and repair service fitted an extra hand rail in his bathroom, so he can now wash more easily.

This took 15 hours of staff time, 8 home visits and 20 phone calls over 12 weeks of support. By visiting Mr P at home and using motivational interviewing techniques, the coordinator was able to guide the initial assessment and provide a wraparound service to make a real difference to Mr P's life. He now feels so much better that he no longer needs the counselling that he had been on a waiting list for.<sup>52</sup>

## 2. Look after your link workers

Being able to recruit, and retain, the right staff with the right mix of skills and experience for these linchpin roles is vital. In considering how to fund social prescribing commissioners and funders should consider the ongoing sustainability challenges that many charities face. Whilst senior charity pay is under increased scrutiny, what is less well understood is that many frontline staff are employed on part-time or fixed term contracts, where the associated low salaries<sup>53, 54</sup> may not reflect their experience and skillset.

Some social prescribers have experienced link worker burnout. This is due to staff becoming overloaded with cases and, for some, lack of adequate support and supervision.<sup>55</sup> The work can be emotionally draining. One worker in **Brightlife Cheshire** said, “I think the challenge for me is that some of the visits that we go to can be quite sad situations sometimes so you go in and they might have hit rock bottom.”<sup>56</sup>

Providing opportunities for staff to reflect on their work and share experiences with one another is an important way to support their wellbeing. Grant holders have done this through peer support or establishing formal supervision from senior or experienced staff. A **Brightlife** link worker reflects, “We have a really supportive team, so if there is anything where we go away from a visit and think ‘oh god, that was really difficult’, we can go and speak to them. It was really important for me to know that.... And also, to talk about the different approaches as well, because they will have experience of different things.”<sup>57</sup>

Volunteers can also help add capacity, but it’s important to consider what work is appropriate for volunteers, and where trained staff may be more suitable. You may need to set clear boundaries specifying what volunteers are asked to deliver or build in additional support. **Time to Shine** found that it was often inappropriate to use volunteers to provide their wellbeing service, due to the participants’ level of need and the pressures on link workers.<sup>58</sup>

### Working with volunteers

**Brightlife Cheshire** wanted to get volunteers involved in running their project and knew they had a gap in their service for isolated older people. Social prescribers could link people to local groups and services, but some older people faced additional challenges in joining them.

They set up regular drop-in sessions in three neighbourhoods. These include coffee mornings in community centres and events in a community pub where volunteers run activities, such as quizzes or games, and help people arrange transport so they can attend.

These sessions have become the main support offer for some of the older people, with some becoming constant attendees over the 18 months they have been running.<sup>59</sup>

# People are more than just patients

Good link worker practice can't be bottled or synthesised into strict criteria, as every individual and situation is different. What we do know is that how the link worker works with people can be as important as the activities they refer them to. Here is what we've learnt about person-centred approaches to social prescribing:

## 1. Make people welcome and safe

Get off to a good start by making sure that the people feel safe. They may not know what to expect or feel worried or daunted about trying a new activity or meeting new people. Cheranne, a volunteer with the **Valley Steps** scheme in Wales said, "The most important part of my role is the meeting and greeting, the welcoming people, making them realise that they don't have anything to fear and that they're coming into a friendly environment."<sup>60</sup>

When possible, offer a choice of where to meet for the first time, maybe at home or somewhere not too institutional, like a local cafe. Christine, a beneficiary of **Brightlife Cheshire** noted, "I don't think I would have made that step to have actually gone to her [the link worker], I think the fact that she came to me and that we had a meeting on my ground and that I got to know her helped me such a lot."<sup>61</sup> **Time to Shine** staff told us that home visits help to build relationships and can tell you a lot about the person.<sup>62</sup>



YMCA White Rose Centre

## A warm welcome

**Valley Steps** is a community led health organisation working in the Rhondda Cynon Taf area of Wales.<sup>63</sup> It provides six-week stress control and mindfulness courses, as an alternative to, or in combination with, prescription medication. This project set out to change the culture of treating common mental ill health issues with pills and to provide people with effective ways of supporting themselves.

In addition to providing a warm welcome, this scheme has successfully engaged people through making the service accessible by:

- Taking a no pressure approach. People are welcome to dip in and out of courses or mix up the day or time of the course they attend to suit their lives.

