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**Healthy London
Partnership**



Social prescribing: our vision for London 2018-2028

Improving lives, improving health

December 2018

[v0.01. DRAFT DOCUMENT FOR FEEDBACK]

About Healthy London Partnership

Healthy London Partnership formed in 2015. Our aim is to make London the healthiest global city by working with partners to improve Londoners' health and wellbeing so everyone can live healthier lives.

Our partners are many and include London's NHS in London (Clinical Commissioning Groups, Health Education England, NHS England, NHS Digital, NHS Improvement, trusts and providers), the Greater London Authority, the Mayor of London, Public Health England and London Councils.

All our work is founded on common goals set out in [Better Health for London](#), [NHS Five Year Forward View](#) and the [Devolution Agreement](#).

About this document

This document was developed by the Greater London Authority, NHS England, Healthy London Partnership and the London Social Prescribing Network, in collaboration with partners across the NHS, local authority and VCSE sectors to support the scale and spread of social prescribing across London.

How to respond to this document

We would like to hear your views on the draft vision, in particular:

- Do you think this is the right approach to support the mainstreaming of social prescribing in London over the next 10 years so that every Londoner can easily have access to a social prescription?
- In your view what more should be done to support:
 - Helping Londoners to understand SP and how it can benefit them and help them to take more control over their health and well-being.
 - The growth of digital solutions
 - Ensuring more/better access to social and welfare advice in London
 - Supporting workforce development, in particular the link-worker role, including improving career pathways and providing effective support for staff
 - Supporting GP's and other health professionals to engage with social prescribing
 - Supporting volunteers to engage in social prescribing

Please send your written responses to hlp.proactivecare@nhs.net by close on 28 February 2019. There will also be opportunities to engage in the debate about social prescribing through [Talk London](#) in the New Year. We would also be interested to see any case studies you would like to share.

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Social prescribing: Improving lives, improving health

‘I don’t have to be alone’

“I was totally blind before I met with Ray [social prescribing link worker]. I had no idea about what was going on in my community and what social activities are here. But after meeting him I would recommend social prescribing to everyone. Google can give you the address of a community centre or service, but it can’t give you the idea of what is going on inside the centre and what things you can join. So, then I understand what I can join and what organisations I can volunteer with. I don’t have to be alone, I don’t have to stay at home, I get help from everyone and now I’m giving back help to others.”¹

‘A people-centred approach, rooted in communities’

“We must shift away from the old factory model of care and repair, towards a people-centred approach, rooted in communities, enriched by local knowledge and experience, and focused on shared activities to promote better health for all. This is not to replace existing health and care services, but to knit them together with community life so that they help and reinforce each other.”²

Our vision

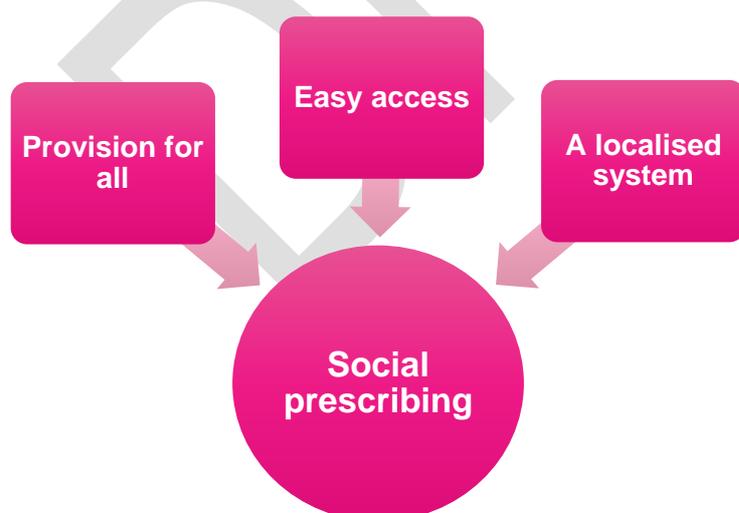
The vision was developed by the Greater London Authority, NHS England, Healthy London Partnership and the London Social Prescribing Network, in collaboration with partners across the NHS, local authority and VCSE sectors to support the scale and spread of social prescribing across London.

Our vision is for every Londoner to have easy access to social prescribing to meet their changing needs, from cradle to grave, with a focus on developing Healthy and thriving communities.

This means:

- **Provision for all:** with a focus on meeting the needs of disadvantaged groups and those with multiple complex needs
- **Easy access:** through education, self-referral and referral by a wide range of partners, which might include GPs and practice teams, pharmacists, hospital teams and other health professionals, education services, social care partners, care homes, housing associations and many others
- **A localised system:** that nurtures local innovation and coproduction between commissioners, the voluntary, community and social enterprise sector (VCSE) and service users, so that provision is tailored to individual needs and builds on and develops local assets.

Social prescribing: our vision for London



Introduction

Some Londoners enjoy the highest living standards anywhere in the world. But for others, it's a different story. For evidence of this, we need only look at the variation in life expectancy. A baby boy born today in one part of London could live up to six years longer than a boy born in another part of the city.

Much of Londoners' ill health stem from isolation, loneliness, or stress caused by work, money or housing problems. Many of these have social and economic exclusion at their heart. These are problems that clinical services alone cannot prevent or cure. If they are not dealt with, they can exacerbate long-term health, well-being and care problems that are bad for individuals and bad for the communities they live in.

