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Deliverable 2 - VCSE Sector Engagement and Social Prescribing

Healthy London Partnership

NHS

GREATER LONDON AUTHORITY

ELEMENTAL
The social prescribing people

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ACKNOWLEDGEMENTS

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ONES TO WATCH

With thanks to those involved in the 'ones to watch' examples, who were so generous with their time when being interviewed for this report:

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EXECUTIVE SUMMARY

The Mayor's draft Health Inequalities Strategy,[1] *Better Health For All Londoners,* included an aspirational objective (4.4) that 'social prescribing becomes a routine part of community support across London'. In response, this report, commissioned by the GLA, looks at the role of the voluntary, community and social enterprise (VCSE) sector in scaling social prescribing in London – in particular, the role of the sector in effective delivery of services, the challenges and opportunities the sector faces and the support required, as well as outlining its future role.

The report is grounded in a range of consultation processes including interviews, workshops and deep dive compilations of good practice case studies and brief summaries (ones to watch) with over 100 experts – predominantly across the VCSE sector but also statutory-sector commissioners and representatives of the health and social care sectors.

The report concludes in section 7 with a number of actions for the Mayor and the GLA to consider in taking forward social prescribing in London. It acknowledges that some of the actions will be within the Mayor's gift to support change or will require partnership working and influencing to achieve.

The breadth and depth of services provided in the delivery of social prescribing programmes across the capital is captured in this report, and we looked intensively into the issue and potential of providing pan-London coverage of social welfare legal advice services in health settings.

In the context of a *Better Health For All Londoners*, the provision of pan-London coverage of social welfare legal advice services can make a significant impact in addressing health inequalities in London, and may provide an exciting and suitable starting point for the Healthy London Fund supported by the Mayor of London.

Delegates at one of the VCSE workshops

1. What is social prescribing?

1.1 Introduction

This report addresses five scoping questions set out in sections 2 to 6 and concludes with section 7 on the role of the GLA and the Mayor.

The report is complementary to the work of the Healthy London Partnership (HLP) in creating the Healthy London Fund supported by the Mayor of London to support the wider health and wellbeing of Londoners. There are numerous opportunities for the fund to catalyse opportunities that the GLA and the Mayor can implement or support to ensure social prescribing becomes a routine part of community support across London. A staff member from HLP was interviewed in the engagement process and attended the Social Welfare Advice in Healthcare Settings Workshop.[i] Potential opportunities for the Healthy London Fund can be found throughout the report.

There are also clearly identified actions that the GLA and the Mayor might consider, some of which may be eligible for support from the Healthy London Fund. They are summarised in Section 7.

The engagement process outlined in Appendix A has consistently raised the issue of funding and the general funding climate for supporting the voluntary sector role in social prescribing is described throughout the report.

And, to deal immediately with the question of the future role of the VCSE in social prescribing, section 2 sets out the pivotal role of the sector in social prescribing in London. As this report will demonstrate, the question is better framed around how social prescribing can get the best out of the VCSE sector for London's most vulnerable communities.

The answers to the future role of the VCSE sector in social prescribing lie in understanding the challenges and opportunities for the sector (section 3), the resources required for the sector to participate optimally in social prescribing (section 4), the sector's scope for meeting the needs of vulnerable groups (section 5), how the sector is engaged in social prescribing (section 6), and what role the GLA and the Mayor may take in acting as a champion (section 7).

i See Appendix A – Engagement Process.

Delegates at one of the VCSE workshops

1.2 What is social prescribing?

The consensus in the engagement process is to have a clear definition of social prescribing to ensure that the concept is easily understood by everyone – from commissioners, the primary and secondary care workforce, housing associations, providers of community-based services in the VCSE, and to the citizens themselves.

The engagement process revealed that the term 'social prescribing' is not universally liked. However, as a concept it now has significant traction across the statutory and VCSE sectors and we (authors) assume and hope that it is here to stay!

It is a term that is now becoming understood by health-sector commissioners, and each community can brand delivery in their own way – in Bexley, for example, the social prescribing programme is called

Community Connect (see Bexley 'one to watch' in section 2).

In most cases, the heart of social prescribing beats around:

- **addressing the social determinants of health**: *'Social prescription is about what matters to people; it's about people's employment and environment'*[ii] and *'GPs didn't have the links – it's the VCSE who understands the impact of the social determinants';*
- **typically, a referral to a link worker**: *'The essential item in social prescribing is the link worker, who has the time and the personality to see the patient and refer to a menu of possible options'* (London is also witnessing the emergence of self-referral approaches to social prescribing with link worker time and attention being allocated to those most in need: *'Social prescribing is for everyone, but not everyone needs a link worker')*;

- the **resources** of the health, local government and VCSE sectors working together to provide a sustainable solution;
- **the presence of a high-quality range of local community assets** to facilitate *'a referral to non-medical support for issues that underpin or exacerbate medical issues'*; and
- **evaluation** – measuring the success of the social prescribing process in providing a suitable outcome and proving the case for funding.

Definitions of social prescribing often centre on the formal process of referral of a patient to a link worker – for example:

- The CentreForum Commission considers social prescription to be 'a mechanism for linking patients with non-medical sources of support within the community';[2] and
- the Social Prescribing Network acknowledges the importance of improving patient outcomes by changing their conditions, defining social prescription as **'enabling healthcare professionals to refer patients to a link worker, to co-design a non-clinical social prescription to improve their health and well-being'.**[3]

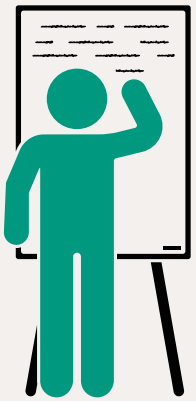
But it is important to note that, as noted in section 2.2.4, given the enhanced time available in the referral process, it may be the case that the link worker refers a patient to a medical solution (via the GP) in preference (or in addition) to a social prescription.

Nevertheless, the defining principles behind social prescribing suggest that healthcare providers must look beyond clinical treatment and assess their patients' needs in a more holistic manner, promoting shared decision-making and treating the underlying causes of illness. A holistic approach becomes even more important in deprived and vulnerable communities where there are significant health inequalities: as Sir Michael Marmot has noted, 'What good does it do to treat people and send them back to the conditions that made them sick?'[4]

This report prefers any definition of social prescribing to include not only the mechanism, but that the solution must address 'the conditions that made them sick' (the social determinants of health) and reach the most vulnerable communities:

ii Notes: 1) All interviews, meetings and workshops, unless otherwise stated, were conducted as part of the research for this report: see Appendix A – Engagement process. 2) All the quotes presented in 'italics' were drawn from interviews during the engagement process.

‘There is a danger of increasing the health inequalities that already exist by investing in a social prescribing system that works best for people who can already self-manage – those most likely to turn up at a GP’s surgery. The voluntary sector is best placed to reach those seldom-heard, seldom-reached communities. It’s what the sector does best. Enabling the sector to reach these communities through a diverse social prescribing offer could reduce the inequalities in access to health services. However, we recommend that this strategy broadens the conversation from just being about reducing primary and secondary care appointments and that we use this [Health Inequalities] Strategy to drive towards social prescribing being a vehicle to address the social determinants of health, and ensure prevention is prioritised.’[5]



It is almost always the case that the earlier the need for a social prescription is recognised, the better the outcome for the patient.

‘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.’[6]

1.3 The danger or the opportunity in social prescribing becoming a catch-all term

The engagement process has expressed concern that there is a danger of the term becoming a catch-all – and being clear about what the VCSE sector can and cannot do is highlighted in section 2 and section 4.3.2.

The jury is out in the engagement process on this issue, but this may be an opportunity for social prescribing.

The engagement process has confirmed that the statutory (Health and Local Government) and VCSE sectors (and Londoners in vulnerable communities!) are inundated with pilots, the next new idea and short-term approaches.

The engagement process has uncovered a range of community resilience, community cohesion-building approaches in London including:

- Local Area Coordinators;[7]
- Communities Driving Change;[8]
- local place-based interventions;[9]
- community-led approaches; and
- extensions of work undertaken by link workers involving volunteering (see Redbridge Case study, section 6).

They are all characterised by principles such as:

- resident or patient empowerment;
- asset based;
- co-production; and
- local solutions.

There is an argument to state that such approaches lie in the slipstream of social prescribing. They are best kept within the broad concept as the next stage of the evolving concept, or as inevitable developments in the journey to shift residents from consumers of scarce health resources to co-producers of their own and their neighbours’ good health.

2. The voluntary sector and social prescribing in London

This section sets out the role of the voluntary sector in social prescribing in London, highlighting good and effective practice and successful partnerships models.

'The primary care system is busy, overstretched and not always responsive to change: as things stand, social prescribing is far from routine. London boasts, however, an exciting network of innovative GP practices, housing associations, faith leaders and community activists. We need this network to lead by example – demonstrating good and effective practice, to encourage the scaling of social prescribing at pace.'[10]

2.1 The voluntary, community and social enterprise sector

The term 'voluntary, community and social enterprise sector' (VCSE) describes over 35,000 charities working in the health and social care sectors, plus at least 10,000 more social enterprises, and tens of thousands more unregistered community groups operating below the radar in England.[11] A significant percentage of this sector operates in London.

2.2 The voluntary sector and social prescribing in London

The VCSE sector has not changed its spots with the arrival of social prescribing – for the most part it has always been about addressing the social determinants and the provision of a high-quality range of local community services.

'A healthy London requires a healthy voluntary sector. Ensuring pan-London coverage of a diverse range of VCSE services is a key enabler for a social prescribing strategy.'[12]

Social prescribing is not new: *'VCSEs have been doing social prescription for a very long time. This has now become a trendy term but is not a new concept in the community and voluntary sector. They have been doing this for a long time and has become more sophisticated in recent years.'*

2.2.1 The range of VCSE services in social prescribing

The range of local community services can be split into four broad categories (Figure 1).[13] London hosts a relative abundance of VCSE organisations of each type, and Figure 1 lists examples of organisations with which discussions were held during the engagement process for this report.

Figure 1: Categories of local community services in social prescribing

	CATEGORY	EXAMPLES OF ACTIVITIES	EXAMPLES OF ORGANISATIONS
	Community groups: **Creative**	Art classes, dance, singing, gardening	The Conservation Volunteers, Food Academy, Core Arts
	Community groups: **Connected**	Peer-support groups, neighbourhood help, fishing, knit and natter, faith groups, time banking	Buddy Hub, Living Centre, Somers Town Community Centre, Healthwise Social Prescribing
	Community groups: **Active**	Keep moving, getting out of the house, volunteering and employment support, getting fitter	Charlton Athletic Community Trust, London Sport, Volunteering Matters
	Voluntary organisations: **Safe**	Housing, debt, domestic abuse, falls prevention, benefits	Macmillan, Legal Advice Centre, Shelter

2.2.2 Social hierarchy of needs element: social welfare advice services

There is an element of social hierarchy of needs to social prescribing – services must prioritise addressing the most urgent needs of patients: 'There are some basic needs – including safety, financial security and housing – which have to be addressed before any other initiatives can work.'[14] *'Many more people are in desperate need of financial management than we ever thought was possible.'* Waltham Forest has appointed a part-time social prescriber specifically to focus on housing. And, as was pointed out regularly in the engagement process, *'many things the community most values – capacity-building, resourcefulness, confidence and stronger connections between people – are not funded at all.'*

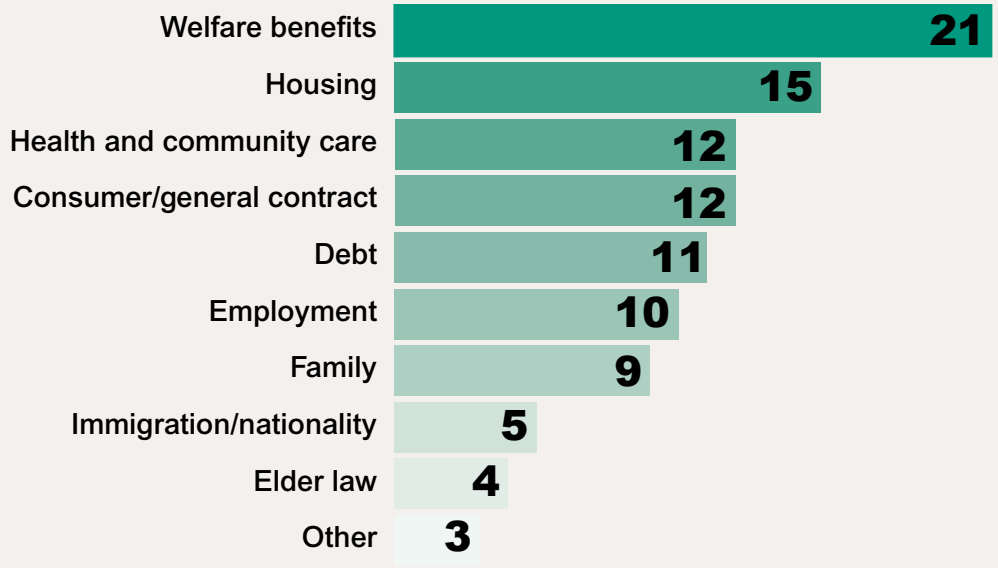
In the Safe category (see Figure 1), for example, there is increasing evidence and experience showing the essential role that social welfare advice services must play in tackling health needs and health inequalities in London: 'Social welfare advice should form a core component of social-prescribing initiatives to address the most pressing of needs and empower individuals to improve their circumstances. Without the fundamental conditions that enable individuals to lead a decent life, such as income and housing, other support services are likely to have limited effectiveness in improving health.'[15]

A recent mapping exercise undertaken by University College London[16] identified a total of 63 advice services working in connection with healthcare in London. These include national and local charities, local authorities, health services and independent organisations. The largest national providers were Citizens Advice and Macmillan Cancer Support, both of which run significant numbers of services in London.

