

REPORT OF THE ANNUAL SOCIAL PRESCRIBING NETWORK CONFERENCE

Wednesday 20 January 2016, Park Crescent Conference Centre, London



Co-funded by the University of Westminster, the Wellcome Trust and the Fit for Work UK Coalition with support from the College of Medicine

Contents

| | |
|---|-----------|
| Foreword | 01 |
| Glossary | 03 |
| Executive summary | 04 |
| Social Prescribing Network Steering Committee | 08 |
| Background: the social prescribing landscape | 09 |
| Gathering experienced social prescribers together: inaugural conference... | 11 |
| Morning session: | |
| Welcome and objectives | 13 |
| Plenary 1: social prescribing questionnaire findings | 13 |
| Plenary 2: defining social prescribing | 17 |
| Afternoon session: | |
| Workshop 1: Economics | 20 |
| Workshop 2: Integration and engagement | 23 |
| Workshop 3: Regulation and standards | 25 |
| Workshop 4: Great quality provision | 26 |
| Workshop 5: Research | 29 |
| Social Prescribing Network: next steps | 31 |
| Organisations represented at the conference | 33 |
| Social prescribing initiatives | 34 |
| Social Prescribing Network Steering Committee biographies | 42 |

Foreword

It has been estimated that around 20% of patients consult their GP for what is primarily a social problem; in fact the Low Commission reported that 15% of GP visits were for social welfare advice¹. For these patients, a medical approach is inappropriate and equally frustrating for both patient and GP. At the same time, GP training places remain unfilled and insufficient numbers of GPs are applying to join general practice because of a perceived impossible workload. But it is not just GPs who are affected by the current pressures in healthcare. Healthcare professionals generally work tirelessly to do their best for their patients under ever increasing workloads.

Social prescribing can alleviate some of these pressures by addressing unmet needs of patients, whose needs are not currently met by the NHS. It can also alleviate pressure on GPs and other healthcare professionals, general practices and the health service more widely, all of whom are struggling to survive difficult times. Social prescribing goes further than that. By facilitating the patients' access to a whole range of voluntary and local services, including becoming volunteers themselves, there is much potential to nurture local social capital and catalyse health-creating communities that strengthen their ability to care for themselves and each other. Social prescribing recognises that the third sector is a largely untapped asset that can deliver further integration between health and social care in the creation of a more responsive and efficient local health economy. Social prescribing can be used to empower the patient to look for solutions to social problems before a crisis occurs that might affect their physical or mental health.

Perhaps the most striking finding from this report is the number of committed men and women in many areas of the country who are already successfully pioneering social prescribing. Through the new Social Prescribing Network, we have helped connect up far more people than we expected. These are courageous people who are showing us how social prescribing can produce positive outcomes for their patients and local communities despite the current lack of central direction or dedicated funding streams.

It is time today for the whole health service from clinical commissioning groups (CCGs), NHS England, Public Health England, the Department of Health and Government to put its full force behind these efforts. These social prescribing services offer the health service a potential safety net and answers to key problems of our time, whether it be overburdened general practices, the need for better NHS outcomes, the burnout of our health professionals, the unsustainability of increasing health costs or how to improve the fabric of society itself.

¹ The Low Commission. The role of advice services in health outcomes: evidence review and mapping study, June 2015. Available at http://www.lowcommission.org.uk/dyn/1435582011755/ASA-report_Web.pdf

In this report, we offer a definition of social prescribing and point to the core principles that underpin the process when it works well for stakeholders. Furthermore, we set out recommendations on the principles underpinning effective service provision and the steps needed to capture and measure the impact of social prescribing, both of which facilitate moving social prescribing from the local to the national agenda. It is the first time that this has ever been done.

Social prescribing has been led to date by people who are enthusiastic, committed and who have given their all to make things better for their patients and communities. We owe them the same in return. Indeed, social prescribing might be seen as a last rallying cry from those who believe in the NHS and in a sustainable health service that is owned and co-produced by professionals, patients and local populations. Social prescribing provides potential answers when everywhere we look there are tales of despondency, cynicism and conflict. We argue that social prescribing now needs universal support. In 1805, Lord Horatio Nelson raised the flag 'England Expects...' That is the flag that we in social prescribing are raising in this report. Today we are imploring you to support and to collaborate with us. We are optimists and we believe in the Five Year Forward View vision for the NHS. Delivering the vision will be challenging but social prescribing can help us rise to this challenge. Today, we ask you to support and collaborate with us, as social prescribing gathers momentum to become an unstoppable social movement.

Dr Michael Dixon and Dr Marie Polley: Co-Chairs, Social Prescribing Network.

Glossary

There are several terms being used to describe different aspects of social prescribing. For clarity, definitions of the key terms mentioned in this report are set out below.

A social prescriber – refers to any healthcare professional or otherwise who refer people to a social prescribing service.

A social prescribing service – refers to the link worker(s) and the subsequent groups and services that a person accesses to support and empower them to manage their needs.