The greatest potential to reduce health inequalities between Londoners, particularly in the longer term, is through addressing the wider determinants of health: the conditions in which people are born, grow, live, work and age. These conditions affect how easy it is to get on in life and achieve our ambitions, which in turn have a big impact on health and wellbeing. These are also closely linked to health-related behaviours, including smoking and substance misuse. Determinants include our early childhood experiences and the homes and neighbourhoods we live in, our schooling and skills, our income and wealth, our work and job prospects.

Social prescribing can help tackle these problems.

What is social prescribing?

- Social prescribing – sometimes referred to as community referral – is about helping people find ways to improve their health and wellbeing by linking them up with what's going on in their local area. From gardening clubs, food growing spaces, art classes to toddler groups, from social activities for those who are isolated to benefits and legal advice, social prescribing enables people to access activities that meet their wider emotional, physical and social needs.³
- Social prescribing seeks to move away from a medical model and towards a holistic person-centred view of well-being, identifying the root causes of the individual's issues and tackling them head on.

What's new about this approach?

In many ways, it's not new at all. From service brokerage in the 1970s to health trainers in the early 2000s, health and care professionals have often supported patients to access amenities beyond medical services, on an informal basis. More formal forms of social prescribing have existed for some years, too, in parts of London and beyond, growing from the Department of Health's White Paper *Our Health, Our Care, Our Say*⁴ and spreading into NHS services.

“Social prescribing is not a new idea – good GPs have always done it, it just didn’t have a name.”

Professor Helen Stokes-Lampard, Chair, Royal College of GPs⁵

What is new is the growing evidence⁶ that social prescribing can significantly improve people’s health and wellbeing – particularly those with complex health and social needs – and the level of coordination required across different services, to support people. That is why social prescribing is gaining increasing interest as a way of meeting unmet needs and tackling social inequality.

A review of the evidence... showed average reductions following referrals to social prescribing schemes of 28% in GP services, 24% in attendance at A&E and statistically significant drops in referrals to hospital.⁷

Our Partnership want access to social prescribing to become the norm across London, as a means of ensuring good health outcomes for all with shared tools and referral pathways, and link workers who support and signpost people to local services. That way, if a healthcare professional sees anyone who could benefit from these activities, they know exactly how to refer them, simply and quickly, to high-quality support.

Why now?

Around 20% of people visit their GPs for non-clinical reasons – from finance to social isolation. Social prescribing can help them tackle the root of the problem. For those with personalised care, including personal health budgets (PHBs) and personal independence payments (PIPs), it is more important than ever that people can access high-quality services that can complement clinical provision, to protect people’s health and wellbeing.

The Mayor of London’s Health Inequalities Strategy, published in October 2018,⁸ sets out social prescribing as one of the important ways of meeting its core aim: to create a fairer, healthier city.⁹

Age expectancy and healthy age expectancy vary widely across London. The average healthy life expectancy is 63.5 years for men and 64.4 years for women, but for men this ranges from 58 years in Barking and Dagenham to 70 years in Richmond upon Thames. For women, it ranges from 56 years in Tower Hamlets to 70 years in Richmond upon Thames.¹⁰ Social Prescribing can help reduce these health inequalities. (DN: Turn into graphic)

Nationally, social prescribing is supported by the Royal College of GPs (RCGP)¹¹, NHS England¹² and the Department of Health and Social Care,¹³ and is on the agenda of The King’s Fund.¹⁴ In government, there is an All Party Parliamentary Group on Social Prescribing. Meanwhile, many local commissioners and health and care partnerships are looking for ways to develop or expand their existing social prescribing activities.

Social prescribing also supports the GP Five Year Forward View.¹⁵ It is one of the 10 High Impact Actions¹⁶ and is included in the Releasing Time for Care programme.¹⁷

The All-Party Group on Arts and Health conducted a two-year inquiry into the arts and health between 2015-2017. The report “Creative Health: The Arts for Health and Well-being¹⁸” contains a number of recommendations on how to utilise the arts when developing social prescribing.

Social Prescribing also features in the Government’s Loneliness strategy – A Connected Society, Strategy for Tackling Loneliness published on October 2018¹⁹. The strategy outlines a number of ways that social prescribing can support the reduction of loneliness.

Already, local authorities and voluntary, community and social enterprise organisations (VCSEs) across the capital are developing opportunities for Londoners to access social prescribing. This vision is designed to take everyone to the next step – building on what exists and strengthening the infrastructure that supports high-quality provision.

Examples of different areas of social prescribing

Social prescribing involves local authorities, health providers and VCSEs working in partnership. This guide seeks to open up the conversation about how to bring these partners together to find collective ways of running and funding social prescribing schemes, while identifying and unblocking barriers in the wider systems.

It sets out our road map for social prescribing: how we would like to see it work across London, so that everyone can access a wide variety of support within their community, whatever their income or ability. This guide launches our journey to champion social prescribing and to drive, promote and build capacity for lobbying and leadership on this issue.

This vision does not set out to describe everything that would be needed to ensure that social prescribing is successful in each local area. Instead, it sets out the core building blocks that we can develop collectively, at scale, across London, to support areas with their local offer. The range, mix and spread of services that communities need will be different from area to area, and must be developed by local areas alongside their communities.