Figure 2 provides an overview of the range of areas of law provided by social welfare advice services in London. Welfare benefits and housing are the most common issues.

'Health justice partnerships, in which access to free legal advice is provided in health settings, can help to tackle the social determinants of health through, for example, alleviating poverty, improving housing conditions, and securing stable employment.'[18] There are examples of 'health justice partnerships' in parts of London that are truly world-leading, but this is not the picture across the capital: access is far from routine: *'Social welfare advice in healthcare settings across London is sporadic and based on short-term funding. Services are almost always scrambling for*

Figure 2:
On which areas of law does the service provide advice?[17]



funding and some services have disappeared.'

There is a clear argument to suggest that creating good access to locally available social welfare advice services across London will enable the Mayor to take a significant step in addressing health inequalities in our most disadvantaged communities. This is discussed further in section 5.3.

2.2.3 VCSE: pivotal to social prescribing in London

Given the definition of social prescribing and the importance of addressing the social determinants of health, a referral to a link worker or self-referral options, and the presence of a high-quality range of local community services, the role of the VCSE is pivotal to social prescribing in London.

In practice, link workers across London can only be as effective as the capacity of the local VCSE sector to effectively receive a referral. Interviews and discussions with link workers have made clear the high priority afforded to the need for good-quality VCSE organisations to which to refer patients. Link workers seek to refer to organisations that can provide holistic support, as this prevents 'circular referrals' or a 'revolving door', where the patient quickly returns to a GP or link worker because their relatively complex needs cannot be fully met in one place, and because IT systems are not adequate to ensure continuity.

The valuable role of the VCSE in reducing health inequalities has been well documented, and holds just as true for the benefits of the VCSE sector in social prescribing:[19]

- user-led;
- community experts;
- trusted;
- accessible;
- holistic; and
- reduces pressure on systems.

2.2.4 Referral beyond the VCSE sector

Understanding patients with complex needs, and who may require a referral into the VCSE sector, takes time. As noted earlier, the social prescribing process involves a referral to a link worker, who has the time, training and skills over one or more meetings to unpick the solutions required to match the needs of the patient. GPs, during their limited time with patients, may not be able accurately to diagnose need – so it may be the case that the link worker refers a patient (via the GP) to a medical solution in preference (or in addition) to a social prescription. This is good practice and should be supported.

Where the social prescribing service sits can also facilitate ease of referral both within and beyond the VCSE sector. City and Hackney's Social Prescribing Services is under the Long Terms Conditions Board, and Waltham Forest Social Prescribing is based in Adult Social Care, which was a deliberate attempt to better integrate health and social care.

ONE TO WATCH

City and Hackney: City & Hackney Social Prescribing Service

Following a pilot in 23 GP surgeries across City & Hackney, this has now been rolled out to 42 practices, with around 1,200 referrals a year. There are three full-time and one part-time social prescribers, employed by Family Action, who refer into almost 100 organisations. The service is CCG funded, and the Health Foundation's Shine Innovation Fund facilitated an evaluation by the University of East London and Queen Mary University of London. Social prescribing sits under the CCG's Long Term Conditions Board, enabling it to become part of the contractual work of local practices.

- Shine 2014 final report: Social Prescribing: Integrating GP and Community Assets for Health **https://health.org.uk/sites/health/files/City%20and%20Hackney%20CCG%20final%20report.pdf**
- D. Carnes et al., 'The impact of a social prescribing service on patients in primary care: a mixed methods evaluation' (2017) BMC Health Services Research 17: 835: **https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2778-y**
- Video: **https://www.youtube.com/watch?v=Asy-XupljIM**

2.2.5 Reflecting local need

The term 'pan-London' does not simply equate to generic or regionally delivered services:

> 'Localism remains a key strength of London's voluntary sector. Local services should reflect the local community they serve and support a place-based approach to care. The right thing to do is what works locally, and so we're advocating for a social prescribing strategy (approach) with localism at its heart (including digitally enabled) and recognising that delivery models, providers and funding may look different in each local community (Borough Level and smaller).'[20]

Almost all the conversations held as part of the engagement progress for this report highlighted the need for local social prescribing services to be the right fit for the community they are planning to serve: *'Social prescribing must be locally focused and driven.'*

It is the local interaction between health, social care and voluntary sector that makes it a success: *'While it is great that the big system has cottoned on to social prescribing, it is essential that we understand what the magic of social prescribing has been up to now, and how we continue to maintain that.'*

Social prescription is not about replication; it is about translation to a specific community.

2.2.6 Working together to provide local provision

Many of the residents most in need of a social prescription lead very geographically restricted lives – the 'roaming distance' of residents in low-income communities is often limited to the neighbourhoods in which they live.[21] For social prescribing solutions to be sustainable, it is imperative that a range of high-quality community services are available locally. In times of austerity, it is vital that the VCSE providers offering similar services collaborate, for example, to produce pan-borough and pan-London access wherever possible – the Merton Social Prescribing Project, for example, works across the border with Wandsworth.

Commissioners and VCSE organisations should seek to work together: 'A social prescribing strategy with localism at its heart … can only be achieved by developing trusting partnerships between public, voluntary and community sector organisations.' Hence, London's approach to social prescribing 'has to be about developing collaborative and equal relationships, recognising that all stakeholders bring something to the table'.[22]

In Bexley, for example, Andrew Fairhurst, Primary Care Transformation Manager, comments: *'The way these [VCSE] organisations have been funded or commissioned in recent years has made them competitive rather than collaborative, which has done little good for the populations they seek to support. Part of our Integrated Care System plans are to change this, bringing in the VCSE as full partners in the delivery of health and care outcomes and distributing resources and making decisions in a way that promotes collaboration and partnership where it benefits patients to do so.'*

2.3 Good and effective practice and successful partnerships models

This report identifies nine examples of good and effective practice and successful partnerships models with the NHS, London boroughs and the voluntary sector, appearing here as 500-word case studies or brief 'ones to watch'.

It is important to note that the emergence of social prescribing models in London and elsewhere has taken place against the backdrop of little or no national guidance – only broad principles, good practice and a fledgling set of outcome measures.[23]

There are different models emerging across the case studies and ones to watch:

- **extended from initial pilot schemes**, with a range of funders – although it is worth noting that two examples (Redbridge Social Prescribing Programme and Waltham Forest Social Prescribing Service) are jointly funded by the CCG and the local authority or public health team;
- **hosted by a lead VCSE organisation or CVS** (Merton Social Prescribing Project) – which is a common commissioning engagement and participation of the sector theme explored in detail in section 6.1.3;
- **hosted in adult social care** (Waltham Forest Social Prescribing Service);
- **based on telephone support** rather than/ as well as face-to-face contact (Waltham Forest Social Prescribing Service and Live Well Greenwich Social Prescribing Programme);
- driven by **specific long-term conditions** (e.g. cancer – Bromley By Bow Centre);
- **specific to a life course stage** (e.g. old age or later life – Age UK Islington);
- **social prescription referrals from hospital wards** as well as from GPs (Harrow: Healthwise Social Prescribing);
- **serving the whole community** as a 'Healthy Living Centre' (Bromley by Bow Centre); and
- **sharing 'what works'** in terms of practice, research and evaluation (the Bromley by Bow Centre, for example, has contributed to national policy initiatives such as Sure Start and fosters a community of learning through seminars and publications).

ONE TO WATCH

Bexley: Community Connect

Community Connect began in nine GP surgeries in Clockhouse and is now a three-year funded programme across all Bexley's 27 GP surgeries. The target is for the three full time-equivalent social prescribers to reach 900 patients annually. The pilot was extensively evaluated by Christ Church University and Mind in Bexley, and renewed CCG and local authority funding was forthcoming because of the demonstration that the scheme was effective (e.g. average stays in hospital were seven days longer in the six months prior to social prescribing referral compared to those admitted after engagement with the scheme).

- Community Connect website: http://mindinbexley.org.uk/community-connect/
- Video: https://www.youtube.com/watch?v=wodKQzXZMw4&feature=youtu.be

ONE TO WATCH

Harrow: Healthwise Social Prescribing

Healthwise Social Prescribing was initially a nine-month pilot from June 2017 but has been extended to the end of 2018, with ongoing discussions to expand. Run by Capable Communities, referrals are made into over 50 local services (including health education, wellbeing activities and advice and information) from 33 GP surgeries and – unusually for a social prescribing scheme – two hospital wards. The project also grows social enterprises and runs a time bank initiative. The scheme has been shown to have a high financial return on investment.

- Healthwise on the Social Prescribing Wiki: https://wiki.healthylondon.org/Social_Prescribing_in_Harrow

In most cases, the partnership between primary and secondary care and the VCSE remains an unequal one, with funding and capacity proving to be ever-present issues across the capital for VCSE organisations (see section 3.2.3). Nonetheless, it has been eye-opening and encouraging to discover so many cases of effective practice and successful partnership models across the capital.

The VCSE is a largely under-celebrated partner, and the Mayor should take every opportunity to celebrate and acknowledge the work of the VCSE sector in London.

3. Challenges and opportunities

This section sets out the challenges and opportunities for the VCSE sector in efforts to mainstream social prescribing across London.

3.1 Introduction

The bottom line for the Mayor's Health Inequalities Strategy[24] is the need to empower Londoners to shift the dial from being consumers of scarce health resources to co-producers of their own, their families and their neighbours' good health. Scaling social prescribing programmes will make a major contribution towards this aim. There are, however, challenges and opportunities for the voluntary and community sector in its objective of making social prescribing a routine part of community support across London.

3.2 Challenges

This section places the challenges in rough order of priority. However, front-line VCSE workers are likely to argue that funding is the number-one issue, and strategists may cite fear of change by the medical/treatment community – so there is no definitive order that will please everyone!

3.2.1 The lack of a senior political leader to support London's social prescribing champions

Many interviewed for this report are themselves (or enthusiastically mentioned) champions – in the council, individual GPs, commissioners, directors of public health, or others – who never miss an opportunity to speak up on the value of social prescribing and who have been fundamental to its success locally. London is also host to the Social Prescribing Network,[25] the Social Prescribing Network for London and the Healthy London Partnership – vital organisations in making the case for the concept.

What is lacking is the passion for social prescribing at a London-wide political level. Until the publication of the draft Health Inequalities Strategy, there was no political owner of social prescribing in London.

Social prescribing needs an advocate: a leader who is prepared to bring about system-wide change in how the broad health and VCSE sectors work seamlessly together to improve the health of Londoners.

3.2.2 Fear of change in the statutory sector

Everyone seems to be so busy in the statutory systems in health and local government!

The systems do not seem able to stop and pause about assessing the approach to addressing health inequalities in London to:

- assess current efforts;
- contemplate a more radical approach;
- think long term;
- identify leaders and champions to find and implement solutions; and
- take stock of what we do well in London, and pool efforts and budgets.

Getting the statutory sector to invest in change is hard. Barriers to change include *'bureaucratic, resistance to change [in the NHS] – the NHS needs money, but this is not the most important barrier.*'

The engagement process undertaken for this report has uncovered frustration: *'We need to look at a five-year investment plan not a Five Year Forward View!'* And these frustrations are most clearly directed at the perceived tendency of the health system to fear change: *'NHS managers don't understand social prescription.' 'Are the heads at the CCG table all clinicians with a really clinical background who have not had much exposure to the VCSE?'*

3.2.3 Funding

In the words of the Social Prescribing Voluntary Sector Task and Finish Group Meeting, 'It's not about funding, but it is.' The group has been clear in stating that the issue is that 'a healthy London requires a healthy voluntary sector. Ensuring pan-London coverage of a diverse range of VCSE services is a key enabler for a social prescribing strategy, and this in turn, requires funding.'[26]

Nevertheless, the engagement process for this report clarified that there is an unequal partnership between the health and VCSE sectors, with funding and capacity proving to be ever-present concerns across the capital for VCSE organisations: *'The NHS sees VCSE as a free service.'*

Social prescribing was often described as a funding afterthought or a luxury, with no owner accountable in the system: There is lack of ownership of the commissioning of social prescribing – with responsibility often falling between the cracks of CCG and local authority responsibilities. *'CCGs consider it a public health or local authority communities issues. Public Health considers it a CCG issue.'* And, returning to the fear of change issue above, *'There is lots of money in the UK [health system] but we are spending it on the wrong things.'*

Funding is mostly short term and does not always match demand with capacity. There is frustration with continued short-term funding and pilots in the VCSE sector – notwithstanding that the health sector is also victim to short-term funding cycles. It may not always be within the gift of local commissioners to agree longer and more sustainable funding.