A link worker – link workers have a variety of names e.g. health advisor, health trainer and community navigator. In this report it refers to a non-clinically trained person who works in a social prescribing service, and receives the person who has been referred to them. Briefly, the link worker is responsible for assessing a person's needs and suggesting the appropriate resources for them to access.

Executive Summary

Social Prescribing

It has been estimated that around 20% of patients consult their GP for what is primarily a social problem. Social prescribing also recognises that a large proportion of health outcomes are the result of the social and economic determinants of health and acknowledges the need for patients to access non-clinical resources to enable them to improve their health and wellbeing.

Using a social prescribing approach widens the scope of what is possible to do as a community of health practitioners. In its broadest sense, social prescribing may connect the GP practice, the voluntary groups, the services designed by the social prescribing organisations, the housing provider, the children's centre, the timebank, the faith organisations, the police and so on.

A variety of evaluations have been conducted on social prescribing projects, clearly demonstrating proof of concept, yet traditional evidence of randomised controlled trials is thin on the ground. Since there are randomised control trial data on the effectiveness of the interventions that social prescribing implements, it is the aspect of comparative effectiveness of social prescribing vs standard care that now needs more research carrying out.

The Social Prescribing Network

There are many groups of people currently associated with social prescribing initiatives who are not aware of each other. There are many variations that exist in the interpretation of how social prescribing is articulated, delivered and funded. The term social prescribing is also not yet widely recognised beyond the social prescribing community. It was for these reasons that the project to develop a social prescribing network and understand what underpins social prescribing was conceived.

Inaugural Social Prescribing Network Conference

A mixed stakeholder steering committee was convened to plan the inaugural Social Prescribing Network conference. To ensure we were informed and guided by the emerging social prescribing community, a short online qualitative survey was designed to explore social prescribing stakeholders' experiences. 96 delegates attended the conference and a full list of organisations represented at the conference is appended.

The aims of the day were:

1. To bring together people experienced in social prescribing to learn from each other's experiences.
2. To develop a shared 'story' and definition of social prescribing.
3. To understand the barriers that prevent social prescribing approaches gaining traction locally and nationally.
4. To explore how the barriers to social prescribing could be overcome, and how social prescribing could develop locally and nationally – potentially with the support of a Social Prescribing Network.
5. To explore how the impact of social prescribing can best be evaluated.

Key findings from the pre-conference survey:

- Key ingredients that underpin social prescribing were identified and were expressed as a model to describe social prescribing. Components of this model included funding, healthcare professional buy-in, simple referral process, link workers with appropriate training, patient centred care, provision of services, patient buy-in and benefits of social prescribing. This model is summarised in Figure 1.
- Over 40 benefits of social prescribing were reported; these are summarised in Figure 2. The main themes included: physical and emotional health and wellbeing; cost effectiveness and sustainability; building up local communities; behaviour change; capacity to build up the Voluntary and Community Sector; social determinants of ill health.
- There is a variety of theoretical concepts and models that have been applied when developing a social prescribing approach to healthcare. These included: Complexity Theory; Social Identity Theory; Resilience Theory; and Motivational Theory. A further 10 models were reported. Analysis of these data is ongoing.
- A wide range of funding sources were identified. Over half of respondents cited their clinical commissioning group (CCG) as the funder. Local authorities, Public Health England and National Lottery funding were reported as project funders by respondents, but to a much lesser extent than CCGs. Some respondents reported joint funding from their local authority and CCG. Other funders included charities, research councils and academic institutions, government departments and private companies. Some projects also reported functioning without specific funding.
- 56 variations on social prescribing definitions and descriptions were submitted at the time of the conference. These definitions of social prescribing ranged in complexity from broad brush and general to highly specific. A breakdown of social prescribing elements identified by survey respondents included: understanding the social underpinnings of ill-health; trusted health professionals making referrals to community-based approaches; the essential role of a link person; listening to and coaching

recipients; co-production of solutions; and promoting better social connections. Social prescribing needs to be understood by key stakeholders, especially commissioners, whose support is required for the funding and national take-up across the country.

The afternoon session involved delegates signing up for a choice of five workshops, each facilitated by two members of the steering group.

Economics

In this session, participants reflected on the barriers to getting better economic data on social prescribing; considered what should and should not be monetised; and shared experiences of exploring efficiency.

Integration and engagement

This group shared experiences of issues and challenges they had faced in engaging different stakeholders in social prescribing and how these have, or could be, overcome. The group also discussed how successful services had integrated within a general practice or community.

Regulation and standards

This group recognised that, as momentum behind social prescribing grows, so too will the level of scrutiny. A range of proposals on how and what standards and regulations could be applied to social prescribing services and what would be both appropriate and acceptable were discussed.

Great quality provision

This session provided insights into what high quality social prescribing services look like and the barriers to high quality provision. Participants considered the prerequisites, qualities, knowledge, values, skills and experience necessary to provide and inform the commissioning of high quality services. The conversation largely focused on the link worker and the service within the GP practice.