Developing the vision: the GLA’s partnership approach

February 2018 Convening 100 social prescribing stakeholders at the London Social Prescribing Conference to help develop a vision of a social prescribing road map for London. Participants proposed five priorities for successful pan-London delivery: identifying digital platforms; supporting VCSEs; enabling cross-sectoral partnership; developing sustainable models; and evaluation to assess the case for change, return on investment and impact on health inequalities.

March 2018: Establishing a Social Prescribing Advisory Group including clinicians, local authorities, VCSEs, STP leads and senior leaders from HLP, the GLA and SPN, to develop the actions and commission reports and pilots.

March 2018 onwards: Meeting current social prescribing practitioners to understand the challenges, provide practical support and identify ways to support the scale and spread of social prescribing across London.

[DN: Links to be added to key pieces of work through the Wiki, GLA Social Prescribing page etc]

What our vision aims to achieve

An effective, broad and holistic social prescribing offer is made up of many different elements. If our vision is to be effective, there needs to be a strong collection of VCSEs in local areas offering people access to a range of opportunities, services and support. Some of these are set out below.

Arts and culture

There is evidence that taking part in arts and cultural activities can improve people's subjective well-being and well-being measures.²⁰ Arts activities can lead to savings for health and social care, ranging from savings of £2.58 for every £1 invested² to a social return on investment of £4 for every £1 invested.²¹

The Dragon Café in Southwark organises creative arts events to support people with experience of mental ill-health in their ongoing recovery.

The Bromley-by-Bow Centre uses creative arts to help people build connections while learning new skills.

Creative Sparkworks is a Lambeth-based community arts charity that provides film, media and design workshops and training for young disadvantaged and under-represented groups.

Dance for Parkinson's which is a dance and cultural programme that supports people with Parkinson's. English National ballet NB uses dance to help people manage their symptoms, rebuild their confidence and provide opportunities for personal expression, social interaction and peer support they might otherwise lack. Findings suggested a variety of positive outcomes such as helping people with Parkinson's to stay motivated and maintain an active lifestyle and enabling participants to feel more capable and certain about their future despite degenerative symptoms.

Environment, food growing and green spaces

The environment we live and work in has a very significant effect on our health. We also know that "those living in the most deprived neighbourhood are more exposed to environmental conditions, which negatively affect health."²²

Green spaces have been associated with a decrease in health complaints²³ blood pressure and cholesterol, improved mental health and reduced stress levels^{24,25}, perceived better general health²⁶ and the ability to face problems²⁷.

There is strong evidence that provision of green space effectively improves mental health and less strong/inconclusive evidence that it improves levels of physical activity²⁸.

The main types of nature-based interventions specifically designed and structured to support health and care services, (green care) offered within the UK are Social and therapeutic Horticulture, care farming and environmental conservation.²⁹

Voluntary organisations offer a range of activities to support people engage in their environments, from groups like Friends of Clapham Common, that brings people together to maintain this common in South London, and supporting local families to understand and appreciate the nature on the common, to gardening clubs and societies, and a range of green care organisations supporting people who have experienced or are at risk of poor mental health.

Food growing

We know that access to community food growing can offer huge benefit to Londoners, It is widely recognised that regular contact with plants, animals and the natural environment can improve our physical health and mental wellbeing.

For many Londoners gardening, community food growing and receiving fruit and vegetables on prescription can be especially beneficial. Food growing activities can relieve the symptoms of serious illnesses, prevent the development of some conditions, and introduce people to a way of life that can help them to improve their well-being in the longer term.³⁰

The Lambeth food co-op build gardens in GP surgeries so everyone who wishes to learn how to grow food can do so in a safe, secure and supported environment. The GP garden communities provide a space and a reason for people to socialise, learn and grow food together. People who participate are improving their own health and wellbeing. This results in people feeling less isolated and better in themselves and, as GPs are now reporting, they don't require so many appointments.

Sport, wellness and leisure

The positive health benefits of taking part in sport and physical activity are well recognised, from reducing our risk of disease to increasing our ability to manage stress and improving sleep quality.³¹ We know that getting more activity can improve our physical and mental health, as well as protecting against a range of health risks.

Local VCSE groups offer a very broad range of sport and physical activities, from walking (rambling clubs) and running groups (such as parkrun and GoodGym), to yoga (Yogarise, The Life Centre) and sports clubs (such as Charlton Athletic Community Trust and Coping Through Football). Many groups focus on the physical benefits of being more active combined with mental health benefits of looking after your body and becoming more socially connected.

The effectiveness of these activities varies.³² Coping Through Football demonstrated a 12% reduction in inpatient mental health bed days for its participants with schizophrenia. Participants reported other positive impacts such as entering or re-entering education, employment or volunteering, smoking cessation and weight loss.³³

Education and employment

Employment is one of the most important determinants of health. Unemployment is a cause of premature mortality, long-term unemployment is associated with socioeconomic deprivation and has a significant impact on people's mental health³⁴. The simple fact is that if you have a job you can expect to live for longer and in better health. However, this work should be 'good work' which is healthy, safe, offers individuals some influence over how their work is done and provides a sense of self-worth. The workplace is also a great place to offer health promotion/prevention activities and encourage people to take responsibility for their own health.

Social prescriptions often include activities that support people with securing employment or continuing education to support job readiness. Services often support people with specific needs or issues, for example those with mental health conditions that may require additional support to sustain work, people with criminal records, individuals with physical disabilities or young people needing help to secure work for the first time. Programmes such as Southwark Works support local people and local employers to secure long term and secure employment options.