Challenges outlined during the engagement process included:

1. 'We need funding for the long-term, and it [funding] reaching the VCSE providers on time.'
2. *'Programmes and projects like this come and go; they happen, and they finish but no one knows about them.'*
3. 'Resources – managing the demand with limited resources and balancing ambition with the reality!'
4. *'In London the challenge is the services being used and the social prescribers facilitating the use of services. The challenge is then when you are flooded as a VCSE to deliver on social prescribing – we need to explain to commissioners to fund extra capacity.'*
5. *'There are capacity issues, and high demands in the system naturally cause funding pressures.'*
6. *'The days of just asking the CCG for money have gone! You have to work collaboratively and pull together.'*
7. 'Funding does not often cover infrastructure issues in the VCSE sector: *'Commissioners like to fund service delivery but there is limited funding for infrastructure and business development in VCS organisations, even on full cost recovery (FCR) projects.'*
8. *'Successful social prescription will increase demand for advice and support – increasing, not decreasing, the need for funding.'*

The devastating consequence may be that residents who most need a social prescription may be marginalised by poor strategic thinking and inadequate funding.

3.2.4 Evaluation

There is currently no common evaluation framework to prove the case for social prescribing, although a draft outcomes framework is currently out for consultation.[27] Concerns were consistently raised about the complexity of evaluating the impact of social prescribing: *'Some people are obsessed about developing the evidence base for social prescription… The work to date indicates social prescription works. You can't prove outcomes of social prescription.'*

Discussions in the engagement process identified:

- 'the challenge of knowing what to monitor and to develop a common framework';[28]
- *'community voluntary services' struggle to illustrate impact of social prescription such as attendance figures etc.'*;
- having a system in place with consistent ways of measuring effectiveness and the resources required; and
- evidence sufficient to allow GPs to trust that the VCSE services are effective and legitimate.

Requirements to show the impact of social prescribing over short timeframes is also an issue: *'Social prescription is difficult to evidence, the work [project and programmes] within social prescription is complex to evidence. In this area, we need to come up with broader outcomes and allow time to demonstrate impact. Social prescription type of work requires years to gather evidence to measure impact.'*

But data is crucial: *'The future of social prescribing will depend on how effective the evaluation is.'*

3.2.5 Conservative commissioning

Unimaginative commissioning largely results from the factors listed above, particularly the fear of change in the statutory sector and lack of an evidence base. This can lead to frustration about 'status quo commissioning – reproducing the status quo by recommissioning the same people – and not recognising broader, better opportunities'.[29]

3.2.6 Digital connectivity

Firstly, what does 'digital connectivity' mean? For the purposes of this report, it means any digital solution, technology, information, computer or electronic system that enables social prescribing to support the people it serves.

This could be a referral management platform, an app, a website, a wearable, a simple database, an online directory of services, a system used by a provider delivering social prescribing style services – it is very much a broad and unconstrained definition.

Discussions in the engagement process around digital connectivity raised three main issues:

- The importance of establishing a digital flow of information from GP to link worker to VCSE provider: *'Having a system where the CVS can flow back the outcome to the referring professional is really important because the professional needs to know what happened. One of the weaknesses in exercise on referral – certainly in the early years was the data flowback never happened.'*
- The recording of information for evaluation purposes: *'Using the data and intelligence that social prescribing gives you provides you with a gap analysis of the needs and how they are met and extent; it provides you with a framework with commissioning as you need to use different data capture to understand the effectiveness of your interventions.'*
- The availability of VCSE services information to aid referrals.

This broad approach is one we have taken throughout our work. It is highly likely that the correct action for London will be a blended solution of relevant digital technologies to support its citizens to take best advantage of social prescribing.

There are many examples of projects using digital and most schemes have either adopted some form of digital (as seen in the Digital Social Prescribing Report commissioned by Greater London Authority and produced by Elemental Software) or are considering the adoption of digital.

3.2.7 Difficulty in ensuring pan-London local coverage of VCSE services

There is a broad bucket of challenges that all make it harder to ensure pan-London coverage of services. The engagement process identified a range of issues:

- *'There's no standardised model, and the strengths and opportunities of the VCSE are different in every area.'*
- Social prescribing VCSE services ideally need to be provided locally (as noted in section 2.2.6, residents most in need of a social prescription often have limited 'roaming distance' from home). For social prescribing solutions to be sustainable, it is imperative that a high-quality range of local community services is available at a local level.
- There may often be little or no joined-up thinking and collaboration against the backdrop above: *'There is a challenge for the VCSE in mainstreaming social prescribing in that they have been forced in to a competitive and transactional culture and that collaboration has risks for smaller charities with low-margin budgets when getting into contracts with bigger organisations and statutory commissioners.'*
- There are sometimes difficult relationships between the local VCSE sector and national providers: *'National organisations play a role but there is a danger in not talking to smaller groups – you will leave out the local social tapestry of an area that is playing a vital role.'*
- In times of austerity, it is vital that VCSE providers that are offering similar services collaborate to produce pan-borough and pan-London access wherever possible, to avoid duplication and take advantages of economies of scale.
- Signposting is not social prescribing! Section 1.2 describes how a referral to a link worker is one of the five 'heart beats' of social prescribing. For residents most in need of social prescription, in most cases a careful placement involving introductions to a warm community service will ensure take-up of the service on offer.

Delegates at one of the VCSE workshops

- Often, communication with the VCSE sector, and its involvement in social prescribing partnerships from the beginning, is lacking. Getting all partners from health and the VCSE sectors together at the start of projects is vital: 'What's made our pilot a success has been all the stakeholders being involved … the actual engagement and understanding of everyone, because we all know how it works…'[30]
- There is also a lack of knowledge of the VCSE sector by commissioners in the statutory sectors and by many members of the public: *'The NHS does not require any further marketing, but the VCSE does.'*

3.2.8 Engagement of elected members, GPs and the public

The buy-in of elected members will be critical in making social prescribing routine in London. To date there has not been any systematic approach to communication with elected members.

There is also no tidal wave of GPs currently advocating for social prescribing in London – but 'GP engagement is key … if you can get the engagement piece right and people can understand how it works and what the point of it is, then that's a real enabler.'[31] GPs are time poor and inundated with initiatives: 'Primary care has been booted around like a critical football for years and years and years, and therefore lots of GPs have seen various initiatives come and go.'[32] However, once a successful programme begins to show successes, *'GPs love us!'* as the burden of non-medical issues is lifted. Peer-to-peer communication can be helpful here: GPs make the best advocates to other GPs.

There is little or limited clear communication of what social prescribing is for the public.

Framing concepts or issues for the public such as social prescribing is vital. How social prescribing is ultimately communicated to citizens may make or break delivery efforts:

- 'Getting the community to use social prescribing can be very confusing if you don't have a simple description of what it is for potential users.'[33]
- *'Social prescribing is not yet in the public mind – we need PR to make it a two-word phrase that everyone understands.'*
- *'The name social prescribing doesn't work with the target audience.'*
- *'The UK is a nation that is addicted to pills.'*
- *'Let's change the language, and frame the issue around improving your own health.'*

Whilst GPs and others may primarily look for hard, numerical evidence, the stories of people who have benefited from social prescribing can be very powerful: the use of short videos about social prescribing can help to raise awareness among public and more widely.

The recently published Healthy London Partnership videos on social prescribing[34] are a good start, but more needs to be done.

3.3 Opportunities

This section attempts to place the opportunities in priority order but, as per the challenges, there is not a definitive order to the list that will please everyone!

3.3.1 The Mayor as champion

The Mayor can act as a much-needed champion for the VCSE sector and social prescribing. To our knowledge, there has never been a stronger statement ('Social prescribing becomes a routine part of community support across London') by a systems influencer on the benefits of social prescribing than the one made by the Mayor within Better Health For All Londoners. All conversations in the engagement process included positive responses about the Mayor's advocacy for social prescribing: *'It's brilliant what the Mayor has done to date on social prescription… People respond to their role models; the Mayor is one of the best role models we have seen to date as Mayor of London.'*

That being said, all conversations in the engagement process included discussion around the need for a long-term plan and funding. The Mayor's Health Inequalities Strategy is a 10-year plan and there were consistent calls in the engagement process for the Mayor to drive the conversation on social prescribing over this period: *'The Mayor doing a monthly podcast on social prescribing that could sit on lots of different websites would be a really useful thing.'*

There is also the opportunity for the Mayor to act as a social prescribing systems convenor – influencing change by, for example, convening a senior group of health strategists, commissioners, GPs and VCSE representatives across London to take forward the scaling of social prescribing in London.

And there is also the opportunity to challenge directly to keep social prescribing high on the radar, particularly when change should be a possibility – 'the Mayor should challenge the bodies that are newly emerging from Strategic Transformation Plans to commit to mainstreaming social prescribing as part of service redesign'.[35]

Finally, there is an opportunity to challenge the business community in its role in social prescribing, as it is seen by many as having a part to play. Morgan Stanley, for example, supports social prescribing at the Bromley by Bow Centre (see case study, section 5). *'The corporate sector can't just be about walls, accounts, and legal services – business has also to support the VCSE sector through meaningful engagement and support.'*

3.3.2 Advocacy

This may be a tipping point for social prescribing and now is the time for the GLA to build the communications and influencing flow.

Although the Social Value Act should have provided a prompt to the statutory sector, a social prescription solution should prove to be a best buy for London's approach to health inequalities in any case! *'The opportunities [in social prescribing] are predominantly around improving community cohesion, improving health, helping the health system and helping the social care system.'*

Social prescribing becoming a routine part of community support across London can make a significant impact in addressing health inequalities in the capital. Discussions in the engagement process highlighted the need to advocate for this:

- Take the argument to the statutory sector! Establish a lobbying army of patients, GPs, primary-care practice managers, commissioners and VCSE champions to keep the agenda high on all radars. The identification and support of GPs to be champions '*is a model that's worked well for other initiatives around cancer care, around the PHE clinical champions, physical activity'. 'Peer-to-peer communication [is important] – clinicians do tend to believe clinicians and not many other people. There are real champions out there e.g. Dr Zoe Williams and Dr Andrew Boyd, both in London, who are employed by PHE to some degree as peer-to-peer champions, so get them on board.'*
- *'Let's reinstate London as the capital of public health to the world!'*

- Openness and transparency in the VCSE sector: *'Invite [GPs and Commissioners] to our conference and events to see the level of rigour we put together and [we would] be very happy to accept a challenge via questions. We must be open to that and recognise that people are coming from different perspectives.'*
- Raising the profile and building the capacity of the VCSE sector – *'The VCSE can bring communities together, can care for a wide range of conditions, can reduce isolation, the burden on A&E and GP attendances, the burden on social care, and reinstate the sense of family and community.'*

Points to stress in the advocacy piece include:

- Social prescribing can be the driving force behind the need to make health everybody's business;
- 'supporting upstream prevention before health problems escalate, become complex for the health service user, and become expensive to treat';[36] and
- the sector's proven ability for 'better engagement with hard-to-reach communities'. [37]

3.3.3 Funding and capacity-building

The opportunities for funding and capacity building of the VCSE sector can only be unpicked by addressing the challenges outlined in 3.2. For example, if work can be undertaken to:

- champion social prescribing;
- address the fear of change in the statutory sector;
- provide clarity that social prescribing should be funded across the statutory sector from health and local government sources;
- implement a common evaluation framework – 'thinking as one' on evaluation and measuring impact: 'We need to be more savvy to demonstrate impact';
- develop commissioners' understanding of the VCSE sector;
- build pan-London digital capacity to drive the effectiveness and evaluation capabilities of social prescribing; and
- inform elected members of the benefits of social prescribing

… then opportunities for appropriate funding of the VCSE sector may emerge.

There are opportunities here for the Healthy London Fund to play a catalyst role – personalised budgets are a specific opportunity: *'We're looking at technology where the person can tap in and the personalised budget will then be allocated to that activity, and automatically that VCSEs can draw down that fund, that is an option. It doesn't exist at the moment, but technologically there's no reason why it couldn't exist.'*

An opportunity and the case to create pan-London access to locally available social welfare advice services via health justice partnerships across London is outlined in section 5.

There are also opportunities for innovation in capacity building – including referrals being made, managed and measured by the use of digital technology that connects GPs, link workers, VCSE providers and citizens (e.g. Poplar HARCA Housing Association), the use of telephone support (e.g. Waltham Forest and Live Well case studies) and trained volunteers, mentors or buddies to support the primary link worker (including involvement of corporate volunteering as part of corporate social responsibility programmes).

CASE STUDY

Waltham Forest Social Prescribing Service

The Waltham Forest Social Prescribing Service, which is 50% funded y the CCG and 50% by Public Health, launched in April 2016. Initially an 18-month pilot, it has been extended to the end of 2018 across 42 GP practices. It is unusual among social prescribing programmes because contact with patients is almost exclusively by telephone, and because the social prescribers sit in Adult Social Care (rather than being positioned as a community-development initiative). This helps to integrate social prescribing into the broader social-care system. The Service benefits from strong support from the associate director, Health & Social Care Integration Waltham Forest CCG and senior public health consultant, London Borough of Waltham Forest – in addition to the senior social prescriber's past experience in senior roles in both statutory and voluntary sectors. A detailed evaluation of patients in the pilot was published in June 2017 by the University of East London.