- Delivering courses at different times to suit different needs. Venues are accessible, warm and have adequate parking. Staff learned that they could make men feel more at ease by running the course in the local rugby club. Schools often have the facilities but may put some people off because of their own negative experiences of school or because their children go to that school.
- Not giving people a diagnosis or assessing or scoring them against a wellbeing framework. They are welcome to take the courses as a preventative measure, to top up their methods of self-care or in response to a specific need.

Around 30% of the scheme's referrals come from GPs. The word of mouth referrals from family or friends and referrals through social media have now overtaken GPs as primary sources of initial referral.



## 2. Build rapport and connections

In Newcastle, **Ways to Wellness** supports people with long-term health conditions. They found that the rapport and quality of the relationship between their link worker and client is central to improving wellbeing.<sup>64</sup>

Of course, building relationships takes time. **Time to Shine** told us that initial appointments can take a couple of hours and that using these to get to know the client as an individual and explore what would improve their life is preferable to having a fixed agenda.<sup>65</sup>

A link worker from **Brightlife Cheshire** explained, “what I like about this model is that you get to know the person so you have that time to actually learn about their life. So I mean, we say two hours for the first visit, but sometimes it will be longer than that, or maybe a bit shorter.... I think it works really well because then you get to know that person and you can connect them to things that will go well with that person.”<sup>66</sup>

But you can't build a good relationship just by putting in the hours. It's equally important to use the time well: listen, ask questions, explore where the referral has come from, find out about each person's wishes and needs, and explain what the service can and can't offer. Sometimes this can involve complex social and emotional issues, so link workers should know when and where to signpost to other services.

### **“All of a sudden, there was somebody taking an interest in me”**

“It wasn't so much where she took me, but the contact itself, it gave me self-confidence to go out... I didn't have friends, and my family are always very busy...so I felt a bit neglected.

All of a sudden, there was somebody taking an interest in me, they gave a boost to my self-confidence to lift up my mood. Then we agreed on visiting this community centre, to see what's available there...

The other thing she did for me, which was very useful, was putting me in contact with people who can help me...I am 73 years old, and I need a little bit of help with the cleaning, and shopping.

Through her, I met other people... Now I've got friends, I go to the café every day”

**Participant,  
Ageing Better in Camden<sup>67</sup>**

### 3. Work together to co-create options that support independence, not dependence

To find out what activities or services would suit someone best, ask what they can and want to do, rather than what they can't.<sup>68</sup> The key is to move away from traditional client/worker relationship to a more equal partnership where the social prescription is co-produced with the patient.

The link worker can often act as a motivational coach, encouraging people to take small steps to overcome issues that are affecting their lives (a “stepped care approach”).<sup>69</sup> A beneficiary of **Bristol Ageing Better** reflected, “[A link worker]... helped me to realise that if I take things in ‘baby steps’...that I can actually do more for myself than I had originally realised. I now feel more motivated and capable than before I met [the link worker] ... I like their mind-set and they are easy to get along with. I am now thinking that I might try some voluntary work... as I am feeling like the strings holding me back have been cut.”<sup>70</sup>

Be flexible when working with people and support their independence. Being prepared to adjust support plans to meet a person's change in life, wishes or needs at the centre of the support.

It's also important to consider how much of a relationship to develop with the individual - too little and you're an information service, too much can encourage dependency.

### Getting the support levels right

The **Brightlife Cheshire** project supports isolated older people through three tiers of service - ranging from simple onward referrals to an intensive 16 session plan.

But they remain flexible and responsive to the person's needs. A link worker from the project pointed out, “Everyone is different aren't they. So, when you get to the 12th visit, you have to look at different ways to support them.”<sup>71</sup>

Our **Help Through Crisis** projects, which support people experiencing hardship, found that developing a trusting and professional relationship right from the start was significant in reducing the risk of dependency. It helped to have the same advisor, to set boundaries and make the support clear. One staff member stated, “It's a fine line between continued engagement and creating dependency - we need to be as responsive as we can to the individual's needs but focus on the outcomes we can achieve.”<sup>72</sup>

## 4. Identify and overcome barriers

Before connecting people to activities, you also need to understand and explore whether there are underlying issues, such as debt, benefits or housing. An evidence review from the Low Commission recommended that providing social welfare advice in primary health settings would reduce the time GPs spend on dealing with benefits-related issues by 15% and lead to fewer repeat appointments and prescriptions.<sup>73</sup>