Why social prescribing?

Social prescribing can lead to important changes in people's and their families lives. But that's just the start of it. The benefits go well beyond the individual, benefiting society at all levels – from individuals to communities, from community groups and health organisations to local authorities.

Benefits of Social Prescribing

For individuals

The needs of an individual are identified working together with a link-worker. The offers and opportunities are varied. Some of the benefits reported by individuals of using social prescribing services can include: *[DN: present as diagram]*

- social contact
- mental stimulation
- a structure to the day
- Increased sense of control
- physical exercise
- improved diet and lifestyle
- relaxation
- fun and laughter
- employment
- a sense of achievement
- inspiration and support
- help around the house
- specialist legal support
- benefits, housing and employment advice
- self-management tools for long-term conditions
- Unlock creative potential.

Social Prescribing is strongly associated with improvements to emotional wellbeing and mental health, increasing physical activity, and reducing social inclusion, as well as reducing the need for GP and hospital appointments.

A pilot evaluating social prescribing for 103 patients found improvements in the domains of 'feeling positive', 'looking after yourself' and 'money'. For the six service users whose outcomes could be costed, there was an average saving of £3,828 [4, pp5-6] [Amelia suggests Tower Hamlets primary care]

Who can benefit? *[DN: present as diagram]*

Social prescribing can be particularly helpful for people who:³⁵

- have mental health needs
- have wider social issues such as debt, housing problems, trouble finding work, or relationship problems
- are lonely or isolated
- have long-term conditions
- use the NHS the most
- struggle to engage with services
- are carers.

For communities

Each area has different needs, depending on who lives there, the local environment and economy what amenities, opportunities and challenges there are. That's why a local approach is crucial. And local communities may span boroughs, so joint working is important. But social prescribing can bring so much to communities, as well as individuals. It actively encourages people from all groups to participate in community life who otherwise might not, engendering a sense of ownership, shared responsibility and community pride and social integration. It encourages use of and can increase and help develop community assets too, such as parks, gyms, museums, arts venues, pools and libraries.

For local authorities

Social prescribing can help local authorities fulfil their public health and citizen participation duties and hit targets. An audit of a Kensington and Chelsea programme highlighted one person who had, through the programme, avoided entering long-term care placement, with a proxy value £42,341. Other benefits included a drop-in demand on local authority helplines.³⁶ Appropriate housing and/or benefits advice could also help people from becoming homeless. Or ensure that problems in the condition of their homes that may adversely affect health are dealt with.

An eight-month evaluation study of the Tower Hamlets social prescribing scheme identified a number of social prescribing clients who went on to training, volunteering or employment as a result of their involvement. As well as the significant impact on the individuals' health and wellbeing, these outcomes have corresponding reduced costs for local authorities and health systems.³⁷

For health and social care

Social prescribing can reduce demand and costs as fewer people attend primary care, emergency mental health, adult care and safeguarding services for problems that cannot be solved through health and care. Other outcomes include fewer delayed discharges because there is better support when people return home, lower use of day services and fewer people being evicted from their homes (according to independent studies on social prescribing schemes at Derby City and Thurrock councils).³⁸ Services have also seen improved staff morale and better whole-system provision, due to better multi-sectoral working.

We know from the evaluations of various social prescribing projects that it also saves the NHS money, by reducing people's need to visit their GP and accident and emergency (A&E) departments. For example, a 2016 evaluation into the Rotherham social prescribing service showed that A&E attendances of scheme participants reduced by 17%, with reduced costs to the NHS of more than £500,000 between 2012 and 2015: an initial return on investment of 43p for each £1 invested.³⁹

Many of the benefits of social prescribing are long term, and for many outcomes (such as reduced social isolation and loneliness), it can be difficult to measure quantifiable savings. Often, funding, especially in health and social care is short-term. But social prescribing can support the delivery of wider and longer-term system change and support local health and social care priorities.

Social prescribing has the potential to enable new models of care and a transformed workforce that supports an ageing population with increasingly complex needs. It presents an opportunity to remodel our approach to meeting local population's needs, inviting communities to be part of the solution.

For Voluntary, Community and Social Enterprise (sector) organisations

For many VCSE organisations, the principles of social prescribing are already at the heart of what they do. VCSE organisations are the backbone to any social prescribing scheme, without a vibrant voluntary sector, social prescribing schemes will not be successful. VCSE organisations add significant value to their local communities, in 2012-13 volunteers in the UK contributed an estimated £23.9bn to the UK economy.⁴⁰

Our London-wide plan aims to strengthen the work VCSEs can do, enabling a wider, more diverse and more responsive local offer, with more opportunities for

volunteering and work experience. It will also lead to more joined-up working with statutory partners, resulting in better coordinated support for individuals.

The success of the vision depends on the experience and expertise of the VCSE sector. We need to develop London's vision hand in hand with these partners, to ensure that it presents opportunities for them too, with networks and tools that underpin what they already do: helping build relationships, enhance services, and broaden their scope even further.