Project delivery

The Service is delivered by two social prescribers, joined recently by a part-time 'housing social prescriber': the majority of people referred to the Service are anxious, most of this anxiety is driven by housing worries. Referrals are received from GPs, community health services and Adult Social Care. The social prescribers contact patients by phone to discuss their needs and aspirations and to direct them to local public-sector or voluntary services. A follow-up call is made after eight weeks to assess whether and how support services have been accessed.

Initially, the pilot focused on people aged over 85. Now, however, it seeks to reach a younger demographic of vulnerable people – the recently unemployed or bereaved, for example – where there is greatest potential to make a difference. Around 10% of these referrals are met face-to-face in a local library.

Impact

The 2018 target is to reach 600 patients – a number that is feasible because the service is delivered by telephone. The UEL evaluation – which was not sufficiently light-touch to be a sustainable model of measurement over the long term, but which provided 'hard' evidence sought by GPs – found significant improvements in respondents' concerns on housing, practical support, work and finance. There were positive changes among users in all health outcomes, with the greatest reported improvement in wellbeing and quality of life.

Key to success is being able to talk to people on a one-to-one basis about very emotional issues, and to provide them with appropriate support.

Challenges

Because the Service is delivered by telephone, managing to speak to those who have been referred can be challenging. In addition, the current IT systems operate independently of one another – GPs receive updates only by email rather than automatically, and patients may be re-referred to services they have already accessed because the system does not record previous attendance.

Looking to the future

The Service is waiting to hear the results of a proposal to NHS England for social prescribing in the community – some voluntary organisations would receive funding through the bid, and it also includes the development of a new digital system that would facilitate and streamline follow-up with patients.

Sources

- M. Bertotti et al., The Social Prescribing Service in the London Borough of Waltham Forest: Final Evaluation Report (2017) https://www.researchgate.net/profile/Marcello_Bertotti/publication/320280866_The_Social_Prescribing_service_in_the_London_Borough_of_Waltham_Forest_final_evaluation_report/

Increasingly, organisations are looking at social prescribing platforms to make and manage referrals, provide online directories of services, easily update and manage details on the citizen, social prescribers and services, provide analysis, capacity management, utilisation and take-up of services offered, and social and financial return on investment impact analysis.

These software platforms provide the intelligence to manage a social prescribing programme, across an area or multiple areas, and all of the services, users and social prescribing professionals who need to be involved.

Some of these systems are now integrating with leading GP clinical systems, such as EMISWeb from EMIS Health and SystmOne from TPP, as well as some platforms having open APIs to provider systems (for example in the VCSE or charity sector), to build on existing systems that are in place.

3.3.4 Evaluation

The engagement process provided several suggestions for improving evaluation:

- design a pan-London systematic approach to the collection of evidence to support the scaling of social prescribing: *'In the long term there are opportunities and benefits of mainstreaming social prescription across London for those VCSEs that are or will be developing good outcome measures; by this I mean sophisticated qualitative outcomes. Mainstreaming will help [establish a] feedback loop into the NHS for the first time'*;
- accelerating the basics and getting the house in order: *'Having a quality assurance tool, and referral pathways and outcome framework: all those things are in process [of being produced] and … all those things have common language the health sector understands'.*
- *'[eventually] the Common Outcomes Frameworks will show a reduction in GP visits or, for example, an improvement in respiratory profile etc. equal to or better than the standard medical model. And "equal to" in most cases would be good because it would cost less, so the outcome is the same, but cost is lower'*;
- personal stories as well as hard data can help to make the case and communicate impact; and
- a need to evidence short-term gains whilst building the larger and longer-term picture.

Several social prescribing programmes have been developing their own evaluation schemes (in partnership with universities including the University of East London and Christ Church University) – for example, Age UK in Islington, City and Hackney, and Community Connect in Bexley.

3.3.5 Digital connectivity

The range of digital and technology solutions in place already – whether directly or indirectly supporting social prescribing, or not yet supporting social prescribing but have potential – is extensive and varied.

Building on these foundations to positively enhance what already exists, as well as delivering new capabilities and functionality for those engaged in social prescribing and the citizens of London, is vital. Whether it is ensuring existing information is included, population data is visualised appropriately to identify gaps in service provision, tap into existing community assets, support services, or existing systems are integrated and become part of the social prescribing digital ecosystem, even where digital maturity may be lower than desired, positive work already exists that can be built on.

It's important to acknowledge these key principles relating to digital:

1. The Digital Strategy is not about digital, IT or technology: it is about people, place and communities.
Never forget this!

2. Person-to-person, face-to-face contact is at the heart of social prescribing. It's about people and communities. Digital is not designed to replace this.

3. Digital needs to support services for Londoners to give them choices or provide easy access to support.

4. Digital needs to support those working in the social prescribing arena (whether in health, local government, housing, voluntary and community sectors) to help them be more efficient to deliver services to their communities.

5. Digital can help deliver on the recommendations being made to mainstream social prescribing, gathering evidence, helping identifying gaps in services and demands and enable some social prescribing services to be scaled across larger populations of Londoners than is possible via face-to-face support.

6. The focus is on what digital can have a positive impact on, in a reasonable timeframe, not digital innovation for the sake of it.

The key opportunities identified by those engaged in this project are:

- any digital strategy for London should include social prescribing;
- London may want to consider a number of social prescribing global digital exemplars – identifying areas to focus on and a digital champion in support of social prescribing;
- as part of the digital strategy, London should consider establishing a capital-wide framework to support social prescribing across all sectors with information sharing, interoperability between different IT systems and the use of data to support population health and wellbeing;
- build on existing local initiatives and systems but consider providing London-wide support for referral management and monitoring;
- measure how digitally mature areas of London are in term of social prescribing and digital to support them – plot current position and set goals within a community area; and
- align the key themes and recommendations being made by HLP and GLA reports to strengthen the messages around a social prescribing strategy for London.

Poplar, Merton, Clapham, Barnet, Greenwich are some of many areas utilising digital in some shape or form, either directly or indirectly, for social prescribing.

3.3.6 Ensuring pan-London local coverage of VCSE services

The scaling of social prescribing in London is the opportunity for the VCSE sector to be acknowledged as a key player in addressing health inequalities in London.

There are many opportunities for the sector and for funders.

Borough-wide umbrella VCSE organisations can play an important role in providing the resources to support the delivery of high-quality community services.

Their role may include:

- encouraging partnership working and providing central back-office services such as bid-writing support, IT and information governance to deliver larger contracts; and
- advocating for and supplying representation on Health and Wellbeing Boards, local integrated care boards and STP delivery boards: *'The opportunity for the VCSE is to bring their contact with at-risk populations, skills, expertise and resource into being full partners in how health and care services are devised and delivered is too good to be missed – and VCSE organisations should be pushing for representation on local integrated care boards and STP delivery boards.'*

The VCSE sector needs to establish models of partnership and collaboration.

Commissioners and VCSE organisations should work together to provide optimal patient care. In Bexley, for example, its acknowledged that *'the way [VCSE] organisations have been funded or commissioned in recent years has made them competitive rather than collaborative, which has done little good for the populations they seek to support. Part of our Integrated Care System plans are to change this, bringing in the VCSE as full partners in the delivery of health and care outcomes, and distribute resources, and make decisions in a way that promotes collaboration and partnership where it benefits patients to do so.'*

There are some key areas of work to help scale social prescribing programmes in London that can be best undertaken by using a pan-London approach. Examples include:

- **Social welfare advice in healthcare** settings: Creating good access to locally available social welfare advice services across London will enable the Mayor to take a significant step in addressing health inequalities in the city's most disadvantaged communities. Section 5 describes how this report's authors worked with a small group of social welfare advice thought-leaders in London (led by Dame Professor Hazel Genn and Matthew Smerdon) to recommend a series of actions that can lead to the provision of pan-London (locally available) social welfare advice services.
- A **pan-London approach to digital connectivity** (see Digital Social Prescribing report).
- **Transition the evolving range of link workers into an established, recognised workforce:** Establish a generic but locally flexible job description, defined required core competencies, an accompanying CPD framework, and with career progression routes mapped out: 'Experienced / knowledgeable

link workers are vital – we've been blessed with [name] who's excellent and he's the link worker we have here at the practice, he's got a lot of experience, and he's been able to understand what works and what doesn't work and actually giving us feedback about what's out there in the community'.[38]

- **Workforce development:** There are many specialist interest groups in the VCSE sector that can be built on to offer high-quality provision – and workforce development is one example. In physical activity and sport provision, London Sport has recognised that many of its front-line coaches and instructors are less confident and motivated to work with inactive people and are unlikely to encounter inactive people. *Building a Workforce for the Future* focuses on two strategic priorities: 'A broader [physical activity and sport] workforce enabling all Londoners to lead active lives, and a workforce that better meets the physical activity needs of all Londoners'.[39]

- **Quality assurance kitemark**: *'GPs are not going to send their patient to someone or something they know nothing about, and it would be unethical to. So, one of the challenges is a level of trust – a solution might be a kitemark or something similar.'*

3.3.7 Hitting other agendas

Social prescribing is a cross-cutting intervention that lends itself to contributing to a range of other agendas in London, such as employment and volunteering.

'With a growing number of non-clinical navigator/ link worker type roles, there is a fantastic opportunity to recruit a local workforce, ideally from the "hard to reach"/ seldom-heard communities which experience the most health inequalities. There can also be an accessible pathway from volunteering to employment. However, this local employment approach must still recognise that navigator/link worker roles are still skilled roles but present a great opportunity to wrap these local roles in a holistic training/education programme.'[40]

Figure 4 in section 5 briefly mentions a case to expand Team London with a legal pro bono project, in which the legal workforce in London can volunteer to support the provision of social welfare advice in health settings.

3.3.8 Engaging elected members

There is a lack of a systematic approach to communicating with elected members on social prescribing – and this is relatively easy to rectify. A Practical Guide for councils on delivering a whole systems approach to obesity, developed by the Whole System Obesity programme (Leeds Becket University), will be published in 2018[41] – it is recommended that a similar document for social prescribing be made available to elected members in London.

4. Resources for social prescribing

This section sets out the resources required in terms of leadership, staff training, fundraising, technological, capacity building and other support to build an effective business case for voluntary and community-sector organisations to engage with social prescribing.

It addresses the four key issues that the VCSE sector must address to build an effective business case to engage in social prescribing: leadership and building capacity; the evidence for social prescribing; handling social prescribing referrals (earning trust); and workforce development.

4.1 Leadership and building capacity

4.1.1 Levels of leadership

Leadership in the VCSE sector will be a vital enabler in making social prescribing a routine part of community support, becoming a cost-effective and collaborative sector locally and across London.

Leadership is needed at many levels:

- **Pan-London:** There is currently no single body that speaks for the pan-London VCSE sector; however, natural social prescribing pan-London VCSE champions are emerging. The GLA Social Prescribing, Voluntary Sector Task and Finish Group, and the Social Welfare Advice in Healthcare Settings Workshop attendees, are examples of this. Section 3.3.2 above advocated taking the social prescribing argument to the statutory sector, through establishing a lobbying army of patients, GPs, primary care practice managers, commissioners and VCSE champions. The Mayor is a now potentially a systems influencer on the benefits of social prescribing: he will need the very best and trusted advisors and advocates at his side when he takes the convening role that is outlined in section 7. Pan-London leadership will also help identify key areas of work to help scale social prescribing programmes that can be best undertaken by using a pan-London approach. Social welfare advice in healthcare settings is highlighted in section 5. London-wide leadership will filter down to STP, borough, and local levels.
- **The five London Sustainability and Transformation Partnerships (STPs):** If there is to be genuine transformation change across the health and community systems, it is strongly recommended that (if not already the case) STPs have a strong representation of the VCSE sector in appropriate visioning and decision-making groups.
- **Borough level:** The engagement process demonstrated a variety of models in which commissioners can commission the VCSE sector in a locality or borough by commissioning a representative body. This body could be the VCSE organisation or a single organisation with ongoing commissioning capacity. Either way, the organisation must be supported to encourage partnership working and, where needed, provide central back-office services such as bid writing support, IT, staff training, and information governance to deliver larger contracts; advocating for and supplying representation on Health and Wellbeing Boards, local integrated care boards and STP delivery boards; and taking the big-picture approach and ensuring collaboration and partnership working between VCSE organisations to provide local coverage of services.
- **Sub-borough level:** There are also examples of more localised leadership – Social Action for Health, for example, operates a consortia approach of much smaller organisations to supply social welfare advice in local communities in Hackney and Tower Hamlets: ‘Social Action for Health leads two consortia working with nine local community partners to deliver advice and support from 27 GP practices in Hackney and

Tower Hamlets. We support our community partners by providing overall contract management, monitoring and reporting systems and frameworks, ongoing guidance and training including quality assurance, in order that they can focus on what they are specialists at – providing locally informed, culturally and group specific advice sessions.'

4.1.2 Long-term commitment

All levels of leadership should push for a long-term plan and commitment to social prescribing:

'Having a long-term vision, commitment and consistency can galvanise the local voluntary sector – don't keep changing the plan. London's voluntary sector applauds the 10-year vision of the Mayor's Health Inequalities Strategy. Let's be clever about not being clever! The really innovative thing is not to do anything new, but to simply use the assets of the sector/community and collect the little things done well, into one coherent offer to improve a community's health outcomes. So, we ask that the Health Inequalities Strategy resists the temptation to continually launch shiny new initiatives and instead work out ways to keep social prescribing and the role of the sector at the forefront of the wider strategy.