So, some social prescribing schemes look at being safe, having adequate housing and finances, and include options around social welfare or guidance. These issues have an impact on health and wellbeing and must be addressed to increase the chances of other, softer initiatives working.<sup>74</sup> In London,

63 advice services work within health settings. Waltham Forest local authority has appointed a social prescriber specifically to provide housing advice; **Citizen's Advice** place a welfare advisor in GP surgeries one day a week.<sup>75</sup>

Some barriers are a mix of practical and emotional: help with navigating transport options or accompanying someone to sessions can help them feel more confident. Our **Help Through Crisis** projects found that simple, inexpensive actions – providing a diary and writing in the next appointment, or texting reminders – helped people to keep appointments. Geographical barriers can be overcome by offering to hold sessions out in the community, using technology such as skype or helping with transport costs.<sup>76</sup>



Akuzie Amuta

# Activities people want to do, services that meet their needs

There is no formula for the kind of activities that social prescribing schemes should use – it’s much more about finding the right fit for each individual. As one **Bristol** participant reflected, “Being able to talk to someone, [the link worker] explored my needs/interests... I was feeling I wasn’t good for anything... Now I feel I can take part in cooking/reading/walking groups and engage more.”<sup>77</sup>

There’s a wide range of activities on offer. **Gateshead Older People’s Assembly** works with GPs to match older people with activities such as Tai Chi or dancercise, which also helps reduce isolation and falls. **Sussex Community Development Association** offers support for people with mental ill health to become volunteers or access education, training and employment. In Wigan, **Vicarage Lane Community Allotments** received an Awards for All grant for an allotment that includes accessible raised beds for less mobile gardeners and a dementia-friendly buddy service.

More broadly, a study from London found four main types of activities, provided by community and voluntary groups.

- Creative activities such as art or dance lessons, singing or gardening groups.
- Connecting activities such as peer support services, “knit and natter”, time-banking and fishing.
- Active groups such as fitness, volunteering, employment support.
- Safety. Ways to improve people’s practical circumstances, looking at issues such as housing, debt, falls prevention, domestic abuse and benefits advice.<sup>78</sup>

The scope is only limited by what already exists in the area. But we’ve learned that link workers should also be able to spot gaps in what’s available and look for opportunities to create new options. Projects build relationships and awareness through getting out and about to local VCS networking events. Word of mouth and mutual connections create a ripple effect, which can translate into more organisations getting involved and a richer choice of options for patients. VCS organisations that provide activities could become sources of referral and vice versa.



Stranraer Water Sports Association

## 4. Making social prescribing work within the wider health and VCS systems

Pay for the whole service, not just parts of the process	Show what's possible and be intentional about adding to the evidence base
Standards and quality assurance can improve confidence	Work together towards shared goals at all levels

### Pay for the whole service, not just parts of the process

Only paying for the mechanics of social prescribing, like the post of link worker, will only go so far, and could simply shift the burden of demand from statutory to voluntary services. It is essential that the services and activities recommended to patients are also adequately and sustainably funded. Without this VCS providers can face increased demand, with no capacity to meet it. As Dr Marie Polley, the Chair of the [Social Prescribing Network](#), observes, “If we don’t invest in the voluntary sector there won’t be social prescribing in 10 years’ time”.<sup>79</sup>

A 2018 study found that not only is funding for social prescribing failing to meet the growing demand for services, it’s mostly short-term and doesn’t reach VCS providers on time. The study also found a lack of support for important infrastructure developments (such as upgrading IT systems) for providers, “even on full cost recovery projects”.<sup>80</sup>

Making sufficient money available to support the whole interconnecting system of people and services, puts the VCS and referrers on a more equal footing, addresses an imbalance in the system and makes social prescribing more sustainable. In Newcastle, [Ways to Wellness](#) contracts the VCS to deliver its social prescriptions. This means that funding passes down through the referral process, from the link worker organisation (or earlier) to the VCS organisation providing the service/activity.

The Bogside and Brandywell Health Forum model uses anchor organisations for each area, usually a leading health charity, to fund the local VCS to provide prescribed activities and services on a per person/ referral basis.



Manchester Cares

## Follow the patient: funding from referral to delivery

The **Bogside and Brandywell Health Forum** has a designated anchor organisation in each of its 15 locations across Northern Ireland and Scotland. Each anchor is a community-led VCS health organisation, with good local knowledge of other local providers and their offer. This deep understanding of, and connection to, community organisations with a track record of delivering health improvement projects, means anchors are better able to make appropriate referrals that don't overload other organisations.