The VCSE sector can reach the whole community, think whole person and act whole lifetime. At its best, the VCSE sector does not just deliver to individuals, it draws upon whole communities: for volunteering and social action which addresses service resistant problems like loneliness and stigma, and for the expertise of lived experience in designing more effective, sustainable services and systems.⁴¹

We know that for VCSE organisations secure funding is critical to ensure they can maintain their services and continue to provide the support they offer to their communities.⁴² Whilst this vision does not propose to resolve these issues, core to all elements of the vision is the understanding of this issue and the need to support VCSE's where ever possible to secure funding.

For London as a whole

Where social prescribing has already become a routine part of community support within a London borough, it has made a significant impact in addressing health inequalities in the capital. [Add quote from Bromley-by-Bow or Bexley.] It does this by addressing the social determinants of health, such as debt, poor housing, isolation and physical inactivity.⁴³

By reaching out across the city we can make London a healthier, fairer city where people have an equal opportunity to live their life in good health.

Social prescribing today

There is a growing focus on social prescribing. As well of Mayor of London Sadiq Khan and clinical leaders such as Dr Michael Dixon, National Clinical Lead for Social Prescribing, the approach has been championed by NHS England Chief Executive Simon Stevens and is at the heart of the Strategy for Tackling Loneliness.

Local commissioners and Strategic Transformation Partnerships across England have all expressed an interest in developing or expanding social prescribing, harnessing activities within local community to help people get better and stay well. Each of the five STP plans across London include plans to further develop social prescribing within their local areas.

At a national level, in 2017/18⁴³ more than 60% of CCGs invested in social prescribing. The total CCG investment in social prescribing was over £30 million, and around 200,000 people benefitted directly from social prescribing.

England – a snapshot: three services in 2017/18

Camden CCG was the highest investor and referrer in London, allocating £1.95 million and referring 10,500 people out of a population of 250,000. This equated to 4.2% of the population receiving social prescribing, at £7.80 per person.

Dorset CCG made the largest investment: £3 million (jointly with the local authority), providing social prescribing for 3,000 people, out of a total population of 800,000. That's 0.4% of the population receiving social prescribing, at £3.75 per person.

Liverpool CCG made the largest number of referrals to social prescribing, at 26,000 among a population of 500,000, at a cost of £1.8 million (provided by the CCG, LA and VCSE) – representing 5.2% of the population, at £3.60 per person.

The London picture

There is huge variability in access to social prescribing services in London. While in some London boroughs, the entire population has access to services, meeting a large range of needs for individuals. Other areas focus provision on particular locations or populations. Others still are at the development stage and currently offer no services at all.

The way social prescribing is organised and funded varies across London too. In 2017/18, 47% of services received funding from CCGs, 29% from local authorities and 23% of services receiving joint funding from both.⁴⁴

There are currently 146 link workers employed across London (107 of whom are full time), supported by 177 volunteers. Most of these roles are hosted by VCSE organisations (51%), with CCGs and local authorities hosting much smaller numbers, at 26% and 19% respectively.

Just over half (55%) of link workers spend some time based within GP practices, while a further 23% have developed relationships with local GP practices. All five

STPs across London include plans to further develop social prescribing within their local areas.

London seeks to lead the way internationally on this issue, drawing on specialist players in the field, including the Social Prescribing Network, The Institute of Health Equity, UCL Centre for Access to Justice, The Healthy London Partnership-led Proactive Care Delivery Group.

What we're doing to help

We are exploring how we can build on the excellent work that is already happening in London. Working with stakeholders we have identified four key areas of work to strengthen the provision of social prescribing:

- **Digital:** Developing platforms to enable individuals and organisations to share information
- **Evaluation:** Building tools to enable consistent and rigorous evaluation across the capital
- **Workforce:** Ensuring staff and volunteers with the right skills
- **Social Welfare and Legal Advice:** Promoting social prescribing services in areas such as employment, housing and debt advice.

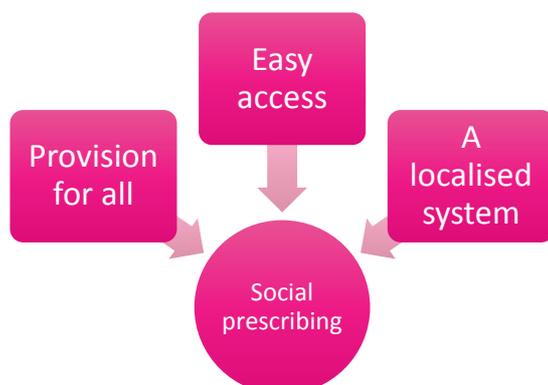
These are described in the following section.

Our other activities include:

- Influencing and championing the wide benefits of social prescribing, by talking to leaders, providers and the public.
- Advocating for and bringing together the players that need to collaborate for social prescribing: health providers, local authorities and the VCSEs.
- Developing models and systems to smooth the way for organisations to get involved.
- Including social prescribing in wider conversations and activities relating to health and wellbeing in the capital.

Paving the way for our vision

Social prescribing: our vision for London



To make sure our vision becomes a reality, we are paving the way for partners to expand and develop good quality social prescribing that reaches out to those local communities that need it by developing four important areas – workforce development, evaluation, improving digital connectedness and the provision of social welfare and legal advice. Each of these is explained below.

Developing the workforce

In high quality social prescribing, the linkworker (or ‘community connector’) role is pivotal. We need to make sure this becomes an established role, with some consistent elements of a job description (although with local flexibility), defined core competencies, recognised training and CPD, and career progression routes mapped out, to attract high-quality staff. Current link workers should be supported to move into this established workforce.

