The Richmond Group of Charities

‘Social prescribing’

Learning from *Doing the Right Thing,* including our work in Somerset

The Richmond Group of Charities

This slide deck brings together some of our learning about social prescribing. The majority of this learning has come from our *Doing the Right Thing* programme, including our work in Somerset, but we have incorporated relevant learning from our wider work.

We recognise that 'social prescribing' is a somewhat clunky term. It's not ideal, but it is now being used and recognised across health and social care. We are have tried to clearly explain what we mean by 'social prescribing', both here and on our website, and we welcome suggestions as to how we can improve this.

Please contact us if you could like to find out more about *Doing the Right Thing* or other Richmond Group programmes (using the details on the final slide).

Contents NB. PowerPoint hyperlinks only work in slide show view

The Richmond Group of Charities

Context – Richmond Group

Doing the Right Thing is our programme to explore meaningful **collaboration** between the VCSE sector and the statutory sector. The programme includes a practical collaboration in Somerset, which began in late 2016.

We scoped where a collaboration could add the most value. We had no pre-conceived ideas about products or providers. Prevention quickly emerged as a shared ambition.

Pronounced issues in primary care, including around workforce and demand, quickly stood out. Social prescribing services are working well, but are only available in a few parts of the county. With a specific idea emerging, we held a workshop with Somerset residents. They were overwhelming positive about social prescribing approaches.

It felt sensible to focus our collaboration with the local VCSE and statutory sector on sustainably and equitably scale social prescribing across the county. We secured funding to explore and test the feasibility of doing this from the government's Life Chances Fund and the South West Academic Health Science Network.

Context – Richmond Group

There were three strands to this research:

1. A **community research** exercise, which used local community researchers to engage with over 100 Somerset residents (mostly face-to-face) about the design of social prescribing, and included a survey of around 100 local GPs.
2. A **rapid evidence review** by the University of West England, which focused on understanding evidence and good practice in a number of social prescribing approaches across Somerset and Devon, and considering these within the context of the national picture and learning from other areas.
3. A feasibility study conducted by OPM (now Traverse), which brought together the findings from the first two strands with **data modelling and financial feasibility testing** of different approaches to scaling social prescribing.

This slide deck brings together the learning from our various research pieces with practical learning from our collaborative project and its National Steering Group, as well as learning from Richmond Group charities' experiences of providing, working with and advocating for social prescribing services.

Context – External picture

Social prescribing isn't new, but its profile has grown quickly over the last few years. Recent developments include:

- Government's A connected society: A strategy for tackling loneliness (October 2018) commits to "improving and expanding social prescribing services", with all local health and care systems having implemented schemes by 2023.
- The NHS Long-term Plan reiterates and expand these commitments: Over 1,000 trained social prescribing link workers will be in place by the end of 2020/21, rising further by 2023/24, with the aim that over 900,000 people are able to be referred to social prescribing schemes by then.
- NHS England has published a Comprehensive Model for Personalised Care, of which social prescribing is one of six core themes.
- We understand NHS England will shortly publish social prescribing guidance. A collaborative working group was convened to advise on this.

Context – External picture

- Matt Hancock, Secretary of State for Health, recently stated his support.
- The RCGP has strongly backed the expansion of social prescribing, if based in GP surgeries, including its role in advancing the prevention agenda.
- DHSC announced a National Academy for Social Prescribing, which will be 'an online platform' for people to share training, guidance and research.
- The RCPsych's Sustainability Team has convened a National Working Group on Social Prescribing to bring together a wide group of people (beyond the work NHS England is already doing) to consider the next steps for social prescribing.
- The King's Fund has promoted and run a number of events on social prescribing, which have tended to focus on a health perspective.
- The Social Prescribing Network brings together a range of people and organisations to share knowledge and good practice, to support the concept at a local and national level, and to inform good quality research and evaluation.

What is social prescribing?

'Social prescribing' (as described by the NHS and others) links people into personal networks as well as practical and emotional support within communities and the voluntary sector. This is often via their GP, nurse or other primary care professional.

The aim of social prescribing is to help people live their lives as well as possible, with a focus on supporting them to take control of and to improve their health, wellbeing and social welfare.

Services are normally time-limited (but with some flexibility).

What is social prescribing?