Anchors hold the budget for their area, employ the link workers and also may provide services themselves. Where people are prescribed services run by other organisations the budget passes to that provider, so funding follows the patient. This ensures

that all parts of the system have sufficient resource and support to provide services sustainably.

Each anchor also has a dedicated annual budget for capacity building and training for staff and volunteers. All groups providing services are helped to handle increased demand, and to raise their profile with referrers.

Each location uses an integrated online system that is connected to the GP patient information system. This joins up all parts of the system and means that individual outcomes can be tracked.

Currently in early delivery, this project is being evaluated and learning will be shared through the project wide advisory panel and the **Social Prescribing Network**. The scheme plans to co-create 16,000 social prescriptions over 192,000 contacts across the 15 areas. [twitter.com/SPRINGSocialPre](https://twitter.com/SPRINGSocialPre)

## Show what's possible and be intentional about adding to the evidence base

The health sector is grounded in evidence-based practice, so showing how social prescribing contributes to preventing ill health and improving health and wellbeing is essential to gaining credibility, buy-in and sustainable funding. As we've seen there are important gaps in the evidence, and grant holders tell us there can be a tension in showing how outcomes like self-reported improvements in wellbeing add to an evidence base that often demands higher standards of rigour.

Commissioners and other health and social care funders may be seeking proof of impact, like reduction in hospital admissions or cost-benefit analysis. Many charities are not able to provide evidence to this standard and asking them to do so may be disproportionate to their financial and structural capability. For example, many smaller charities do not have sophisticated IT systems for tracking their beneficiaries and having a large number of referral partners and service options can make it harder to track outcomes too.

Using methods that are appropriate to the different parts of a system level intervention are acceptable, and it has been suggested that, “for pathway features (like a link worker element) this might include qualitative descriptions of patient experience, or realist evaluations of pathway sections (for example, enrolment, engagement, and adherence).”<sup>81</sup>

Our funding is helping grant holders develop new ways to address these evidence gaps. The [University of Westminster](#) is working with the [Social Prescribing Network](#) on an outcomes framework, which is designed to capture changes to an individual's wellbeing as well as benefits to the community and VCS.

NHS England has also developed an outcomes framework which proposes consistent measures that show the impact on social prescribing on individuals, community groups and the health and social care system.<sup>82</sup> These two initiatives offer practitioners a steer on the evidence they should look to generate, which will be relevant and useful to meet a range of stakeholders' needs.



Portstewart Men's Shed

## Impact measures for social prescribers to consider

### Individual

- Feel more in control and able to manage own health and wellbeing.
- More physically active.
- Better able to manage practical issues, such as debt, housing and mobility.
- More connected to others and less isolated or less lonely.

### Community groups

- More resilient.
- Changes in the number of volunteers.
- Capacity to manage referrals.
- Support is needed to make social prescribing sustainable.

### Health and care system

- Change in the number of GP consultations.
- Change in A&E attendance.
- Change in the number of hospital bed days.
- Change in the volume of medication prescribed.
- Change in the morale of staff in general practice and other referral agencies.

Common Outcomes Framework (NHS England 2019).<sup>83</sup>



Starlings



## A new way of working with long term conditions

**Ways to Wellness** is a social prescribing scheme in Newcastle that enables people aged 40-74 to manage their own long-term health conditions. Previous experience suggests that self-management can both improve quality of life and reduce demand for health and care services. Currently 55% of GP appointments in England are with people who have one or more of these conditions.<sup>84</sup>

Ways to Wellness was the UK's first health social impact bond (SIB). This form of funding pays by results, allowing the project to secure long-term funding on a scale that wouldn't otherwise have been available. It also gives commissioners the opportunity to test new services without high levels of risk.

The scheme must achieve two primary outcomes, which were identified after a long review of different options. (Other planned outcome metrics turned out to be unmeasurable in practice or failed to capture the range of potential cost

savings.)<sup>85</sup> The chosen primary outcomes are:

- improved wellbeing, reduced isolation and fewer GP visits measured by the **Wellbeing Star**. 30% of outcome payments are dependent on this result
- a reduction of secondary healthcare costs, such as hospital use (the other 70% of outcome payments).