There is some debate and confusion about the difference between the various titles (including health coaches, local area co-ordinators and signposters) that help people access non-statutory services that benefit their health and well-being. NHS England’s *Guide to Social Prescribing* [DN to be added once published]⁴⁵ offers definitions of each of these roles.

Whatever their job title, if these individuals are to play an effective part in a social prescribing scheme, they will need to spend time with the people they support, undertaking motivational interviewing and person-centred planning. We cannot overestimate the need for the social prescriber to have excellent listening and confidence building skills to build the relationships required both with the individuals they support and the local VCSE and public-sector partners. They will also need a strong understanding of the local community and the services, groups and activities available, and to work closely with the local statutory services, including GP practices, social services, local hospitals and local authorities. This will ensure easy referral both to the social prescribing link workers and by the link worker to the required statutory services.

Motivational interviewing

Motivational interviewing is a therapeutic technique that focuses on what matters most to the person as its starting point. It gives people time to tell their stories and empowers them to set their own priorities and targets.

This is especially important for social prescribing as many of these clients have a range of needs, ranging from housing or employment to social isolation and physical or mental ill health. The evidence shows that focusing on the person's priorities, rather than priorities set by professionals, makes people more open to change, more enthusiastic and more likely to achieve their goals. The approach must be adapted for people with communication needs such as those post-stroke or with dementia.⁴⁶

This will present opportunities to recruit from local communities that experience the most health inequalities. It will also be important to support and acknowledge the role of volunteers, and to forge a pathway from volunteering into employment.

What we're doing:

- Developing and expanding existing workforce training and awareness courses within the NHS
- Exploring ways to provide more accredited courses for social prescribing linkworkers
- Looking at how we can support more volunteers to participate in social prescribing and receive the right training and support.

Evaluation

Though the evidence base is growing, an important challenge in getting support for social prescribing and embedding effective programmes into systems and communities, is getting good quality evidence on the impact social prescribing in general, but also different models of social prescribing, have on different individuals and communities, and on systems and costs.

However, many social prescribing initiatives are small scale, short term and have limited resources, lacking the opportunity to demonstrate their long-term impact, value for money and real benefit for Londoners. With so many different models of Social Prescribing, led by different partners operating in different contexts, outcomes collected are often driven by local circumstances or funding, rather than to the end of providing data that can be used more widely to ascertain effectiveness of models.

Through agreeing shared outcomes to measure, and by supporting local partners to assess and evaluate their services, we can help everyone to learn and develop effective support.

This encourages and supports partners to use the most effective approaches, presents opportunities for learning, sharing and improvement and helps present a business case for social prescribing as a concept, and for replicating and spreading the most successful models.

What we're doing:

- Providing tools to make high-quality evaluation as easy as possible
- Creating a London-wide forum where partners can share learning and best practice
- Supporting local partners to conduct rigorous evaluation across selected models of social prescribing in London, to increase the robust long-term, quantitative data
- Analysing existing evaluations to identify the most successful approaches
- Providing clear guidance and advice to schemes on how to develop evaluations
- Working with the digital workstream to support data sharing.

NHS England are developing a Common Outcomes Framework to provide a consistent way to measure the impact of social prescribing. This assesses impact of the intervention in three ways:

- **Impact on the person:** how their wellbeing has improved, whether they feel more in control and have a better quality of life.
- **Impact on the health and care system:** impact on demand for services such as primary care or A&E
- **Impact on community groups:** to ensure that local community groups are fully involved and supported to get involved in the social prescribing initiatives.

Improving digital connectedness

At the heart of social prescribing is partnership working. How we use digital technology to enable joined up working, sharing, and timely effective communication across the NHS and voluntary sector will be hugely important to enable individuals and organisations to talk to each other – for example, finding out about local activities or sharing outcomes data.

With 94% of Londoners online, people already rely on digital tools to manage their health and wellbeing. As well as supporting service providers to work together, a strong digital offer will help individuals find the right services or to self-refer, especially when developed alongside, rather than instead of, face-to-face provision.

This work links with the Mayor's [Smarter London Together](#) – a flexible digital masterplan for the capital.

What we're doing:

- Supporting partners to incorporate social prescribing in an integrated pathway, with agreed protocols and processes for sharing data, so they can collaborate efficiently

- Supporting partners to use population-based social prescribing analytics to inform commissioning
- Encouraging organisations that already provide self-care tools to include social prescribing options
- Developing ways to support individuals and volunteers use digital tools so they can easily find information and support
- Supporting local social prescribing schemes to harness digital at every step, from publicising activities to demonstrating outcomes. We designed the digital maturity index (below) to help organisations assess where they are, and what they need next.

Providing social welfare and legal advice

A high proportion of the health problems that GPs see are caused, or exacerbated, by unresolved social welfare issues. Socio-legal issues such as debt, housing, welfare, employment is strongly linked to health and wellbeing (especially mental health)⁴⁷ particularly among people who are socially excluded or have a low income.^{48, 49}

What we are doing:

Working with the Legal Education Foundation to increase access to legal support in London, drawing on models such as the Australian health justice partnerships and the US medical legal partnership, which provide access to free legal advice in health settings.

What works

Today, social prescribing in London comes in many shapes and sizes. It must be tailored to the needs of individuals and specific communities. But the most successful schemes share some key features.