Social prescribing is just one of a wide range of **preventative** interventions that contribute to good outcomes for people and can reduce demand for health and care services.

Social prescribing supports secondary prevention – it can empower people to look for solutions to social problems before a crisis occurs that might affect their physical or mental health.

Social prescribing can also enable tertiary prevention – it can support people with one or more long-term condition to build self-management and coping skills and to maintain independence.

What is social prescribing not?

There are a wide range of needs that social prescribing is unlikely to prevent or de-escalate. Social prescribing is **not an alternative to social work, social care or occupational therapy**. Nor is it an alternative to properly funding and supporting these essential eligibility-based services.

Social prescribing is **not the same as providing information, advice and signposting**. Nor is it an alternative to properly funding and supporting these essential universal services.

Social prescribing is not **a panacea** to system and funding pressures within health and social care.

What is social prescribing not?

Social prescribing is **not new**.

Schemes have been successfully running within the UK and around the world (including Ireland, The Netherlands and South Africa) for a number of years. Some English schemes have been around since the 1980s.

Social prescribing schemes have grown in recognition, number and scale over the last five years. NHS England estimates 60% of Clinical Commissioning Groups have commissioned some sort of social prescribing scheme. Many voluntary organisations, local authorities and GP Networks have also invested in schemes.

Who is social prescribing for?

Anyone who has non-medical needs that are (or are likely to start) causing or exacerbating a physical or mental health problem may benefit from social prescribing.

- These non-medical needs might relate to work, money, relationships, lifestyle, loneliness, social isolation or housing – but there is no exhaustive list.
- Social prescribing is sometimes targeted at people who frequently use their GP surgery but are unlikely to benefit from new / additional drug-based interventions. This can include people living with multiple long-term conditions.
- Some schemes in Scotland were initially aimed at people aged 50+ to secure Government funding. However, referrers found this to be limiting, especially with regard to people with stress and low mood as a result of life circumstances (e.g. Walker & Thirwell, 2015). Referrers and commissioners have also found clinically-focused access criteria to be unhelpful, e.g. because it excludes people who are lonely or socially isolated (Kimberlee & Beardmore, 2018).

Why social prescribing?

Problems for people:

- People go to see their GP when they "don't feel well" in the broadest sense, e.g. due to bereavement, feeling stressed about a work situation, or feeling lonely. They recognise they are "probably asking the wrong person for help", but don't know where else to go (BritainThinks, 2017).
- Having multiple long-term conditions has a range of impacts on people's lives. These include a loss of mobility and a loss of the social connectedness that comes with being able to get out and about and participate in social activities (Taskforce on Multiple Conditions, 2018).

Why social prescribing?

Problems for people: (BritainThinks, 2017)

- People want a long-term relationship with their GP: Someone who knows them well and who they can open up to.
- But they usually see a variety of doctors, have to repeat themselves, and are not able to build a trusting relationship.

- People want appointments that are long enough to discuss multiple issues and to allow problems that are harder to talk about to come to the surface.
- But they usually get 5-10 minute appointments that leave them feeling rushed and unable to get through everything.

Why social prescribing?

A solution for people: (BritainThinks, 2017)

The idea of social prescribing has immediate resonance with people, who see it as a sensible way to meet needs unfulfilled by the current system. They recognise health services are under pressure and are open to new ways of doing things.

There are five key aspects that appeal:

1. It is tailored to the individual.
2. There is a personal relationship at the centre of the service.
3. It offers support with emotional and social needs.
4. It empowers people to make changes in their own lives.
5. It feels positive and solution-focused.

Why social prescribing?

Problems for 'the system':

- Demand for primary care is increasing (Baird et al, 2016).
- GP workload growing in complexity (Hobbs et al, 2016; Dayan et al, 2014).
- The number of GPs has increased, but is insufficient to meet demand (Baird et al, 2016; Hobbs et al, 2016).
- Non-medical demand on GPs is rising (Citizens Advice, 2015).
- An estimated 20% of patients consult their GPs for what is primarily a social problem (The Law Commission, 2015).
- This costs the equivalent of 3,750 GP salaries (Citizens Advice, 2015).

Why social prescribing?

A solution for 'the system':

It is difficult for GPs to give people the non-medical advice and support they need (BritainThinks, 2017).

GPs don't always know about the range of VCSE practical and emotional support available in their area (BritainThinks, 2017).