Research

Delegates in this session explored the barriers and possible solutions to collecting data and designing appropriate research studies on social prescribing. There was manifold and rich discussion from a mixture of stakeholders. The groups acknowledged that there is a diverse amount of research and evaluation that has been carried out in social prescribing, but it is hard to compare like-for-like. Solutions for improving the quality of research in social prescribing were identified.

Next steps for the Social Prescribing Network

There was consensus that social prescribing provides untapped potential to reduce pressures on health and care services through referral to non-medical, and often community-based, sources of support.

Delegates were keen that the Social Prescribing Network continues beyond the conference – creating a community to share information, make practical recommendations for action and for stakeholders to work together to achieve common goals.

To provide a focus on immediate efforts, delegates agreed that the Social Prescribing Network should concentrate on social prescribing within the GP practice, initially.

Steps to be taken as a priority include:

- Extending the survey to include more participants including those unable to attend the conference, to build a more detailed national analysis of social prescribing provision, perceptions and experience. (At the time of writing this report, we now have 172 responses.)
- Expanding and consolidating the Social Prescribing Network, to drive local and national discussions on embedding social prescribing in the NHS.
- Facilitating regional events to understand members' experiences of social prescribing and support members to grow as a community and share best practice.
- Creating a standards group to support the quality of social prescribing nationally. The group will review the existing standards and regulations in place within all parts of the social prescribing model, and bring findings and recommendations back to the Social Prescribing Network for further consultation.
- Translating the core principles of social prescribing into a framework for commissioning so that potential commissioners can determine what good quality social prescribing provision looks like.
- Developing further understanding and documentation of the range of benefits of social prescribing, and developing more appropriate research and evaluation designs for social prescribing. The long-term aim is to build a research and evaluation toolkit for social prescribing approaches that will encompass not just health and wellbeing, but also the social and economic determinants of health.
- Mapping the economic benefits of social prescribing and the associated outcomes, and to explore pros and cons of different economic models to better understand the economic case for social prescribing.
- Ensuring we have a process for patient and citizen involvement in all of our discussions.

The Social Prescribing Network Steering Committee

The members of the Steering Committee, who authored this report, reflect a range of stakeholders in social prescribing and have contributed a wealth of knowledge and expertise. (WT denotes the members involved in the Wellcome Trust Seed Award bid.)

Dr Marie Polley, University of Westminster (Co-Chair and WT Principal Investigator)
Dr Michael Dixon, College of Medicine (Co-Chair, WT Collaborator)
Dr Karen Pilkington, University of Westminster (WT Co-Investigator)
Professor Damien Ridge, University of Westminster (WT Co-Investigator)
Dr Nick Herbert, University of Westminster (WT Co-Investigator)
Professor Chris Drinkwater, Ways to Wellness (WT Collaborator)
Dr James Fleming, The Green Dreams Project (WT Collaborator)
Ms Alyson McGregor, Altogether Better (WT Collaborator)
Dr Marcello Bertotti, University of East London
Ms Caroline Frostick, University of East London
Mr Dan Hopewell, Bromley by Bow Centre
Dr Richard Kimberlee, University of the West of England
Mr Lev Pedro, National Council for Voluntary Organisations

For more information about the Social Prescribing Network, please contact:
Dr Nick Herbert: n.herbert@westminster.ac.uk

Acknowledgements

The conference and report have been made possible by the generous contribution of time and resources from many people – thank you.

Thank you to the Wellcome Trust and Fit for Work UK Coalition for providing the initial funding for this initiative and to the Fit For Work UK Coalition's secretariat, Incisive Health, for coordinating the conference.

Thank you to all the volunteer note takers who managed to capture the breadth and depth of discussion that occurred in the break out groups at the conference.

Last but not least, we express our gratitude to all the people that attended the conference and shared their experiences and expertise.

Background: the social prescribing landscape

Social prescribing acknowledges the need for patients to access non-clinical resources to enable them to improve their health and wellbeing. This approach also recognises that a large proportion of health outcomes are the result of the social and economic determinants of health, not just the quality of the healthcare that individuals receive. Health is no longer about the absence of disease. Today, the challenge we face is to create a system within which people are able to adapt, change and self-manage in the face of social, physical and emotional challenges.

Whilst healthcare professionals are best placed to support patients' clinical needs, they are not always equipped to help patients with their social and economic issues which also have an important impact on their health. Social prescribing offers patients the opportunity and, crucially, the time to talk about their issues in an informal and often non-clinical setting. The link worker aims to increase levels of patient activation, motivation and self-efficacy through discussion, coaching and goal setting with the patient – often seeing patients several times to review their individual goals. Link workers may also suggest appropriate resources and support for the patient to access depending on their specific needs. The aim is to provide the patient with a 'voice' in this process. These resources may be within the GP practice or via voluntary or community groups, or created, designed and maintained by the social prescribing organisation.