The diversity of the voluntary sector's offer is incredibly valuable – build on what works and don't overlook the role of voluntary sector infrastructure organisations as a key enabler to bringing the little things together.'[42]

4.1.3 The role of the VCSE lead organisation

'You need a top-notch VCSE that provides support for the sector in the borough, and picks things up when funding dries up.'

In Haringey, for example, the Bridge Renewal Trust *'provides tools, builds relationships, undertakes co-production methods to understand community needs, is working on a tool to share data across multiple settings, and as a joint action by the Trust and the Local Authority map the sector and keep a public-facing directory up to date as part of the Local Authority digital offer.'*

4.1.4 Building capacity

The leadership models described above are vital in building capacity around issues such as staff training, fundraising, and use of technology: There needs to be a strong emphasis on partnership and innovative collaborative working, particularly where 'for long term sustainability, a full cost recovery model is important. As part of this, it is important that any social prescribing funding is not used as a replacement for other funding. Funding the evaluation, training, delivery, preparatory work before you start your programme is vital for achieving the best outcomes – and this is often underestimated or planned for.'[43]

The VCSE can also coordinate local volunteers to support the link workers – Redbridge Social Prescribing Programme teaches Health and Wellbeing Buddies to meet with patients, extending the reach of the programme (see Redbridge case study, section 6).

4.1.5 Leading in planning and partnerships

The leadership models should also take a lead in complex planning issues and partnership working: '[Social prescribing] referrals also have the potential to be more than just a pathway between GPs and the VCSE sector. It has to be everybody's business and build in partnerships with housing associations, social care teams, specialist organisations (voluntary, public and private sector) and infrastructure organisations without creating local competition of resources. Putting social prescribing at the centre of health and wellbeing boards and ensuring the voluntary sector are well represented on these boards, as a valued provider of [solutions to address] the wider determinants of health.'

4.2 Evidence – making the case for social prescribing

'There are two challenges around evidence: the availability of data to understand who needs a social prescription, and what are we trying to evidence.'

4.2.1 Data – estimating the extent of the social prescribing need

The whole statutory and VCSE system needs to assess the extent of probable demand for social prescribing to plan and budget ahead. To address health inequalities, the system needs to understand where health or social issues may significantly escalate and then profile what preventative actions can be implemented to mitigate cost and personal suffering. *'The VCSE is a massively under-utilised resource in delivering health and care outcomes, and statutory commissioners generally do not support the sector adequately.' In section 5, thought-leaders on social welfare advice in health settings refer to addressing the upstream causes of downstream health problems - 'There is lots of money in the UK [health system] but we are spending it on the wrong things.'*

The literature review undertaken for this report highlighted that 'general practitioners report 19% of their consultations are related to social factors rather than medical issues'.[44] The engagement process has prompted discussion on the need within the health and community systems to take the lead and establish data profiling of health settings in the most vulnerable communities – getting ahead of, and estimating, demand. The VCSE needs *'evidence on the people or cohort group that will require social prescription. GPs and other health care systems have this data but need to share it with the [VCSE] sector'.*

4.2.2 Evaluation – demonstrating impact

The engagement process constantly surfaced issues around evaluation – for example, there is currently no common evaluation framework to prove the case for social prescribing (although a draft outcomes framework is currently out for consultation[45]). Concerns were consistently raised about the complexity of evaluating the impact of social prescribing and proving the case. Evaluation can become too onerous financially, bureaucratic and daunting for those without a research background, and is potentially off-putting for patients taking part – so careful design of user-friendly systems to gather information is urgently needed.

However, there are examples in London of robust evaluation of the impact of social prescribing. In Merton, for example, some of the early evaluation results from the evaluation of the East Merton Social Prescribing Pilot[46] are given in the Merton case study – and the report concludes: 'We are unable to confirm direct causality, for example to say that the reduction in appointments or the increase in self-reported health and wellbeing are due to the SP programme. However, these findings are positive and appear to show that the social prescribing service may have led to a statistically significant reduction in GP appointments in the three months following referral to the programme, and in A&E appointments in the six months following referral.'

CASE STUDY

Merton Social Prescribing

Initially funded by the Merton Partnership, Merton Council and Merton Clinical Commissioning Group (MCCG), the Merton Social Prescribing Programme is managed by an Implementation Group (chaired by the clinical lead for social prescribing) which includes MCCG, Merton Council, GPs, and representatives from the voluntary community sector. It began as a pilot (January–December 2017) in two GP practices: Tamworth House Medical Centre and Wide Way Medical Centre and is delivered by Merton Voluntary Service Council (MVSC) which employs a social prescribing coordinator (SPC) who is embedded within the GP surgeries, as part of the extended team.

An independent evaluation conducted by Healthy Dialogues has been positively received by all partners and MCCG who have committed funding for up to an additional two years and extended the pilot to at least another nine GP practices.

Project delivery

Patients, most of whom have mild/moderate mental-health issues, long-term conditions and/or social needs, are referred by their GP to the SPC. One of the local GPs is particularly enthusiastic and has been responsible for 40 per cent of the referrals – demonstrating the impact of an enthusiastic leader! The SPC reviews the patients' notes and meets with them individually for around an hour, with up to three follow-up visits depending on need. Patient notes are added in to the EMIS IT system. Only patients from the designated GP practices can be referred, because notes on patients from other practices cannot be accessed.

At the consultation, patients are provided with information on around 30 voluntary sector organisations and relevant social or clinical services. Services in neighbouring Wandsworth are also offered, as these may be more convenient for patients living on the borough border.

Impact

An estimate of return on investment, undertaken ahead of the pilot, found that over 300 patients from Tamworth House Medical Centre would have benefited from social prescribing in 2016/17, which could have saved over £140,000 in health and care costs.

In the year to the end of January 2018, 316 patients were referred from the Wide Way practice (of whom around 90 had more than one meeting with the SPC) and 66 from Tamworth House.

Patients complete a Wellbeing Star questionnaire covering eight health and wellbeing categories; average score increased from 2.8 to 3.5 (on a scale of 0–5). Comparing three months before and after social prescribing referral, the average number of GP practice appointments per patient fell from 11.9 to 8 – equivalent to a reduction of 543 primary-care appointments.

Challenges

There are four major challenges: 1) ensuring that those residents can most benefit from the service are actively targeted and engaged 2) Evaluation: demonstrating the savings that are possible through social prescribing and 3) delivering SP at scale will require additional infrastructure to be able to manage and evaluate the service 4) Initial GP reluctance to take part – but significant effort has been put into training and engaging GPs; now, health professionals from beyond the current scope of the Project are keen to be involved

Looking to the future

The programme will work to demonstrate clear savings in primary and secondary care, making the case for investment. Future plans include the expansion of social prescribing into west Merton, and an online digital platform that would further the reach and effectiveness of social prescribing so that it can also support the wider self care offer in Merton.

Sources

- Healthy Behaviours, Evaluation of the East Merton Social Prescribing Pilot: Mid-Programme Report - January to October 2017: https://www.mvsc.co.uk/sites/mertonconnected.com/files/East%20Merton%20Social%20Prescribing%20Evaluation-October%20update%20healthy%20dialogues_0.pdf
- Twitter @SPrescribing / @SekeramMohan

ONE TO WATCH

Age UK Islington

Measurement of outcomes has been a particular focus in Age UK Islington's social prescribing service. An online tool – a 'wellbeing gauge' – takes snapshots of self-management/coping ability, and technology is being developed to track changes over time, building evaluation into delivery. There were around 2,000 calls by this service over the past year, with volunteers (including from local businesses as part of their corporate social responsibility) now involved in making proactive 'wellbeing calls'. The caseworkers also gather information on an ongoing basis, using people's own words as well as quantitative data.

- Video: https://www.youtube.com/watch?v=4EmCdUYjm1I

The Kensington and Chelsea Social Council and NHS West London Clinical Commissioning Group recently published its *Social Return on Investment evaluation* of its Self-Care Social Prescribing model.[47] The report states: 'The Self-Care social prescribing model has led to reduced avoidable need for hospitalisations, reduced need for GP practice hours, and reduced levels of physical pain and depression for patients ... [There is] £2.80 of social value created per £1 invested.'[48]

4.2.3 VSCE confidence

The VCSE sector should become more confident about the evidence it currently has for social prescribing impact. There is a conundrum in the VCSE sector in London concerning evaluation. The engagement process has consistently flagged concerns around collecting strong data. Yet on the other hand there are plenty of examples of robust evaluation.

It is also the case that VCSE organisations collect data to prove the case for funding bids on an ongoing basis.

To make the business case, the VCSE sector may need to form a research group or accelerate or amplify work that may already exist, possibly in partnership with the GLA Social Prescribing Evaluation Task and Finish Group[49] and the Social Prescribing Network to:

- collate and/or reiterate what evidence is currently available;
- identify the gaps; and
- consider designing a pan-London systematic approach to the collection of evidence to support the scaling of social prescribing, working in tandem with the emerging Common Outcomes Framework[50].

Much work has already been undertaken.[51]

4.3 Delivering – stating the case and earning the trust of the statutory sector

4.3.1 Demonstrating value and credibility

The engagement process highlighted the need for the VCSE sector to prove its value and earn the trust of GPs and commissioners in particular. At its most basic, the model of social prescribing for GPs must work consistently: 'It's knowing that whoever you refer the patient to – link worker or whoever – actually takes responsibility and make sure there is an outcome for patients, because the quickest thing to get us to disengage is that they think "oh it's an all singing all dancing service and it will work fantastically", and then it falls apart for the patient. That would just mean that people don't refer again.'[52]

The engagement process made several references to quality assurance: we need 'quality assurance and a cycle of providers e.g. mystery shopping of services etc.'[53] There is some thinking taking place on this: *'one of the challenges is a level of trust – that might be a kitemark or something. For example, some of the work we [The Conservation Volunteers] are doing with NHS England and others is the development of a Quality Assurance tool'.*

'The statutory sector needs to support and encourage organisations that can deliver. Saying we do a good job isn't good enough – we need to be red hot in our results, evaluation and ongoing assessment'.

4.3.2 Clarity: what we can't do!

It is also important to make clear what the VCSE sector is not able to pick up – whether for capacity reasons or because it is not able to make appropriate referrals:

'Voluntary sector organisations already active in the social prescribing space often report a high level of inappropriate referrals. Prioritising training, education and support for frontline workers (GPs, healthcare professionals, link workers and the VCSE workforce) is a key way of addressing this and should feature as part of a social prescribing strategy.'

However, needs identified through social prescribing – even where these referrals cannot be acted upon – 'can be an indicator for identifying gaps in local health provision. Giving the sector the means to share insight and intelligence will support future commissioning and furthermore, giving the sector the simple ability to refer back into the "system" will ensure people access the right services for them.'[54]

4.4 Workforce development

Many of the conversations in the engagement process revolved around the role and capacity of the link worker, but this is a multifaceted issue. In the true spirit of a requirement for systems change (and as an important part of helping to build the business case), four key workforce areas have been identified for development.

4.4.1 Link workers

'We need a model of training for link workers.'[55] There is a need to transition the evolving range of link workers into an established, recognised workforce with clear training and CPD needs. This workforce has emerged organically, but now needs to establish itself with (for example) a generic but locally flexible job description, defined required core competencies, an accompanying CPD framework, 121 support, and clearly mapped career-progression routes (for example, 'Connect Link provides training for link workers – bronze, silver gold'[56]).

4.4.2 The VCSE general workforce

A range of skills development, dependent on role, including establishing the evidence base, partnership and collaborative working, staff training, fundraising, and the use of technology.

4.4.3 Commissioners of social prescribing

Section 3.2.2 highlighted that commissioners in the statutory sectors may have a lack of knowledge of the potential of the VCSE sector to play a role in addressing their objectives. The VCSE sector should consider making the case for or creating a series of CPD opportunities highlighting opportunities for commissioners across the social prescription spectrum from nutrition and diet advice to social welfare services to adult social care.

'The CCGs are the purse string holders and you really need to tap into them. They hold the money that cascades down from NHS central and when there are projects that they want to push forward like managing pre-diabetes, early discharge from hospital initiatives … [and] they can do stuff that make things happen at scale.'[57]

4.4.4 GPs

This report noted in section 3.2.8 that GP engagement will be vital in driving forwards social prescribing in London. The engagement process has revealed that London possesses champion social prescribing GPs, but there is no tidal wave of GPs currently advocating for social prescribing in London. Similar to CPD needs for commissioners, the VCSE sector should consider making the case for or creating a series of CPD opportunities for GPs.

5. Meeting the needs of vulnerable groups

This section considers the scope and remit of the voluntary sector to meet the needs of particular vulnerable groups through social prescribing.

'VCSEs have the local expertise and knowledge of local population needs – they are the thought-leaders and have the eligibility to bring everything together. VCSEs recruit people from within the community they serve and, as a result, have a rich understanding of what the community requires.'

5.1 Addressing the social determinants of health

Social prescribing is the service that sits beyond the GPs prescription pad. It allows us to ask the question 'why?' and solve broader health issues by tackling the social determinants. There are no drugs available to end loneliness, build self-esteem and community resilience, or to tackle debt and poor housing conditions in our most disadvantaged communities – and therefore the VCSE sector is a critical part of social prescribing.