Social prescribing offers a way of interfacing the statutory and VCSE sectors, giving GPs and other health and care professionals a general and consistent route into a service that is highly personalised for patients.

Why social prescribing?

An opportunity for system change:

Social prescribing can bring organisations and people together in an area to discuss and decide the best ways to deploy medical, social and community resources in order to meet health, care and support needs (Richmond Group, 2018).

In some areas, social prescribing provides coordinated support, with GPs, social workers, allied health professionals, hospital discharge coordinators, VCSE organisations and groups, libraries and blue light services able to make referrals to link workers. Self-referrals may also be encouraged.

How to deliver social prescribing?

There is **no definitive model** of developing and implementing social prescribing. Each area has different infrastructure, assets and relationships upon which to build.

Good foundations should be built on rather than duplicated or decommissioned and replaced.

- These might include existing services that connect people to practical and emotional support in the VCSE sector, area-based social care teams, grassroots movements, VCSE infrastructure organisations, and GP networks.

In some areas social prescribing has been / can be led by community movements, while in others the statutory sector or voluntary organisations have taken / can take a lead.

How to deliver social prescribing?

(BritainThinks, 2017; Kimberlee & Beardmore, 2018)

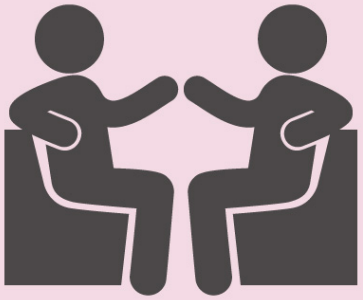
How to deliver social prescribing?

Buy-in from referring professionals

With recognition that collaboration and communication across and within sectors is a necessity and may require additional link workers, which is a skilled role that must be appropriately paid.

How to deliver social prescribing?

A person-centred approach



With appropriate time given to conversations focused on how people want their lives to be, what strengths they have, and what goals they can work towards to live as independently as possible.

How to deliver social prescribing?

Connections

To personal and community networks as well as to practical and emotional support within communities and the voluntary sector.

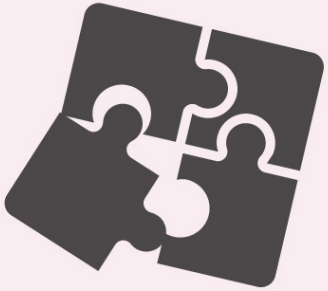
How to deliver social prescribing?

A transfer of resources

From the statutory sector to the voluntary, community and social enterprise (VCSE) sector, in parallel with these connections. This is essential for the sustainability of these approaches.

How to deliver social prescribing?

Community-building service development



With attention given to building on existing assets, generating social capital and creating local responses to unmet needs and goals.

How to deliver social prescribing?

Social prescribing is delivered through '**link workers**' and '**builders**'.

Link workers work with people to understand what they would like their lives to be like, to unpick their needs and any issues affecting their wellbeing, to identify their goals, and to link them to the practical, emotional and community support that can help them achieve these.

'Link worker' is a generic term that has been adopted by the NHS. This role is known by a range of terms across the country, including community connectors, system navigators and village agents. We found 'link worker' to be the term favoured by people (BritainThinks, 2017).

Builders work within communities to ensure relevant support is locally available to meet people's needs. They work with and alongside the wider VCSE infrastructure that is essential for the successfully delivery of social prescribing. This infrastructure needs to be locally understood, but might include a Council for Voluntary Service (CVS) that can offer DBS checks, volunteer training etc., fundraising capacity or access to grant funding to ensure the sustainability of groups and services, and a coordination mechanism for the sector, such as a forum or alliance.

How to deliver social prescribing?

People tell us that to be successful, schemes need to recruit **link workers** who:

- Are flexible. For example, some people will want to have a conversation about their lives, needs and goals within their own home, while others will prefer the GP surgery.
- Are compassionate. A patient may be feeling very vulnerable and find it difficult to open up.
- Are open-minded. To build trust they need to have a degree of authority, but not be patronising or superior.
- Are confident. People may want friends or family to join them and link workers need to be comfortable with others seeing how they work. They may also need to facilitate conversations with family and friends and ensure the patient's views are prioritised.

(BritainThinks, 2017).