Using a social prescribing approach facilitates appropriate care and widens the scope of what is possible to do as a community of health practitioners. Social prescribing has started to connect the many, and often disconnected, organisations working across a geographical area, a locality, or a neighbourhood. In the narrowest sense, social prescribing acts as a signposting service to the available local resources. In its broadest sense, social prescribing may connect the GP practice, the voluntary groups, the services designed by the social prescribing organisations, the housing provider, the children's centre, the timebank, the faith organisations, the police and so on.

A variety of evaluations have been conducted on social prescribing projects, clearly demonstrating proof of concept, yet traditional evidence of randomised controlled trials is thin on the ground. It would, therefore, be simple to conclude that there is no evidence for social prescribing. There is, however, in many cases evidence to underpin the initiatives that are offered to patients within the social prescribing pathway. Take, for instance, promoting physical activity to people who are obese or have prediabetes or type 2 diabetes. There are a multitude of randomised controlled trials demonstrating significant changes in health via increased physical activity. What social prescribing does is translate the knowledge and deliver it in a manner and pace that is appropriate and sustainable for a patient to accept. One could, therefore, argue that it is the comparative effectiveness of social prescribing vs standard care that now needs researching.

There are many groups of people currently associated with social prescribing initiatives who are not aware of each other. There are many variations that exist in the interpretation of how social prescribing is articulated, delivered and funded. The term social prescribing is also not yet widely recognised beyond the social prescribing community. It was for these reasons that the project to develop a social prescribing network and understand what underpins social prescribing was conceived.

Gathering the experienced social prescribers together: inaugural conference

In late October 2015 the Wellcome Trust agreed to fund our project on exploring social prescribing approaches to health creation. Led by Dr Marie Polley at the University of Westminster and involving colleagues listed as the Steering Committee, the project seeks to understand the current scope of social prescribing in the UK and Ireland and to explore the underpinning ideas, principles and theories. Moreover, our intention was to form a social prescribing network so that we could find other professionals who were doing social prescribing, share good practice and work together to bring about much needed change. Our Steering Committee quickly grew and we were rapidly deep in debate on what the inaugural Social Prescribing Network Conference could look like. As we wanted to be informed and guided by the emerging social prescribing community, a short online qualitative survey was designed to explore social prescribing stakeholders' experiences.

Initially the Steering Committee invited all appropriate contacts to the conference ensuring that we reflected the range of established stakeholders to the best of our ability. These contacts then suggested more people until we were inundated with requests to attend. Over this time we became aware just how widespread social prescribing had already become. 96 delegates attended the conference and a full list of organisations represented at the conference is appended.

Each person that responded to the invitation was asked to complete our pre-conference survey. The themes from the questionnaire responses then informed the content of the interactive conference, held in London on 20 January 2016.

In the morning session the analysis of the pre-conference questionnaire was presented, which examined the key principles of social prescribing, the definition, the benefits and funders of social prescribing. Discussions on a common definition of social prescribing then ensued. In the afternoon, delegates signed up to one of the following groups: economics; integration and engagement; regulation and standards; research; and great quality provision. The day closed with a plenary discussion of how delegates wanted their Social Prescribing Network to proceed. This document provides a summary of the emerging themes and discussions from the day.

CASE STUDY: Reading Well Books on Prescription – Cultural Commissioning Programme at NCVO

“We’re getting to understand more and more that sometimes the best way of giving people healthcare messages is not through health routes. There’s a real interest in other routes, including arts and cultural organisations.” **Charles Alessi, Dementia Lead for Public Health England**

Reading Well Books on Prescription helps people manage their mental health and well being by providing accredited self-help reading through public libraries. Books can be prescribed by GPs or other health professionals but are also available on self-referral for anyone to borrow. The scheme, launched in June 2013, brings together a quality assured book list that is endorsed by health bodies and can be trusted by health professionals, with the unique ability of libraries to reach a wide range of people, encouraging self-management and early intervention. The national evaluation of the first year of the scheme (2013–14) showed that 275,000 people borrowed a book from the list (an increase of 113% on the previous year for core list titles).

All prescribers surveyed said the scheme had been useful in helping people understand more about their conditions.

MORNING SESSION

Welcome and objective of the day

Conference Co-Chair Dr Michael Dixon welcomed delegates to the conference and members of the Steering Committee introduced themselves. Dr Dixon outlined the objectives for the day:

1. Bringing together people experienced in social prescribing to learn from each other's experiences.
2. Developing a shared 'story' and definition of social prescribing.
3. Understanding the barriers that prevent social prescribing approaches gaining traction locally and nationally.
4. Exploring how the barriers to social prescribing could be overcome, and how social prescribing could develop locally and nationally – potentially with the support of a social prescribing Network.
5. Exploring how the impact of social prescribing can best be evaluated.

Plenary 1: Social prescribing questionnaire findings

Co-Chair Dr Marie Polley shared findings from the pre-conference questionnaire. Responses were received from 78 people, with representation from general practice, nursing, link workers, commissioners, voluntary organisations associated with social prescribing, charities, academics, patients, citizens and suppliers to the NHS.