What does a good scheme look like?

NHS England has developed the below key features that have been identified as important in Social Prescribing schemes.



Whilst many social prescribing schemes will look different and operate in different ways, the above elements have been present in schemes that are delivering successful outcomes across the Country. These are described further in the NHS England Social Prescribing Guide [\[DN: link\]](#).

The flow of social prescribing referrals generally follows the below flow;



Some key ingredients of high quality social prescribing *[DN: present as graphic]*

- collaborating, commissioning and partnership working, from initial design to delivery
- easy referral routes
- access to link workers
- career pathways for link workers
- co-produced and shared decision making
- support for community groups
- a focus on outcomes
- quality assurance to ensure a high-quality service.
- a choice of activities that fulfil very specific needs of individual communities
- building assets and developing services to fit unmet needs
- access to activities within a short distance from home
- activities focused on local communities, even where these span administrative boundaries

Partnership working

When it comes to social prescribing, there is no ‘one size fits all’. The very thing that makes social prescribing work so well for individuals and communities is that it is tailored to the needs of the local community, and the neighbourhood where they live.

This means that local authorities and CCGs need to involve VCSEs, statutory services and service users from the outset and throughout each stage – from the strategic and planning stages through to delivery.

Supporting the VCSE sector

Social prescribing relies heavily on London having a vibrant and sustainable VCSE sector. This means supporting VCSE organisations of all shapes and sizes, both London wide and within boroughs, wards and neighbourhoods, to provide the services that will help Londoners manage their health and wellbeing.

The Social Prescribing vision will be linking with work being done across London to support the VCSE sector with investment, including working with the emerging work for the Healthy London Fund.

Focus on quality

As social prescribing schemes are developed and owned locally, by people in the community, the services that support individuals are known to referrers. This means that the quality of support provided can be monitored and vulnerable people supported to remain safe.

A supportive environment

As well as including these key ingredients, if social prescribing is to be mainstreamed across the capital, it must sit against a backdrop of a London-wide strategic approach. This means ensuring sufficient leadership, resource, digital infrastructure and funding, underpinned by trusting partnerships between public, voluntary and community-sector organisations. It meant putting infrastructure in place, in areas such as digital and governance, with support for small organisations in areas such as insurance, safeguarding and data protection.

DRAFT

Proposed workplans for 2018 onwards

Workforce



Workforce

The purpose of this slide is to outline the "Plan on a page" for the workforce element of the vision and map out the key activities to progress these.

OPPORTUNITY:	Support Social Prescribing schemes to ensure consistency and quality assurance regrading Social Prescribing Link Workers across London.
STAKEHOLDERS INVOLVED:	STP, CCG and Local Authority leads on Social Prescribing; Clinical Leads, NHS England, GLA, HLP, VCSE leads and the Social Prescribing Network.
ASSOCIATED WORK:	Making Every Contact Count, Health Coaching, Local Workforce Programmes,

1 Link Worker Accreditation, Training and Support

- Working with the Social Prescribing Network, NHS England and training providers, explore ways to ensure there are accredited pathways for social prescribing link-workers. Ensuring clear training pathways for link workers and support mechanisms.

2 Supporting the wider workforce

- Working within the NHS and Local Authority to support training to raise awareness of Social Prescribing to facilitate appropriate referrals and increase the wrap around support and capacity of schemes. Including training within clinician and allied health professional curriculums.

3 Supporting Volunteers

- Developing support and training to increase and upskill the voluntary workforce to support social prescribing.

Evaluation



Evaluation

The purpose of this slide is to outline the "Plan on a page" for the Evaluation element of the vision and map out the key activities to progress these.

OPPORTUNITY:	Support Social Prescribing Schemes across London to increasing the consistency of outcome measures, reduce the cost of evaluations and support business as usual reporting.
STAKEHOLDERS INVOLVED:	STP, CCG and Local Authority leads on Social Prescribing; Clinical Leads, NHS England, GLA, HLP, VCSE leads.
ASSOCIATED WORK:	

1 Advising or something of Social Prescribing Tools and Measures

- Increase the consistency of use of the various tools and measures available to evaluate social prescribing schemes, to ensure the most appropriate tools are being used for each programme and improve the ability to compare outcomes and report across London on Social Prescribing outcomes.

2 Map roles

- Provide clear role and skill descriptions of the various roles associated with Social Prescribing including link workers, community navigators, care co-ordinators, health coaches and guidance regarding how the various roles work together to support each other. Showing how these different roles might best fit for your local area and support what already exists. Ensuring pathways between clinical and non-clinical staff and their roles within social prescribing are clear.

3 Literature and economic summary of the benefits of individual social prescribing interventions

- Provide easy to access and collated summaries of the evidence regarding the most referred into individual interventions to support the development of business cases, plans local services and provide baselines for local outcomes. Including clear effectiveness of interventions with different types of need linked to NICE guidance.

Digital



Digital

The purpose of this slide is to outline the "Plan on a page" for the digital element of the vision and map out the key activities to progress these.

OPPORTUNITY:	Support the adoption and spread of Social Prescribing using current existing tools and digital work programmes across London.
STAKEHOLDERS INVOLVED:	STP, CCG and Local Authority leads on Social Prescribing; Clinical Leads, NHS England, GLA, HLP, VCSE leads
ASSOCIATED WORK:	One London, NHS England Digital Programme, PHE Good Thinking,

1 Baseline analysis

- Work with each local borough/CCG to undertake a digital maturity self assessment.