Around the country link workers are employed within the VCSE sector, as NHS employees, by GP Networks and by local authorities. Culture matters more than contract.

How to deliver social prescribing?

Evaluations of existing schemes show that to be successful, schemes need to recruit **link workers** who:

- Are good listeners, motivating, and able to help people weather set-backs.
- Know when is and is not the right time for someone to engage with life changes.
- Can build relationships across the statutory and VCSE sectors.
- Can 'translate' terminology between people and practitioners.
- Can work using a focused, time-limited outcome-based approach. They must be good at managing constructive endings / exit strategies.

(Kimberlee & Beardmore, 2018).

These people are a valuable commodity. Social prescribing can free-up health and care resources, but the link worker is **not an unpaid or unskilled role**.

How to deliver social prescribing?

Link workers have undertaken the role of '**builder**' in some areas, but in others – especially within more deprived areas with fewer VCSE resources – this role has been undertaken by 'community builders', 'development workers' and similarly named roles that are dedicated to social prescribing services.

It takes time and effort to keep up-to-date with VCSE infrastructure and resources, to build relationships, and to work within communities to ensure relevant support is available to meet people's needs.

It is essential that this function is adequately resourced to ensure social prescribing is feasible and sustainable.

How to deliver social prescribing?

Examples of services, facilities and resources that 'builders' have helped to develop in response to unmet needs and goals:

- Physical activity programmes, such as walking and gardening groups.
- Peer support groups, often with a focus on self-management and coping strategies.
- Access to locally-run online cognitive behavioural therapy (CBT) groups.
- Talking cafes, including those that open in evenings and at weekends.
- Projects offering culturally appropriate meals to people at home and attending day services.
- 'Death cafes' and other initiatives that facilitate conversations about the end of life.

While VCSE services, facilities and resources are cost-effective, they are not free. Successful social prescribing is dependent upon **resources being made available** for their development, implementation and continued running.

How to deliver social prescribing?

Developing and implementing social prescribing services takes **time**, as does expanding and scaling existing services.

Successful social prescribing is usually evolved over time, often from small beginnings. Services are not a quick fix. They are a reasoned intervention developed in collaboration with partners, including within the VCSE sector. Universal, county-wide social prescribing in places like Hackney, Gloucestershire and Rotherham took ten years to develop (Kimberlee & Beardmore, 2018).

It can take two years before a 'builder' feels they are well-known and trusted within the neighbourhood within which they work (Kimberlee & Beardmore, 2018).

How to deliver social prescribing?

Link workers and builders need to know what services, facilities and resources are available within their local area. These should be mapped onto **electronic directories** (Coulter et al, 2013).

Local authorities have a duty to establish and maintain a service for providing people [all people, regardless of need, and including care and support staff] with information and advice relating to care and support (Care Act, 2014: 4; DHSC, 2018: Paragraph 3.15).

Social prescribing services should therefore work with local authorities to utilise and enhance the electronic directories they‘ve already developed as part of their discharge of this duty, rather than inadvertently duplicating or usurping them.

How to talk about 'social prescribing'?

People ask for simple and intuitive language.

- 'System navigation' is a confusing term that makes people think of transport.
- 'Coaching' implies sports. 'Wellbeing' makes people think of smoothies and yoga.
- 'Link worker' is favoured over 'community connector' as "it should be about you as a person".
- 'Journey' and 'steps' can be less intimidating than 'goals' and 'plan'.

People want social prescribing to be positive, inclusive and empowering, rather than a service for 'vulnerable' people.

Emphasising the listening skills of link workers helps people to know they are experts, without them sounding intimidating.

(BritainThinks, 2017).

How to measure social prescribing?

Generally, those setting up or expanding a social prescribing service will be looking for one or more measure that fulfil/s the following functions:

At an **individual level to tell a story about a person** using social prescribing.

- To understand a person and their situation.
- To understand whether a person and/or their situation has changed.
- To continuously improve a person's support.

At a **group level to tell a story about social prescribing**, e.g. "on average, this group of people were at X on a scale and now they are at Y" or "on average, this group of people used 10 of resource type A and now they use 5".

- To understand whether the service is achieving what it was set up to achieve.
- To continuously improve the service.
- To contribute to local and national learning about this type of service.

How to measure social prescribing?

The **primary aim** of social prescribing is to help **people** live their lives as well as possible.