Survey question: What are the key ingredients to social prescribing when it is a success?

51 delegates initially responded to this question. Data analysis revealed several themes that included funding, healthcare professional buy-in, simple referral processes (via a healthcare professional or self-referral), link workers with the right skills, patient-centred care, and useful service provision. These would in turn promote patient buy-in, which was necessary to achieve improved outcomes. Integration between healthcare professionals, linking professionals and partner organisations was essential, and the quality of the communication and relationships between all stakeholders is seen as a crucial factor in combating the current 'silo' way of working. Evidence of quantifiable benefits (for example patient outcomes, value for money and tackling inequalities) was seen as a necessity to underpin social prescribing going forwards (See Figure 1, Key ingredients of social prescribing).

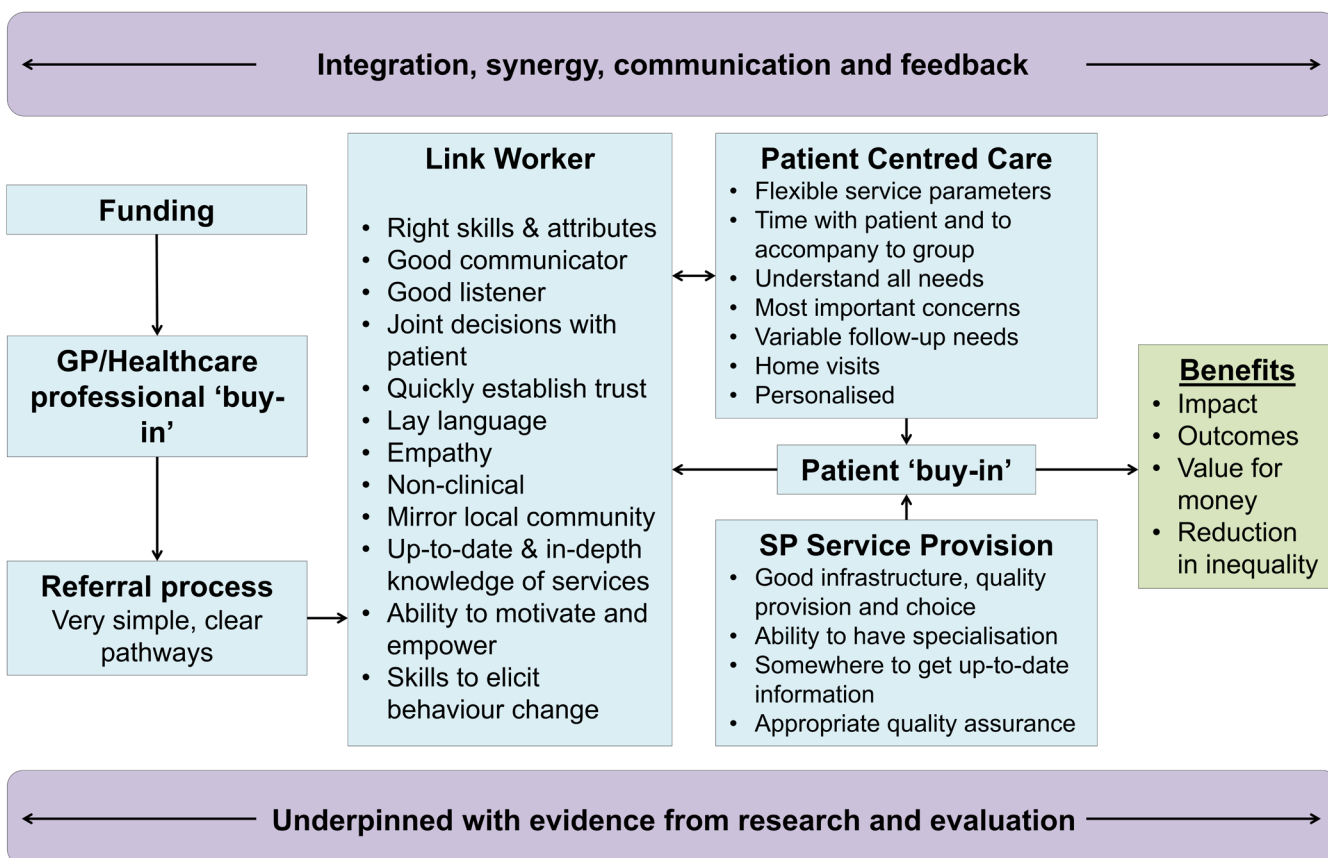


Figure 1. Key ingredients of social prescribing

Survey question: What are the benefits of social prescribing?