Four organisations deliver the services. Link workers propose services to patients to improve physical activity, develop positive relationships and get welfare support. They also help to identify meaningful health and wellness goals that clients can work towards. These interventions and approaches can be adapted to improve people's outcomes.

Between April 2015 and April 2018, the service received over 4,500 referrals and supported 3,400 patients. Almost 2,000 patients have been assessed, showing an average improvement in wellbeing of 3.3 points against a target of 1.5. In 2017, the scheme achieved outcome payments for reducing hospital care costs,

after data showed 11% savings when assessed against a counterfactual study.<sup>86</sup>

A study by Newcastle University found that patients reported, “positive physical and behavioural changes, including weight loss, increased physical activity and improved mental health. Patients also reported increased self-confidence and control, reduced social isolation and greater resilience.”<sup>87</sup>



Rosemount Lifelong Learning

**Leicester Ageing Together** has also seen positive early results. Interventions to improve social connections for people over 50 have contributed to a significant drop in the number of GP appointments for their service users; from average of 3.4 over three months at baseline to 2.5 at follow-up.<sup>88</sup>

### Tracking individual outcomes

The Bogside and Brandywell Health Forum is embedding monitoring and evaluation from the start so as to record impact over time on a large scale.

An online measurement tool tracks activity for each referral. This allows the GP (or other referrer) to monitor the individual’s progress.

At the initial meeting, the link worker uses recognised scales to assess the patient’s wellbeing. These include the **short Warwick Edinburgh (SWEMEBS)** and **General Anxiety Disorder 7 (GAD7)** for low level mental health issues, and at least one general scale such as the **patient health questionnaire (PHQ9)**

for wellbeing. Scores and their meanings are explained to the patient, both for transparency and to keep them engaged in the process. Link workers follow up monthly with patients, who retake the assessments. If necessary, support plans are amended.

As well as tracking individual outcomes, in this way the project can:

- provide evidence on the impact of social prescribing for patients
- report reductions in GP/Health appointments
- estimate cost savings for the overall health system, alongside external evaluation.<sup>89</sup>

[twitter.com/SPRINGSocialPre](https://twitter.com/SPRINGSocialPre)

# Standards and quality assurance can improve confidence in social prescribing

There is no one way to prove the quality of social prescribing. An increase in the number of schemes has led to a wide range of quality assurance approaches and outcome measurement systems.<sup>90</sup> There are also no official standards to define how suitable or effective social interventions are for individual patients.

Knowing when to refer a patient, and how social intervention can help with specific issues would make it easier for GPs to use and promote social prescribing. The development of a recognised, national quality assurance has been identified as, “necessary to protect the whole social prescribing process, especially where there is direct referral and potential for public funding”.<sup>91</sup> The aim is not to take away from the personalised and holistic approach to supporting people, but to provide assurance for all involved (patients, providers and referrers). It could also support scaling and enable VCS organisations to demonstrate that they provide services of consistent standard.<sup>92</sup>

Quality assurance work helps to level the playing field for smaller VCS providers, which are sometimes overlooked for both referrals and funding. **Leicester Ageing Together** found that, in their GP social prescribing scheme, recognised big name providers received more referrals than local VCS organisations. This has been put down to relative levels of awareness and trust from GPs.<sup>93</sup>

Our grant holders do pioneering work in this area. **The Conservation Volunteers (TCV)**, a national charity, is developing a quality assurance (QA) process for social prescribing in England, in a partnership with the Social Prescribing Network and a range of VCS organisations. They launched a **consultation** in March 2019 which sets out a proposal for standards covering: link worker practice, activities and services, and the capacity and capability to deal with

referrals.<sup>94</sup> The intention is to provide a level of protection for the person/patient, provider and the referrer.

Together with the NHS England outcomes framework, this work has the potential to support the development of a national tariff for social prescribing - comparable to the NHS **National Tariff 2017-19**, published in 2016.<sup>95</sup> This could give commissioners and providers a consistent source of prices and payment rules for planning services and support.

**The Conservation Volunteers** are also exploring referral pathways for mental health, musculoskeletal or cardiovascular issues. These pathways will give medical staff confidence and knowledge of when and how to refer patients to community-based activities, alongside existing clinical care.