Measurable outcomes might include:

1. Achievement of / progress made toward personal (self-identified) goals.
2. Reduction in the severity of personal (self-identified) concerns.
3. Improved wellbeing.
4. Increased ability to self-care.

Outcomes 1 and 2 can drive person-centred practice and capture the results of complex and holistic interventions. However, there is potential for perverse practice (e.g. encouraging people to set 'easy' goals or to identify 'easy' concerns). And while there is consensus that it's impossible for 100% of people to fully achieve their goals / completely mitigate their concerns, beyond that, we don't know what a good result looks like. This means these outcomes should not have targets set against them, which in turn means they are not suitable for use within outcome-based contracts.

How to measure social prescribing?

We all have an instinctive idea of what Outcome 3, '**wellbeing**', means and a definition is enshrined in primary legislation through the Care Act 2014. This definition includes personal dignity, control over day-to-day life, participation in work, education, training or recreation, and positive domestic, family and personal relationships.

Measuring wellbeing focuses on people's emotional as well as practical needs. However, demonstrating attribution can be burdensome, and securing before and after measures can be problematic.

A range of tools are available with which to measure wellbeing, including: the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWS), Well-being Star™, WHO-Five Well-being Index (WHO-5) and the ONS Subjective Wellbeing tool.

There seems to be emerging consensus that the **ONS Subjective Wellbeing** tool is a sensible one to pursue**.** This seems to be based on: a) being free to use, b) questions that make (relative) sense to people with a range of needs, c) staff feeling (relatively) comfortable using it, and d) its 10-point scale being sensitive enough to capture changes over short-term interventions.

How to measure social prescribing?

Capturing Outcome 4, increased ability to self-care, is trickier. Despite significant investment into the **Patient Activation Measure (PAM)** by NHS England and others, we have struggled to find much support for using the PAM as an outcome measurement tool for social prescribing.

Activation refers to the knowledge, confidence and skills a person has to manage their health. Measuring activation recognises that the choices and actions people take contribute to their outcomes, and is a concept that is currently being promoted within the NHS. However, the terminology of 'activation' is clunky, and approaches to measurement are focused on a medical understanding of health rather than a more holistic understanding of health, wellbeing and social welfare, e.g. questions focus on medication rather than a broader view of equipment, physiotherapy and other non-drug therapies.

Some link workers have told us they are using the PAM, but they report adapting its use on a case-by-case basis, i.e. selecting which questions to ask. It is not possible to access the calculation used to turn people's responses into an 'activation score' as this is withheld by the developer. It's therefore impossible to understand how changing the tool's administration affects its validation.

How to measure social prescribing?

A **secondary aim** of social prescribing might be to have an impact on **system** outcomes, e.g. reduce demand for medical services.

Measurable outcomes might include:

1. Changes to GP attendance (Polley & Pilkington, 2017).
   - At least seven papers have looked at the effect of social prescribing on demand for general practice, reporting an average 28% reduction in demand for GP services following referral. Results range from 2% to 70%.
   - Unless a social prescribing service reduces GP attendance to the sum of *an entire* GP's workload, the service is making general practice *more efficient* rather than releasing a cost saving. It may be possible to reinvest the saved opportunity costs into an activity that subsequently results in a measureable cost saving.
2. Changes in A&E attendance (Polley & Pilkington, 2017).
   - There is some limited evidence that social prescribing may reduce A&E attendance.
3. Changes in emergency admissions to hospital (Polley & Pilkington, 2017).
   - There is some limited evidence that social prescribing may reduce emergency admissions.

How to measure social prescribing?

There are **limits to what monitoring and evaluation can tell us**. For example:

- It may be possible to show there is an *association* between an intervention and an outcome such as reduced admission to A&E, but is very difficult to show *attribution*.
- Social prescribing brings together a lot of different people and organisations. This means it can be relatively easily influenced by local and national policy and practice change. E.g. something like changes to benefits or changes to local services could an impact on referral numbers, people's needs and goals, and what it's possible for a social prescribing service to achieve.

Cross-sector conversations about outcome measurement need to be **realistic, with all partners held to the same standards and expectations**. Open datasets (where appropriate) may help with this.

Otherwise there is a risk that social prescribing is set up to fail.

How to measure social prescribing?