Social prescribing benefits identified by respondents fell under six broad headings: physical and emotional health and wellbeing; behaviour change; cost effectiveness and sustainability; capacity to build up the voluntary community; local resilience and cohesion; and tackling the social determinants of ill health (See Figure 2 below). Within each of these themes, respondents described a number of specific benefits, totalling 41, which they had identified in the social prescribing projects they had worked with. Examples of some of these benefits are shown below. It should be noted that the benefits did not simply extend to clients, but also to healthcare professionals and health service providers.

| Physical & emotional health & wellbeing | Cost effectiveness & sustainability | Builds up local community | Behaviour Change | Capacity to build up the VCS | Social determinants of ill-health |
|---|---|---|--|---|--|
| <ul style="list-style-type: none"> Improves resilience Self-confidence <ul style="list-style-type: none"> Self-esteem Improve modifiable lifestyle factors Improve mental health Improve quality of life | <ul style="list-style-type: none"> Prevention Reduction in frequent primary care use Savings across the care pathway Reduced prescribing of medicines | <ul style="list-style-type: none"> Increases awareness of what is available Stronger links between VCS & HCP/bodies Community resilience Nurture community assets | <ul style="list-style-type: none"> Lifestyle Sustained change Ability to self-care <ul style="list-style-type: none"> Autonomy Activation Motivation Learning new skills | <ul style="list-style-type: none"> More volunteering Volunteer graduates running schemes Addressing unmet needs of patients Enhance social infrastructure | <ul style="list-style-type: none"> Better employability Reduces isolation Social welfare law advice Reach marginalised groups Increase skills |

Figure 2. The benefits of social prescribing

Survey question: What explanation (or concept or theory) best helps you understand how social prescribing works, when it does go well?

Respondents identified a number of different theories, models and explanations that they thought explained social prescribing. The theories cited included Complexity Theory, Social Identity Theory, Resilience Theory, and Motivational Theory. Some of these theories such as complexity theory could be applied to the whole model (e.g. Figure 1), where as others may apply to parts of our social prescribing model. As well as theories, there were 10 models reported (Asset Based Community Development; Transtheoretical model; five ways to wellbeing; Trust Relationships; Patient Activation; Action Learning Sets for social prescribing practitioners; Sense of coherence; Social Capital; Social determinants of Health; BioPsychoSocial Model). Delegates also reported approximately 30 further bespoke explanations. Further analysis of these data is on going, however the extent of the application of the theoretical knowledge demonstrates the careful thought applied when developing this approach to healthcare.

Survey question: Where does your funding for social prescribing come from?

Survey respondents identified a wide range of funding sources. By far, the most common source of social prescribing project funding was identified as CCGs. Over half of the respondents who provided details of their projects’ funding named CCGs as the source. Local authorities, Public Health England and National Lottery funding were also heavily reported as project funders by respondents, but to a much lesser extent than CCGs. A number of respondents reported more than one source of funding, many of these involving joint funding from their local authority and CCG. A number of other funders were named by individual respondents including charities, research councils and academic institutions, Government departments and private companies. Some projects also reported functioning without specific funding.

CASE STUDY: 'Facilitated Social Prescription' to Improve the Health Outcomes for Those with Type 2 Diabetes and Those at Risk of Diabetes – Culm Valley Centre for Integrated Health and University of Westminster

"When I'm buying things I often think that's a new product and I turn it over to have a look and I think, oh no that's way too high in the fats and sugars and put it back. So it has made me more aware all the time..." **Female patient with type 2 diabetes**

At three GP practices in Devon, an on-site Health Advisor Service has been used to support patients at risk of, or with type 2 diabetes. The service provides a one-to-one forum in which a Health Advisor spends time talking with patients, instilling the ability to manage their own health successfully. The aim of this is to prevent the progression of diabetes and need for medication. Patients using this service have reported making positive dietary changes and increasing their levels of physical activity. This has resulted in significantly reducing their blood sugar level, weight and waist circumference, declassifying a number of patients from being at risk of diabetes. We measured significant increases in patients' knowledge, skills and confidence to manage their own health and health care. Patients appreciate the 'down-to-earth', 'approachable' and 'empathetic' nature of the health advisor. This helps them feel at ease to talk about, and come to terms with their situation, whereas this had not been the case upon diagnosis. These positive outcomes are complimented by a significant reduction in health service use costs.

"I can recall many patients who have found the intensive one-to-one and empowering nature of the Health Advisor Service very helpful in helping them to self-manage their condition." **GP involved with the project.**

Plenary 2: Defining social prescribing

Professor Damien Ridge, Wellcome grant co-investigator, led a session to discuss developing a definition for social prescribing. The analysis of the pre-conference survey revealed a range of views about social prescribing and 56 variations on social prescribing definitions and descriptions were submitted at the time of the conference. These definitions of social prescribing ranged in complexity from broad brush and general to highly specific.

The 'word cloud' analysis of survey data in Figure 3 supports the view of respondents that people, communities and addressing social issues are central to social prescribing for health-related issues:



Figure 3. A WordCloud analysis of descriptions of social prescribing.

A breakdown of social prescribing elements identified by survey respondents included: understanding the social underpinnings of ill-health; trusted health professionals making referrals to community-based approaches; the essential role of a link person; listening to and coaching recipients; co-production of solutions; and promoting better social connections.