2 Support Interoperability of Social Prescribing across London

- Work with One London to develop approaches for incorporating Social Prescribing within the care record demonstrator LHCRE site. Add about the app.

3 Digital Social Prescribing

- Work with existing partners including Good Thinking, to develop support digital approaches for social prescribing as an addition to personal support and referral from areas.

4 Develop Digital Maturity

- Following the outcome of the digital maturity self assessment, develop support plans to increase the overall digital maturity of social prescribing schemes across London.

5 Support Directory of Services

- Support the develop of up to date and consistent linked directory of services across London.

Social welfare and legal advice



Social Welfare and Legal Advice

The purpose of this slide is to outline the "Plan on a page" for the Legal Advice element of the vision and map out the key activities to progress these.

OPPORTUNITY:	Ensure a consistent offer of support across London for individuals to access advice and guidance on issues related too benefits, debt, housing, employment and other legal issues
STAKEHOLDERS INVOLVED:	STP, CCG and Local Authority leads on Social Prescribing; Clinical Leads, NHS England, GLA, HLP, VCSE leads, Legal Education, Citizens Advice.
ASSOCIATED WORK:	Social Fund for London

1 Baseline analysis

- Work with the Legal Education Foundation to establish a baseline of the current provision of basic and specialist legal advice across London.

2 Support Access to Training and Advice for Link Workers

- Working with local areas and specialist advice services to support an increase in access to training and advice for Link workers to increase their confidence and skills in supporting people with less complex legal issues.

3 Develop a consistent offer

- Following the outcome of the baseline review, develop support plans to increase the access to service that provide support regarding housing, benefits, debt, employment law, welfare advice, etc.

Glossary

1. **Medical Model** – the traditional approach to the diagnosis and treatment and illness, focused on the physical and biological presentation, with treatment aimed at addressing the physical presentation.
2. **Service Brokerage** – An investment by health and social care in mobilising and harnessing the local community and building social support networks that help people to remain independent in their homes and free of social services or major health intervention for longer. A broker assists people with their individual budgets, to support them to find and access the services that best meet their needs.
3. **VCSE** – Voluntary, community and social enterprise organisations
4. **Holistic Person-centred** – Focussing on the elements of care, support and treatment that matter most to the patient, their family and carers.
5. **Health Trainers** – help clients assess their lifestyle and well-being, set goals for improving their health, agree action plans and provide practical support and information that will help people to change their behaviour
6. **Social Inequality** – the existence of unequal opportunities and rewards for different social positions or statuses within a group of society
7. **Referral Pathways** – different routes patients take from their first point of contact (usually their GP) with an NHS member of staff through referral to the completion of their treatment.
8. **Signpost** – A process of referring people to information needed to access a service
9. **Personalised care** – People having control and choice over the way their health and care is planned and delivered.
10. **Personal Health Budgets (PHB)** – A way to give people with long term health conditions and disabilities more choice and control over the money spent on meeting their health and wellbeing needs
11. **Personal Independence Payments (PIPs)** – A benefit to help you with everyday life if you have an illness, disability, or mental health condition
12. **Social Isolation** – a state of complete or near-complete lack of contact between an individual and society.
13. **The Mayor of London's Health Inequalities Strategy** – this sets out plans to tackle unfair differences in health to make London a healthier, fairer city.
14. **All Party Parliamentary Group** – Informal cross party-groups that have no official status within Parliament. They are run by and for members of the Commons and Lords, though many choose to involve individuals and organisations from outside Parliament in their administration and activities.

- 15. Loneliness Strategy** – Official document launched in October 2018 by UK Prime Minister to tackle loneliness
- 16. Green Spaces** – open space reserve or protected areas of undeveloped landscape
- 17. Green care** – structured therapy or treatment programmes that take place in natural surroundings and recognise the instinctive connection between nature and health
- 18. Therapeutic Horticulture** – The process of using plants and gardens to improve mental and physical health as well as communication and thinking skills.
- 19. Care Farming** – The use of farming practises for the stated purpose of providing or promoting healing, mental health, social or educational care services
- 20. Environmental Conservation** – Ways of protecting the planet and conserving its natural resources so that every living thing can have an improved quality of life
- 21. Schizophrenia** – mental disorder characterized by social withdrawal, disorganised thinking, abnormal speech and an inability to understand reality
- 22. Premature mortality** – A measure of unfulfilled life expectancy. This relates more to the death of younger people than older people.
- 23. Socioeconomic deprivation** – Lack of material benefits considered to be necessities in a society
- 24. STP** - sustainability and transformation partnerships, each local area will have an STP, which is a collaboration between Clinical Commissioning Groups, Local Authorities, NHS Trusts, and other organisations involved in the health and care within the area. The purpose of an STP is to help ensure health and social care services in England are built around the needs of local populations
- 25. CPD** – Continuing professional development. It refers to the process of tracking and documenting the skills, knowledge and experience that you gain both formally and informally as you work, beyond any initial training
- 26. Health coaches** – People who work with individuals to help them improve their health and then maintain a healthy lifestyle
- 27. Local area coordinators** – They are based in community venues so they are easily accessible to people in the areas they work. They support coordination between the various service in local communities, to assist people connect and navigate to the services they require.

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