Capturing and sharing data:

In order to report on the activity, outputs and outcomes of social prescribing, services need a digital tracking system. This needn't be expensive off-the-shelf software. The **relevant data is usually already captured** and is often already stored in a data warehouse or lake. Collaborating with the relevant data analytics lead/s and developer/s from the outset of setting up a social prescribing service can save a lot of time and money later on.

NHS Digital has created national SNOMED codes [systematically organised computer processable collection of medical terms] for social prescribing **to be used within GP IT systems**. These need to be used within primary care so that social prescribing cases can be easily identified and tracked:

- 871691000000100 | Social prescribing offered (finding)
- 871711000000103 | Social prescribing declined (situation)

Establishing data sharing protocols with health services and other statutory services can be very helpful, but it takes time. Some schemes hold **honorary contracts** with the statutory services with which they are based in order to enable data sharing.

How to model social prescribing?

There is no definitive model.

Most of the social prescribing services we've looked at are not centred around physical hubs. Even if services have a registered base, link workers are usually required to travel around the community and to visit some people within their homes.

Where services are split across multiple hubs, practices or providers within an area, an overarching framework (e.g. of principles and ways of working) plus centralised training and support may help ensure consistency in service quality.

How to fund social prescribing?

This is a live question within the "who is responsible for what?" discussion involving the broad 'system' of NHS, local authorities, VCSE organisations and groups, and other partners. Our learning from Somerset is:

- Social prescribing services can be funded in a number of ways.
- Funding for the 'linking' and 'building' parts of social prescribing need to go hand-in-hand.
- As with other preventative interventions, there are challenges to investment within a climate of reducing budgets. Services can take time and money to set-up, and investment needs to be frontloaded.

How to fund social prescribing?

Recognising this learning in Somerset, we initially looked at spreading social prescribing through a county-wide **outcomes-based contract** commissioned by the statutory sector. This was found to be feasible, but the research suggested a 'blanket' approach might work well in some parts of the county but less well in others. Something more akin to a 'quilt' – knitting together what works well in each part of the county – made more sense for Somerset.

Other areas have pursued a range of funding approaches, including **very place-based approaches**, like ours in Somerset.

Some services have pursued **social investment**, particularly Social Impact Bonds, to spread set-up costs and share risk.

How to fund social prescribing?

The act of linking people / creating a social prescription does not immediately meet people's needs. It is the personal networks and practical and emotional support within the VCSE sector that help people live their lives as well as possible. Therefore, social prescribing schemes must either provide or be developed alongside plans for **sustainable funding of VCSE infrastructure**.

There are various ways local commissioners can provide funding:

- Commission staffed VCSE organisations that provide services.
- Small grants for volunteer-led community groups providing peer support and activities.
- Micro-commission new groups where there are gaps in community provision. This may be in the form of a start-up grant and development support.
- Enable people to use Personal Health Budgets to pay for support in the VCSE sector.

References

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Analysis of 30 million patient contacts found that GP consultations grew by more than 15% between 2010/11 and 2014/15. The number of GPs has failed to increase at pace with the growth in groups most likely to use primary care (over 65s and over 85s).

BMA (2016). *One-third of GP vacancies remain unfilled*.

BritainThinks (2017). *Social prescribing in Somerset: Research commissioned by the Richmond Group*
Two x 30 minute teledepths with GPs with experience of social prescribing; one x 75 minute face-to-face interview with a person who has used a 'social prescribing' service; one x 30 minute teledepth with health worker involved in 'social prescribing'; one full day workshop with 11 potential beneficiaries of 'social prescribing': adults living in the Bridgwater area; spread of gender and age; all C2DE; all currently experiencing or have previously experience number of non-health challenges, e.g. debt, loneliness or unemployment; frequent visitors to GP; some with long-term health condition(s).

Citizens Advice (2015). *A very general practice*.
Almost three-quarters of GPs said the proportion of time they have spent on non-health issues increased between 2014 and 2015.

Coulter, A., Roberts, S. & Dixon, S. (2013). *Delivering better services for people with long term conditions building the house of care*. Kings Fund.

Dayan et al (2014). *Is general practice in crisis?* Nuffield Trust
The demand on GPs' time for participation in clinical commissioning groups and other external work has grown. Not enough GPs are being trained, more trainees now work part-time, and more existing GPs plan to retire early.

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