5.2 The range and extent of services in the VCSE sector

Compiling this report has been eye-opening as to the sheer range of VCSE organisations at work in the capital.

In just 10 minutes during a VCSE workshop that was part of the engagement process, a breakout group listed and described the following:

- MyTime Active: golf for patients with long-term conditions in Bromley, and golf for patients diagnosed with dementia under Admiral nursing care;
- Bromley-by Bow Centre: chronic pain group;
- Lewisham: Meet me at the Albany; Meet me at the Movies (arts-based groups for older people);
- Lewisham (safe and independent living) and Southwark Age UK: target prevention (referrals for social isolation, falls, community alarms, diet and exercise adaptations);
- St Paul's Way, Poplar: Health Champions – volunteering by the local community;
- Hackney: Core Arts (mental health);
- CVS Brent: social isolation in Brent initiative by CVS Brent; an advice matter portal;
- Lewisham SMUK – long-term conditions;
- Kingston: Macmillan's social prescribing (a whole range of services throughout London, including benefits and financial advice);
- Poplar: Neighbours in Poplar (addressing loneliness in the aging community).

In the stakeholder interview with Craig Lister of The Conservation Volunteers, the impact of the 'green prescription' becomes clear:

'Our aim is not to send patients back to the environment that caused them to be ill in the first place. For example, we have a Green Gym and secured mental health facility in Northern Ireland, which is a form of social prescribing if you like – and the clinicians there report a reduction in smoking, improved behaviour and improved sleep. We have some mental-health programmes in Leeds which are working very well with people with enduring mental-health conditions, so doctors in Leeds would refer to Green Gym and other TCV programmes. We have two Green Gyms on the grounds of University Hospital Birmingham (UHB) where we are working with cardiology and musculoskeletal issues to stream patients in.'

Some social prescribing services are aimed at meeting the needs of particular groups – for example, a specific area of the Bromley by Bow approach (commissioned by Macmillan) offers a social prescribing programme for people living with cancer, and the Waltham Forest Social Prescribing Service initially focused on people aged over 85 (but has now extended to a younger age-group). However, many of the case studies are not aimed at specific demographics, instead relying on GPs to refer those most in need, reflecting the age and ethnicity of the local community as a whole.

When you lift the lid on an element of VCSE services within social prescribing – such as social welfare advice – the range and depth of services and the scope to meet the needs of particular vulnerable groups becomes clear.

5.3 The role of health justice partnerships in social prescribing

5.3.1 Introduction to health justice partnerships

There are some significant areas of development to help grow and scale social prescribing programmes in London that may be best undertaken by using a pan-London approach. In doing so, applying a social hierarchy of needs approach helps to focus social prescribing on *'addressing the most urgent needs of patients, and on putting people in a position where their health can begin to improve'.*

In this context, there is growing focus on the role of health justice partnerships in social prescribing – a field in which London has the potential to be a global leader. Health justice partnerships bring social-welfare legal advice services into the health settings that people trust, to address the legal needs that cause or exacerbate poor health. This reflects the growing awareness of the impact of unresolved social-welfare legal problems on health and that many underlying physical and mental health problems have a socio-legal cause. A global summit held in London in November 2017 explored the potential for health justice partnerships:

> 'Poverty, substandard living conditions, insecure employment and debt all have a direct impact on health, as well as having a more indirect impact in denying citizens the capacity to make healthy lifestyle choices. It is against this background that health justice partnerships have been established. These partnerships take a holistic approach in providing free social welfare legal advice in healthcare settings and aim to address the social determinants of ill health through, for example, alleviating poverty, improving housing conditions and securing stable employment. They are the vehicle through which social welfare law becomes part and parcel of the approach to improving the health of citizens.'[58]

Health justice partnerships exist in the UK, US and Australia. In the UK, a recent mapping study uncovered more than 350 examples of these services, nearly 70 of which are in London.[59] Among these are examples of global good practice; however, the development of these partnerships has largely taken place at the grassroots level and has, as a result, been largely uncoordinated and sporadically funded – making these partnerships fragile.

The Mayor's Health Inequalities Strategy is an opportunity to change this once for London, and to realise the potential of health justice partnerships as an integral part of health systems and strategies in the capital.

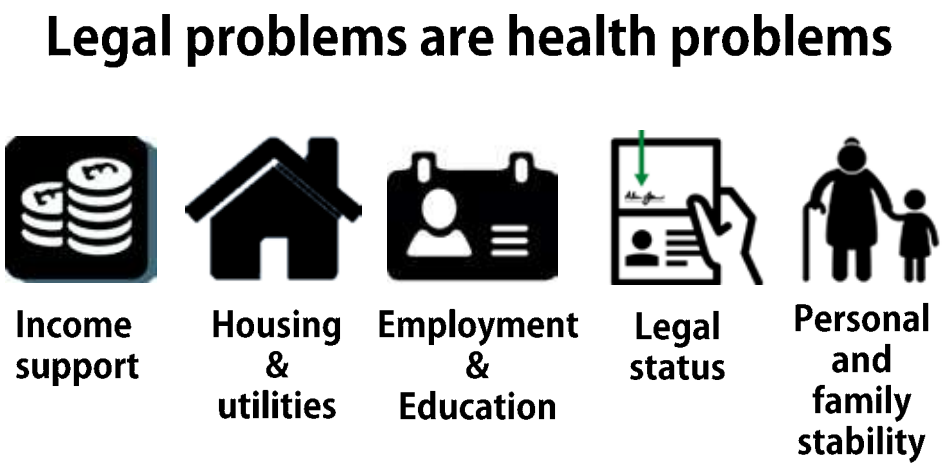
Creating good access to locally available social welfare advice services via health justice partnerships across London will enable the Mayor to take a significant step in addressing health inequalities in the city's most disadvantaged communities:

'How many GPs hear people asking for help in sleeping at night when they are understandably lying awake worrying that they are about to use their job, their home, and maybe their family. We know from Macmillan that cancer sufferers often say that it's not the cancer that keeps me awake at night; it's worrying how I will pay the bills.'[60]

The engagement process brought together a group of London-based thought-leaders,[61] led by Professor Dame Hazel Genn and Matthew Smerdon, to provide initial thinking around a pan-London approach to providing social welfare services in health settings.

The group believes that such a model has the potential to identify communities most in need, to provide pan-London coverage, build on existing legal expertise in the capital, avoid duplication, and provide commissioners with a clear rationale and evidence base to pool resources collaboratively and invest.

Figure 3: On which areas of law does the service provide advice?[62]



5.3.2 Understanding the case for health justice partnerships

The presence of social welfare advice services in health settings is essential to meeting the health requirements of the most vulnerable Londoners.

The range of issues that can be addressed by health justice partnerships includes problems with benefits, employment issues, housing disrepair, eviction, insecure immigration status, domestic violence, and education (figure 3).

Real-life London examples include:

Housing and health: In 2017, a case at the UCL Centre for Access to Justice/Guttman Medical Centre Partnership in Newham involved Alicia, a young baby with persistent respiratory problems. The partnership realised that mould in poor housing conditions was causing the problem and took action to mitigate it.[63]

Insecure immigration status and health: 'In 2018, a case at the Southwark Law Centre[64] involved a man suffering from diabetes who could not be safely discharged to street homelessness whose case was taken on from referral by the King's Pathway Team. Our investigations, including an application for disclosure of Home Office records, have revealed that he was apparently wrongly refused recognition of a right to Permanent Residence under European Union free movement laws by the Home Office some years ago, the consequences of which have included years of insecure accommodation (living in a garage for some time), homelessness and the problems with hospitals being unable to discharge him. He was quite unaware that he might have such a right. He also accessed advice from our specialist housing/community care team on options for obtaining accommodation and support from the local authority and national welfare authorities. Unfortunately, his having been discharged to a temporary situation in a homeless shelter, we have now lost contact with him and have thus been unable to progress his case any further at this time.'

Children's serious illness and family health: Camden CAB[65] recently worked with Martha, 'who had been staying in GSOH [Great Ormond Street Hospital] for a number of months with baby Anna, who was receiving a bone marrow transplant. A social worker referred her because of the problems she was facing in her home life. Sadly, her relationship with her husband had broken down and because if this she was facing serious housing issues. Camden CAB gave her the help she needed to claim tax credits, child benefits and income support, and assisted her to make a disability allowance claim. Camden CAB also helped make an application to the housing register for clean and appropriate accommodation for the two of them…'

The impacts on health are profound. Health-harming legal needs can cause and/or escalate a range of poor health conditions and provide pressure on acute service provision. The good news, however, is that if the appropriate social welfare advice services are made available then many of the underlying causes of ill health can be alleviated.

In 2016, for example, in the first six months of the Legal Advice Centre's (LAC)[66] 'Medico-Legal Project pilot' in Bromley By Bow and the Mission Practice in Bethnal Green, LAC received 42 referrals in which a health diagnosis or condition was linked to a patient's working life and employment rights: 'Most of the clients referred to the Pilot (over 95%) are still in employment. Most clients, having obtained early specialist advice were able to go back to their employer and negotiate reasonable adjustments, amendments to their contract and other matters accordingly without requiring the input of a solicitor.'[67]

'[Social welfare advice services] also makes a difference to the health professional, significantly reducing the estimated 15% of their time that GPs spend on benefits issues, reducing prescription costs and – by reducing repeat appointments – freeing up time for more patients.'[68]

5.3.3 Examples of social welfare advice services

London provides a range of good-practice examples of social welfare advice services including:

Bromley By Bow:
30 years' experience of embedding social welfare law into primary care (see also Bromley by Bow case study)

Macmillan Cancer Care:
Macmillan is focused on embedding advice within the care pathway and linking financial support to the roll-out of Holistic Needs Assessments. In 2017 Macmillan spent approximately £31 million on financial support (£14 million on face-to-face advice, £14 million on patient grants, and £3 million on helpline services). Face-to-face services delivered 73,000 cases and secured £211 million in additional income. In London (based on 40 per cent of provision) for 2017 there were 2,200 new cases and £5 million in financial gains.

Camden CAB:
Multiple health settings, including Great Ormond Street Hospital, where social welfare advice is given to parents and families of seriously ill children.

Springfield Law Centre:
Open to patients in South West London, the Centre provides specialist advice on housing, community care, debt and welfare benefits. Services are delivered in different health settings including Springfield Hospital and the Jubilee Health Centre East. The Centre receives funding from Merton Council to provide legal advice services at community healthcare settings within the borough, and from the Tudor Trust to provide legal advice services on debt and welfare benefits to clients with mental-health difficulties living within the South West London and St George's NHS Trust area.

Southwark Law Centre:
Provides specialist legal advice, casework and representation in employment, housing, asylum / immigration and welfare rights, mainly for people who live or work in the London borough of Southwark.

Legal Advice Centre, University House: This provides social advice services to communities in Tower Hamlets, and advice by Skype remotely across the UK.

CASE STUDY

Bromley by Bow Centre

The Bromley by Bow Centre (BBBC), Tower Hamlets, was established as one of the first Healthy Living Centres in the UK in 1998 and initially developed an informal social prescribing practice. It created its first social prescribing link worker role six years ago and extended its scheme to cover four more GP surgeries. It now forms one of six social prescribing schemes in the borough. It has two additional specialist social prescribing schemes: one commissioned by Macmillan for people living with and beyond cancer (serving City & Hackney, Tower Hamlets, Newham and Waltham Forest) and one funded by the Morgan Stanley Healthy Cities programme aimed at families with children under five.

Project delivery

GPs and other healthcare professionals refer around 700 people into the generalist social prescribing scheme each year, with a further 600 referred through the Macmillan scheme. Each client has an initial phone call with a link worker often leading to direct referral to services; about half receive face-to-face support (up to six meetings). A further 7,000 people access BBBC provision each year and can benefit from the services and signposting on offer.

70 per cent of BBBC services are non-clinical – partners include housing providers, children's centres, schools and faith-based organisations, with support ranging from healthy-eating groups, befriending services and arts and crafts to debt support and employment and education programmes. Social prescribing has helped to identify a number of needs that cannot be met by existing services.

Each of the borough's six social prescribing schemes receive £30,000 a year from the CCG, and the GP networks they serve each top this up with further funding from their network budgets. Foundations currently fund a part-time Bengali-speaking linkworker at the Centre.

Impact

In the six months to September 2017, there were 379 referrals and signposting to 85 different community services. GPs are strongly supportive of the service: a survey found that 78% agreed or strongly agreed that withdrawal of the service would affect the ability of patients to address both their own health and the social determinants of health.

The BBBC also fosters a learning community, sharing knowledge through regular seminars and publications with a growing community of like minded professionals and communities. It encourages a model of 'translation not replication': all social prescribing must be based firmly in the needs of each local community.

BBBC has also contributed to the development of national policy initiatives, including the Health Trainer initiative and Sure Start Children's Centres.

Challenges

Funding is always being sought – and most service funding comes with its own set of indicators to measure. Many things that the community most values (e.g. resourcefulness and stronger connections) are not explicitly funded; this is being investigated as part of a Public Health England embedded research programme. There is an ambition to involve volunteers in social prescribing – although this would require further resource.