COAST

## Social prescribing in an acute healthcare setting

The Conservation Volunteers, a national community volunteering charity, runs a social prescribing pilot in the cardiology department of the Queen Elizabeth hospital in Birmingham. A link worker supports patients with cardiomyopathy, an inherited condition where the heart muscle thickens. Because this limits physical activity, patients are prone to other conditions, such as diabetes, and are likely to be admitted to hospital regularly. The charity funds a link worker and a Green Gym,<sup>96</sup> a

conservation area where people can get involved in physical activity in the hospital grounds. The link worker establishes a relationship with each patient, exploring what they are able to do and prescribing the **Green Gym** and other activities.

This intervention complements the medical approach. The clinical lead for the pilot described this scheme as the missing piece of the treatment, a “powerful opportunity for the link worker to spend a decent amount of time with patients, understand and do something.”<sup>97</sup>



Shettleston Community Growing Project

## Work together towards shared goals at all levels

Understanding the local context is important in preventing barriers to an effective and joined up social prescribing service. Overlapping schemes, multiple players and local politics can create challenges, for example by creating competition for clients or referrals. The commissioners and providers may have different approaches or success criteria. In a very competitive funding environment, we know that there's a temptation for providers to shift focus to chase funding, with all the related risks of loss of specialism, expertise and knowledge of what's really needed by people and communities.

Building trust and understanding between the VCS and CCGs and other strategic partners is essential. Social prescribing works best when organisations are willing to work with each other towards shared goals and to share learning and when funding does not create perverse incentives and competition.

Grant holders have told us that partnerships are most successful when providers aren't precious about their beneficiaries and are open to patients using other services that better suit their situation.<sup>98</sup> Partnership working

to measure outcomes supports social prescribing at both strategic and operational level.

**Brightlife Cheshire** works with two CCGs and four councils, as well as providers like wellbeing co-ordinators, dementia services and Macmillan specialists. This system partnership has worked well because the key parties have made the time to build relationships and understanding strategically. Those on the frontline haven't had to compete and so have been able to put all their energy into supporting patients.



South London Cares

## Working together in a changing context

The original funding bid for **Time to Shine** included a dedicated social prescribing scheme. By the time the group secured National Lottery funding, the local context had changed as CCGs had developed their own schemes.

**Time to Shine** didn't want to give up on their idea so they worked with local partners to identify gaps in services, so that their offer would respond to genuine need and not duplicate the CCG service. They learned about a gap in support for older isolated people, many of whom have multiple long-term conditions.

They discovered that this group requires more support than typical schemes provide. As the project manager said, "social prescribing is not enough - you need more hand holding, motivation, getting [people] to change."<sup>99</sup> As a result, **Time to Shine** developed a more hands on approach for this group, giving the staff more time to build relationships and offer a range of help. This is a unique offer that complements rather than competes with other schemes in the area.



## 5. Conclusion: support and enable the whole system, just as social prescribing supports the whole person

We know that prevention is better than cure and social prescribing offers potential to put that into practice in a joined-up way that transcends organisational and sector silos.

We're seeing more and more funding applications to support social prescribing and different kinds of link worker and community connector roles. With the increasing backing of social prescribing by UK governments, this is likely to continue.

All the pieces of the social prescribing jigsaw need to fit well together, and we need to recognise the need for system wide shifts. What are the key pieces of the puzzle?

Social prescribing schemes need to be joined up. Whether working primarily with the health sector or to support community engagement, key partners – including commissioners and funders need to be on board from the start. They should cooperate at both strategic and operational levels, recognising what each has to offer the others. That recognition should be in place from the planning stage through to final delivery. Stakeholders, especially commissioners, local referrers and partners need to have a common understanding of key terms and principles.

The aim is to create support that can be tailored to the needs of the individual, finding what will best motivate and empower them. This is much more than just signposting; it needs to recognise underlying barriers to wellbeing.

The different pieces of the jigsaw need to be properly funded. If social prescribing is to continue and flourish, both the link worker role and the delivery of services must be adequately supported. Link workers need activities to prescribe to, referrers and individuals need to be confident that activities will actually be available, and VCS organisations must be able to meet demand.

The potential benefits for individuals, the VCS and the health system are great – both in making better use of resources, and in giving individuals greater confidence and control of their own wellbeing but the need for better evidence to show the strength and impact of the approach must be addressed.

Despite growing support from government, some lack confidence in social prescribing as a viable treatment option. Making social interventions more visible, finding ways to demonstrate their impact and providing assurances of the quality of the end service, may go some way towards ensuring that social prescribing can realise its potential and have a lasting impact.



Via Wings

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