Looking to the future

BBBC is supporting the development of social prescribing across London and is working with NHS England on an accredited training programme for social prescribing linkworkers.

Sources

- The Bromley by Bow Centre **http://www.bbbc.org.uk/**
- Social Prescribing: Tower Hamlets Network 6 Interim Report, April 2017 – September 2017: **https://www.bbbc.org.uk/wp-content/uploads/2018/05/Social_Prescribing_Report_Tower_Hamlets_Network_6_MEEBBB_Apr_17-Sep_17_final.pdf**
- Twitter @Bromley_by_Bow

5.3.4 The benefits of a pan-London approach

It is clear that the provision of social welfare advice services in health settings is not a nice-to-have but is essential to meeting positive health outcomes and addressing health inequalities. A rapid evidence review conducted on behalf of the Low Commission in 2014 drew together evidence of the positive effects of resolving social welfare legal problems, including:

- lower stress and anxiety;
- better sleeping patterns;
- more effective use of medication;
- smoking cessation;
- improved diet and physical activity; and
- better general health.

This also contributes to health services efficiency through reducing time GPs have to spend in consultation on non-clinical matters and facilitating planning of hospital discharges.

However, *'coverage of social welfare services in healthcare settings across London is sporadic and based on short-term funding. Services are almost always scrambling for funding and some services have disappeared.'*

5.3.5 The opportunity in London today

The Mayor's Health Inequalities Strategy provides a golden opportunity to make London the leading city in the world for developing and delivering services that resolve health-harming legal needs. In terms of social welfare advice services provision, London may be poised at a tipping point for change: this is 'a once for London moment':

- the mapping undertaken shows that health justice partnerships already exist in London, which have grown organically in response to needs but that are sporadic, uncoordinated and not always sustainably funded;[69]
- London hosts genuine world-leading experts on meeting social welfare legal need in health settings;
- there is a growing evidence base of the positive impact on health outcomes of resolving social welfare legal needs;
- there is international research expertise in London that can be harnessed; and
- the emerging Healthy London Fund provides an important opportunity (see section 1).

Social welfare advice thought-leaders meeting

The thought-leaders involved in the engagement around this report recognise the need to develop a flexible model that provides pan-London coverage of social welfare advice services over three levels:

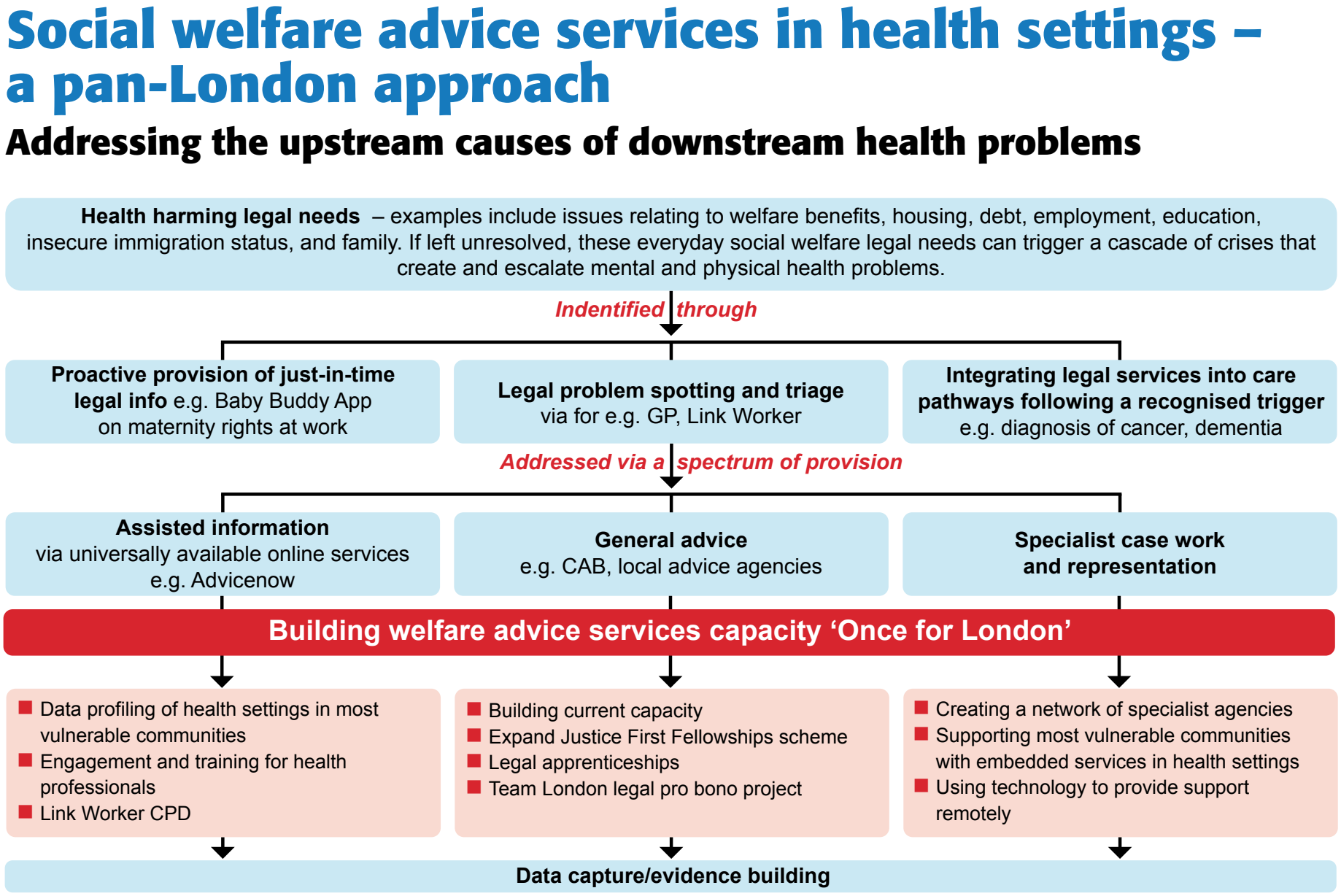
1. Assisted information: link worker and patient review universally available online services, for example. These may include Baby Buddy and Advicenow.
2. General help: The patient for example is referred to a CAB or other local advice agencies.
3. Specialist case working, and then on to solicitor-level work.

The draft model (Figure 4) is built on the following principles:

- identify priorities – i.e. the groups and communities with the worst health outcomes;
- incorporate early assessment of patients' health-harming legal needs and identify the type of service needed in response – for example, 'the most successful outcomes tend to be from cases where the employment problem has been captured at an early stage and crucially before disciplinary or capability proceedings have been commenced by an employer';[70]
- embed social welfare advice services in the full range of health settings, reflecting the different ways people engage with health services, such as primary care, secondary care and specialist clinics. Services may also include virtual services;

- integrate health justice partnerships into care pathways – there are existing effective examples where legal needs assessment and provision of services have been written into treatment pathways for conditions (e.g. cancer, dementia, respiratory disease, mental health). It is not enough to identify and signpost: to achieve outcomes, in many cases advice and sometimes representation is needed. This will be a critical service in the groups and communities with the worst health outcomes;
- identify gaps in geographical provision;
- integrate health justice partnerships into data systems to facilitate service design (e.g. access to schemes such as Coordinate My Care, so as to target services efficiently), service provision (e.g. access to EMIST to capture medical evidence for benefit appeals), and data collection so as to track where patients are receiving support / interventions (e.g. Elemental, EMIST and CMC) and to understand the impact of resolving health-harming legal needs on health outcomes;
- harness London's social welfare advice sector efficiently, including acknowledging geographical gaps in services and how to address this;
- develop the role and contribution of technology – for example, the use of video to provide remote access to specialist advice where this is needed;
- develop the wider capacity to deliver this agenda and make links with the wider GLA workforce development strategy including:
  - building a cohort of health justice specialist legal apprentices
  - building a cohort of health justice specialist solicitors via the Justice First Fellowship scheme
  - harnessing the contributions of pro bono lawyers and
  - the role of other volunteers, recognising the limits of volunteers and the importance of finding the best ways to harness their input;
- engage with researchers to give commissioners and service providers robust quantitative and qualitative frameworks to capture learning and to explore effectiveness.

Figure 4: Social welfare advice services in health settings – a pan-London approach



Matthew Smerdon and Phil Veasey, May 2018

6. Effective engagement and participation of voluntary sector organisations in London

This section recommends ways of effective engagement and participation of voluntary sector organisations in the development and delivery of a social prescribing strategy for London.

6.1 Three approaches

The engagement process has identified three approaches:

- a pan-London strategic approach;
- working together on areas of work best undertaken by using a pan-London approach; and
- local engagement and participation at borough or sub-borough level.

At the heart of each approach is the need for the VCSE sector to be in strategic, planning, and delivery meetings on social prescribing from the very beginning as a trusted partner: '[Scaling social prescribing in London] can only be achieved by developing trusting partnerships between public, voluntary and community sector organisations, and so this [Health Inequalities] strategy has to be about developing collaborative and equal relationships, recognising that all stakeholders bring something to the table.'[71]

6.1.1 A pan-London strategic approach

The engagement process has consistently fed back the need for the statutory and VCSE sectors to work together, and throughout this report we have highlighted the need for VCSE representation in groups at strategic pan-London levels, many of which are echoed in section 7, including:

- if the Mayor can act as a social prescribing systems convenor – establish a senior group of health strategists, commissioners, GPs and VCSE representatives across London to take forward the scaling of social prescribing in London;
- the Mayor to encourage early VCSE representation on all significant decision-making health boards – STPs, for example – to have strong representation of the VCSE sector in appropriate visioning and decision-making groups;
- establish a pan-London lobbying army of patients, GPs, primary care practice managers, commissioners and VCSE champions to keep the agenda high on all radars; and
- establish a representative pan-London VCSE leadership group for social prescribing (perhaps emerging from the GLA Social Prescribing, Voluntary Sector Task and Finish Group, Spring/ Summer 2018).

This representation is vital, as the engagement process has highlighted that the statutory sector does not always understand the potential of the VCSE sector (see section 3.2.2).

6.1.2 Working together on areas of work best undertaken by using a pan-London approach

This report, particularly in section 3, highlighted that there are areas of work that may be best undertaken by using a pan-London approach. These may be generic opportunities including:

- evaluation – see section 3.3.4;
- digital connectivity – see section 3.3.5; and
- engaging elected members – see section 3.3.8.

and specialist areas of interest including:

- social welfare advice in healthcare settings – see section 5.3;
- workforce development – see section 3.3.7; and
- and other areas that may include young people, mental health, loneliness etc that have not been fully explored in the time available to undertake this report.

6.1.3 Local engagement and participation at borough or sub-borough level

The engagement process has been very clear about the strength of social prescribing being in local delivery and reflecting local needs (see section 2.2.5).

In the case studies and ones to watch in this report, the consistent engagement and participation theme has been to commission social prescribing through a host VCSE organisation. This usually happens in two ways, via either a VCSE representative body (such as Merton Voluntary Council – see Merton Social Prescribing Case Study) or a VCSE organisation that understands the borough or local community and can refer into a range of other organisations (see City and Hackney Social Prescribing Service one to watch).

Looking more closely at three other examples:

1. In an interview for this report, Andy Fairhurst, Commissioner at Bexley CCG, made this point clearly:

   'Bexley has a strong community and voluntary sector and a strong CVS infrastructure organisation called Bexley Voluntary Service Council (BVSC) that are prerequisites for this kind of [social prescribing] model – it relies on having enough [providers] to refer/signpost to. The CCG and LBB jointly grant BVSC as lead provider who then subcontract MIND in Bexley as the delivery partner. BVSC as lead provider hold a directory of all VSC orgs in Bexley so are ideally placed for that role.

   In Bexley our Community Connect model is a full part of delivering patient outcomes. We have integrated case management (ICM) meetings every month in each LCN (locality) where patients are referred by GPs who are at risk of emergency admission if not appropriately supported. These ICM meetings have GPs present (or video-conferencing in), secondary care consultants, allied health professionals, community/ district nursing, pharmacy, and both Community Connect CWCs and VCS organisations (usually bigger providers, like Age UK, MIND, Carer's Support, Stroke Association, etc.)'.

2. Likewise, in Redbridge the Social Prescribing Programme is based in RedbridgeCVS and the programme description is given in the case study below.

CASE STUDY

Redbridge Social Prescribing Programme

In 2015, the Redbridge Fairness Commission, set up by the Council to investigate poverty and inequality in the borough, recommended the development of a social prescribing scheme in the borough. Redbridge Social Prescribing Programme launched in October 2017, building on two existing, trusted initiatives: ReFRS (helping older people to remain living in their own homes) and Health and Wellbeing Buddies.

Social prescribing is currently offered through nine GP practices, with committed funding (from the Council and matched funding from the CCG) to roll it out across the borough in 2019. A Social Prescribing Programme Board, made up of local organisations (including adult social care, police, ambulance, housing and voluntary services), meets quarterly – it is chaired by Gladys Xavier, deputy director of public health, who spearheaded development of the Programme.

Project delivery

The service is based in Redbridge CVS, which employs a social prescribing and wellbeing coordinator and a team of 16 Health and Wellbeing Buddies drawn from the local community – most recently from Eastern European backgrounds, reflecting changes in local demographics (between them, the Buddies speak 20 languages). Buddies meet monthly to share experiences and receive training across a range of health issues.

GPs refer patients by email to the coordinator, who assigns each an appropriate Buddy. The Buddy calls the patient to organise an appointment, at which the available options are discussed – ranging from befriending services, employment skills and help with benefits to an arts project and a home library service. At this first meeting, Buddies perform a baseline assessment of the patient, gathering information including demographics, use of services and quality of life.

Each Buddy works with seven or eight people, offering up to five one-to-one support visits – that could include going to a lunch club or being visited at home to help dealing with isolation.

Impact

The aim is to reach 90 patients in the first year. Referral rates have been steady and balanced across the nine GP practices; as of mid-April, there have been 62 referrals. There is a six-month assessment to ensure that the support provided is benefiting the patient – i.e. that they are using services and are more confident.

The University of East London is evaluating the Programme, based on assessment on first meeting and assessment at 12 months – hence, formal evaluation is not due until the end of 2018. A report will then be drawn up to demonstrate cost-effectiveness.

Challenges

The biggest challenge has been shrinking funding, which has led to significant gaps in services. Even where services are available, there are often long waiting lists, and organisations are overwhelmed.

It is also challenging to work with people having complex needs, because decisions have to be made on what to prioritise first.

Looking to the future

There is discussion about extending the Programme to take referrals from social care as well as from GPs, which will need careful management, taking care to complement (rather than duplicate) the existing work of social care. Training for Buddies is also being extended into new areas including healthy eating and weight management.

Sources

- Redbridge Social Prescribing Service **https://www.redbridgecvs.net/content/social-prescribing**
- Twitter @redbridgecvs

3. And finally, engagement models may focus on one area of need and be delivered at sub-borough level. The Social Action for Health welfare advice services model is mentioned in section 4.1.1 and is and is expanded here. The model is based around supporting very small and local community organisations to deliver effectively:

'We lead two consortia working with nine local community partners to deliver advice and support from 27 GP practices in Hackney and Tower Hamlets. Social Action for Health supports our community partners by providing overall contract management, monitoring and reporting systems and frameworks, ongoing guidance and training including quality assurance, in order that they can focus on what they are specialists at – providing locally informed, culturally and group specific advice sessions.

'Providing accessible advice sessions to local residents helps ensure our beneficiaries are supported to take the practical steps needed to address some of the issues that underpin the social determinants of health. Areas of support for local residents include welfare benefits, debt, housing, unemployment and immigration. Our advisors are well networked and able to refer people for specialist support and signpost into networks of other "social prescribing" services. The benefits of co-location in primary care settings are manifold as the services not only free up GP time to deal with medical as opposed to non-medical issues but also provide a vital service, often in mother tongue, in a familiar and trusted setting for local people. This year across both the Tower Hamlets Health Advice Links (THHAL) and Hackney Information Advice Consortium (HIAC) projects we delivered 6630 appointments for local residents.'

The role of the lead CVS or VCSE organisation is highlighted in section 3.3.6 – and there are many benefits from examples given above. The CVS or VCSE organisation can:

- facilitate effective commissioning by contracting a lead organisation who best understands the local VCSE landscape and provides one point of accountability;
- provide a range of back office functions from IT to bid writing skills to allow other providers to do what they do best;
- attempt to prevent competition amongst providers to ensure optimal local coverage of services; and
- represent the sector at pan-London, STP, borough and sub-borough levels, as outlined in section 4.1.1.

7. The role of the GLA and the Mayor

This section identifies the specific roles for the Mayor and the GLA in taking forward social prescribing in London

7.1 Influencing and achieving change

There are a number of actions for the Mayor and the GLA to consider in taking forward social prescribing in London. The report acknowledges that some of the actions will be within the Mayor's gift to support change, and others will require partnership working and influencing to achieve change.

7.2 Actions to consider

Figure 5: The role of the GLA and the Mayor

	ACTION	DESCRIPTOR
1	**Celebrate the role and impact of the VCSE sector in London**	The VCSE is a largely under-celebrated partner, and the Mayor should take every opportunity to celebrate and acknowledge the work of the VCSE sector in London.
2	**The Mayor can act as a much-needed champion for the VCSE sector and social prescribing**	The Mayor's Health Inequalities Strategy is a 10-year plan and the Mayor should drive the conversation on social prescribing over this period.
3	**Act as a social prescribing systems convenor**	• Convene a senior group of health strategists, commissioners, GPs and VCSE representatives across London to take forward the scaling of social prescribing in London • Engage elected members – encourage a systematic approach to communicating with elected members on social prescribing • Encourage early VCSE representation on all significant decision-making health boards – STPs to have a strong representation of the VCSE sector in appropriate visioning and decision-making groups • Identify and celebrate borough-wide and more local successful methods of working to deliver social prescribing • Encourage full cost recovery commissioning of the VCSE sector • Promote workforce development across the statutory and VCSE sectors
4	**The Health Inequalities Strategy may become a tipping point for social prescribing and now is the time for the GLA to build the communications and influencing flow**	• Establish a pan-London lobbying army of patients, GPs, primary care practice managers, commissioners and VCSE champions to keep the agenda high on all radars • Establish a representative pan-London VCSE leadership group for social prescribing (coming out of the GLA Social Prescribing, Voluntary Sector Task and Finish Group (Spring/ Summer 2018)

5	**Identify key areas of pan-London work that can be turbo charged by the Mayor's influence, and funding methods such as the Healthy London Fund and CSR funding**	• Drive existing work on data profiling of health settings in the most vulnerable communities – getting ahead of estimating demand and making the case for social prescribing • Form a VCSE research group to collate and assess current available evidence for social prescribing • Encourage the design of a pan-London systematic approach to the collection of evidence to support the scaling of social prescribing • Encourage a digital strategy for social prescribing to be developed and adopted by London • Provide a catalyst for the transition of the evolving range of link workers into an established, recognised workforce • Encouraging workforce development focused on social prescribing across the statutory and VCSE sectors • Investigate the viability of a kitemark scheme for VCSE organisations • Promote, celebrate and support the improvement of specialist areas of social prescribing, such as London Sport's Building a Workforce for the Future plan that recognises development needs of front-line coaches and instructors
6	**Establishing pan-London local access to social welfare advice services**	• Recognise social welfare advice services as a key enabler for social prescribing that will make a significant impact on the Health Inequalities Strategy • Create a task and finish group to design the approach to pan-London services • Convene a senior group of health strategists and commissioners across London to take forward their role in delivering this agenda; • Appoint a senior advisor to the GLA on the role of health justice partnerships on resolving health-harming legal needs
7	**Hitting other agendas**	• Be open to engaging the delivery of social prescribing and the role of the VCSE sector with other pan-London agendas including employment and volunteering. For example, consider expanding Team London with a legal pro bono project, in which the legal workforce in London can volunteer to support the provision of social welfare advice in health settings • GLA team to map this social prescribing report against all GLA work areas to identify crossover and adopt a joined-up approach
8	**Leading London, UK and global thought leadership on social prescribing**	• Build on the capital's specialist capacity (e.g. The Social Prescribing Network, The Institute of Health Equity, UCL Centre for Access to Justice, The Healthy London Partnership led Proactive Care Delivery Group) to lead the way on taking forward social prescribing • Note work that is being undertaken in the capital such as the Guys and St Thomas Charity research into supporting the growth of social prescribing in Lambeth and Southwark as part of the Multiple Long-Term Conditions Programme (taking place in spring/summer 2018)[72]

APPENDICES

Appendix A – Engagement process

Deliverable 1: Engagement with key community and voluntary sector bodies, NHS, local authority and others involved in social prescribing to gather information as set out under the scope of requirements.

A full outline of deliverable 1 is attached as a separate document.

Most of the engagement process in deliverable 1 took place from 29 March to 27 April 2018.

We used a range of engagement methods in the engagement process in deliverable 1, including:

- literature review;
- nine case studies;
- nine stakeholder interviews;
- two VCSE workshops with 59 delegates;
- GP webinar with three GPs;
- six social prescribing informant interviews involving 14 colleagues;
- four fundraiser interviews involving 6 colleagues;
- two 'So What Workshops' involving 15 colleagues;
- one social welfare advice in healthcare settings workshop involving 10 colleagues.

Note that all the quotes presented in 'italics' in this report were drawn from interviews during the engagement process.

Appendix B – GLA Social Prescribing, Voluntary Sector Task and Finish Group Meeting report (8 May 2018)

Social Prescribing, Voluntary Key Recommendations to the GLA's Social Prescribing Strategy

RECOMMENDATION 1: It's not about funding, but it is.

A healthy London requires a healthy voluntary sector. Ensuring pan-London coverage of a diverse range of VCSE services is a key enabler for a social prescribing strategy, and this in turn, requires funding. However, 'pan-London' should not equate to generic or just regionally delivered services. Localism remains a key strength of London's voluntary sector. Local services should reflect the local community they serve and support a place-based approach to care.

The right thing to do is what works locally, and so we're advocating for a social prescribing strategy with localism at its heart (including digitally enabled) and recognising that delivery models, providers and funding may look different in each local community (Borough Level and smaller).

However, it is recognised that this can only be achieved by developing trusting partnerships between public, voluntary and community sector organisations, and so this strategy has to be about developing collaborative and equal relationships, recognising that all stakeholders bring something to the table.

For long term sustainability, a full cost recovery model is important. As part of this, it is important that any social prescribing funding is not used as a replacement for other funding. Funding the evaluation, training, delivery, preparatory work before you start your programme, is vital for achieving the best outcomes – and this is often underestimated or planned for. When planning funding streams, it is important to consider that if successful, demand is likely to increase, and therefore, so should funding. Finally, it must be recognised that not everything can be solved through commissioning alone, and where possible, enabling small grant schemes is important too.

Finally, understanding each sector's culture is important. Bringing sectors together, building lasting partnerships and lasting trust is key in developing healthy sectoral collaboration and ways of working. We would like to see local Compacts supporting these partnerships.

RECOMMENDATION 2: Let's get referrals right.

Voluntary sector organisations already active in the social prescribing space, often report a high level of inappropriate referrals. Prioritising training, education and support for front line workers (GP's, healthcare professionals, Link workers and the VCSE workforce) is a key way of addressing this and should feature as part of a social prescribing strategy.

It is widely recognised that social prescribing can be an indicator for identifying gaps in local health provision. Giving the sector the means to share insight and intelligence will support future commissioning and furthermore, giving the sector the simple ability to refer back into the 'system' will ensure people access the right services for them.

Referrals also have the potential to be more than just a pathway between GPs and the voluntary & community sector. It has to be everybody's business and build in partnerships with Housing Providers, Social Care teams, specialist organisations (voluntary, public and private sector) and infrastructure organisations without creating local competition of resources. Putting social prescribing at the centre of health and wellbeing boards and ensuring the voluntary sector are well represented on these boards, as a valued provider of the wider determinants of health.

At the heart of this recommendation, is the need to transform a bio-medical model of health, into a social model of health.

RECOMMENDATION 3: Little, but important things, done well.

Put simply, the voluntary sector's offer in a social prescribing strategy is connecting people that need support, with the little, but important things that are available in their community. Resilient communities are about lots of little things done well over time. The collective impact of these little things can transform communities, and the VCSE sector is expert in delivering the little, but important things. Any social prescribing strategy should have, as part of its offer, the strategic connection of all these little things done well and connecting this with the local healthcare system and with local people.

Having a long-term vision, commitment and consistency can galvanise the local voluntary sector – don't keep changing the plan. London's voluntary sector applaud the 10-year vision of the Mayor's Health Inequalities Strategy (HIS).

Let's be clever about not being clever – The really innovative thing is not to do anything new, but to simply use the assets of the sector/community and collect the little things done well, into one coherent offer to improve a community's health outcomes. So, we ask that the HIS resists the temptation to continually launch shiny new initiatives and instead work out ways to keep social prescribing and the role of the sector at the forefront of the wider strategy.

The diversity of the voluntary sector's offer is incredibly valuable – Build on what works and don't overlook the role of voluntary sector infrastructure organisations as a key enabler to bringing the little things together. CVSs and Volunteer Centres in particular, play a vital role that if harnessed, would add huge value to a pan-London strategy.

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RECOMMENDATION 5: Don't increase health inequalities.

There is a danger of increasing the health inequalities that already exist by investing in a social prescribing system that works best for people who can already self-manage – those most likely to turn up at a GP's surgery. The voluntary sector is best placed to reach those seldom heard, seldom reached communities. It's what the sector does best. Enabling the sector to reach these communities through a diverse social prescribing offer could reduce the inequalities in access to health services. However, we recommend that this strategy broadens the conversation from just being about reducing primary & secondary care appointments and that we use this strategy to drive towards social prescribing being a vehicle to address the social determinants of health, and ensure prevention is prioritised.

It must also be recognised that a social prescribing agenda can interact with the skills and workforce agenda, as made so clear in the Marmot review.

With a growing number of non-clinical Navigator/Link worker type roles, there is a fantastic opportunity to recruit a local workforce, ideally from the 'hard to reach'/seldom heard communities which experience the most health inequalities. There can also be an accessible pathway from volunteering to employment. However, this local employment approach must still recognise that Navigator/Link worker roles are still skilled roles but present a great opportunity to wrap these local roles in a holistic training/education programme.

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