Following the survey findings, delegates broke into mixed stakeholder working groups on tables to discuss the definition of social prescribing. In the feedback session, it was clear that the concept is not easily pinned down. Those who work in the area have an understanding of what they mean by social prescribing. The point was raised that patients may not necessarily need an established definition of 'social prescribing,' as long as they receive the intended service and gain benefit from it. It was, however, felt that social prescribing needs to be understood by key stakeholders, especially commissioners, whose support is required for the funding and national take-up across the country. Furthermore, without this clarity on the concept, support for social prescribing, exchange of ideas and the development of relevant services will be limited. It was also agreed that whilst the word prescription may not be optimal, the phrase social prescribing is now accepted and thus could not be changed at this point.

Themes from discussions included:

- A simple definition or 'elevator pitch' and a shared language were thought to be useful in promoting social prescribing, particularly to commissioners, fund-holders and researchers.
- It is critical to convey the non-clinical element of what is being offered to patients through social prescribing.
- The description should set out the needs that social prescribing is trying to meet and its purpose, rather than the activity.
- The description should focus on person-centredness, empowerment and co-production.
- The definition of social prescribing is not same as the social prescribing 'conceptual model', or our narrative about social prescribing. Many models will emerge as different localities respond to local need differently. A spectrum of approaches is to be welcomed, as they will still share the principles of social prescribing.

A preliminary definition (below) that aimed to encompass all of these components is being developed post-conference, based on an original definition provided in the pre-conference questionnaire. To ensure that the definition is meaningful to all stakeholders, further consultation with stakeholders will be carried out.

Short definition

Enabling healthcare professionals to refer patients to a link worker, to co-design a non-clinical social prescription to improve their health and wellbeing.

Fuller definition

A means of enabling GPs and other frontline healthcare professionals to refer patients to a link worker - to provide them with a face to face conversation during which they can learn about the possibilities and design their own personalised solutions, i.e. 'co-produce' their 'social prescription'- so that people with social, emotional or practical needs are empowered to find solutions which will improve their health and wellbeing, often using services provided by the voluntary and community sector.

AFTERNOON SESSION

The afternoon session was built around five parallel workshops, each focussing on a different aspect of social prescribing. The content of the workshops was informed by themes emerging from survey responses to the pre-conference questionnaire. Steering committee members facilitated the workshops, with delegates nominating themselves to groups. Every group ended up with mixed stakeholder groups.

Workshop 1: Economics

Facilitators: Dr Richard Kimberlee and Professor Chris Drinkwater

The relevance and importance of cost effectiveness in social prescribing is one of the least developed areas. It demands urgent attention. The Public Services (Social Value) Act came into force on 31 January 2013. It requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. In this session, participants reflected on the barriers to getting better economic data on social prescribing; considered what should and should not be monetised; and shared experiences of exploring efficiency.

- Delegates identified and discussed two dominant models of social prescribing:
 - a. General practice based, enabling the practice to use a controlled budget to facilitate a redesign to the service to build in social prescribing (e.g. Oxford Terrace, Gateshead model). By doing things locally on a smaller scale, services important to patients can be developed and provided with support from volunteers and healthcare professionals. However, the group noted that not all practices are like this, and it can be challenging to scale up across whole services. They are also very dependent on local practices being dynamic and entrepreneurial to seek appropriate funding from willing sources to deliver their social prescribing service. Funders of this approach included: Big Lottery; charitable trusts like Henry Smith and Tudor Trust etc. There is also one example of social prescribing being provided through an impact bond.
 - b. Whole system CCG/local authority wide model, providing service to GPs rather than being an intrinsic part of a GP practice e.g. for example Ways to Wellness, Rotherham; Hackney; Social Prescribing across Gloucestershire County. The group noted that these models can find it difficult to demonstrate benefits in terms of financial savings in the short-term and need sustained funding to track cost effectiveness into the medium and long-term which are likely to be greater especially if benefits of saved referrals to specialist and secondary care are taken into account in the cost benefit analysis in the long and medium term (Thornett, 2000).²

Social prescribing projects vary. This is sometimes contingent on local circumstances. Delegates noted that a distinguishing feature between social prescribing projects is between those that have eligibility criteria, such as long-term health conditions, and those

² Thornett A. (2000) The economic consequences of treating psychosocial disorders, *BMJ* 320:7232

that don't. Many evolve their criteria and referral to adapt to local need. So undertaking a straightforward comparison of cost effectiveness between projects is difficult. But the delegates and the network noted that:

- Cost-benefit analysis of certain predetermined outcomes have been used to address problems, such as referrals to secondary care – for example in Rotherham and Greenwich. In the former economic benefits were estimated based on the reductions in use of hospital care; social benefits were estimated based on the well-being outcome data and a survey of social prescribing funding recipients. However, more economic assessments are needed to help untangle the full value and costs of social prescribing.
- We need to understand what 'perspective' cost efficiency assessments come from. Most take a health service or state perspective. Potential social and financial benefits may accrue to other agencies rather than the funders or commissioners of the service e.g. public health funded preventative initiatives may result in savings to the CCG rather than the local authority. Alternative cost-effective approaches to demonstrate value may therefore be needed e.g. Social Return On Investment (SROI). A SROI study of Bristol's Wellspring Healthy Living Centre's social prescribing project showed that for every pound invested in social prescribing there was a £3 social return including savings from: reduced GP attendance; prescriptions; secondary care and specialist referrals; savings from a return to employment; and adoption of caring roles.
- The group also considered the cost of a social prescribing intervention. Is it less than the one you're trying to save? It is important to consider that savings from social prescribing interventions can accrue over a range of Government departments, not just the Department of Health.
- The delegates felt that it might need to consider the cost of an intervention. Simple cost effective ratios will help social prescribers to have an intra-network debate about the cost and value of social prescribing. Commissioners like unit cost data, but commissioners should avoid fixating on this figure as this does not fit easily with social prescribing where you have a very variable case mix. Therefore it may be good to compare cost-efficiency ratios of social prescribing with therapies like Improving Access to Psychological Therapies (IAPT), which are broadly commissioned across most CCGs. This comparative approach to cost-effective analysis was undertaken to demonstrate the impact of a social prescribing project in Cornwall.
- The complexity of social prescribing as an idea and the diversity of delivery models means there are challenges to monetisation, e.g. case-mix; complex problems not necessarily fixed with one intervention; and people sign-posted compared to interventions which adopt a holistic approach to addressing a patient's needs.
- Participants discussed whether a toolkit of effective measurement metrics and tools would be helpful. In creating such a toolkit, we would need to consider whom

the Social Prescribing Network is appealing to in terms of costs to examine and costs to save. Different tools could open up the benefits of what social prescribing can deliver.

- The group concluded that a set of the same, standard tools was needed to measure outcomes to ensure equivalence in assigning value to various social prescribing approaches.
- The discussions also suggested that it is extremely important to ensure that health services have appropriate read codes to ensure that the activities of local GPs in CCGs in working with their local social prescribing interventions have their activity included in any broad analysis of what accounts for GP activity. This will encourage acknowledgement that there are non-medical solutions to people who present in primary care. It will also be important to ensure that such referrals are seen as a legitimate activity by read code systems such as SNOMED and appropriately validated and monetised within the NHS.

CASE STUDY: Bright Ideas in Health Awards – Oxford Terrace and Rawling Road Medical Group, Gateshead

The medical group developed a Primary Care Navigator (PCN) role to support patients, their families and carers to better navigate the health and social care system, and signpost them to wellbeing services through social rather than clinical prescribing. Benefits of appointing a PCN included wider practice engagement, supporting the nurse in their interaction with vulnerable patients and identifying peoples' needs and sign-posting to available help. The role was established through open invitations to the surgery for 'catch ups and cuppa' and 'getting to know you' events. The development of this innovation was through the learning and sharing events. Key outcomes included improved staff morale, productivity and motivation, reduction in discharge letters indicating avoided admissions (7-8 a day to 2-3 a week in first six months), improvement in not needing a physician after discharge and more coordinated and personalised care.

Workshop 2: Integration and engagement

Facilitators: Dan Hopewell and Professor Damien Ridge

This group shared experiences of issues and challenges they had faced in engaging different stakeholders in social prescribing and how these have, or could be, overcome. The group also discussed how successful service had integrated within a general practice or community. Areas explored included:

- With the NHS under pressure, the appetite for trying new approaches can be low. In primary care, GPs may not feel they have the time for - or are equipped to explore - the social determinants of health, for example, poor housing. Social prescribing as a concept may also be out of biomedical model 'comfort zone' and is not a component of current medical training.
- Social prescribing 'champions' in GP practices and CCGs are important for raising the profile and perceived value of social prescribing among health professionals.
- The Bromley-by-Bow practice is working with local medical schools to incorporate social prescribing into 'Medicines and Society' modules. Shifting clinical perceptions of social prescribing wholesale will, however, take time. The group agreed that it is best to work initially with 'early adopters' to show that the social prescribing model works. Using social prescribing approaches to help doctors improve their own health and resilience might also encourage them to be advocates.
- Effective link workers have a critical role in making social prescribing approaches work. The group applauded work in Falmouth to build confident communities, the Altogether Better model, and the Cullompton general practice. Each of these had engaging individuals, rooted in the general practice, as link people. The group noted, however, that there could be difficulties in finding skilled, networked link workers. The person specification is demanding, but pay may be relatively low. It is unrealistic to think volunteers could take on such a linking role.
- Funding flows can be a barrier to social prescribing projects getting off the ground. Money follows the patient in some areas, but not in others, and budgets for community-led initiatives vary by area. However, large sums are not always necessary; a small budget for tea and coffee may be sufficient at times, depending on the intervention being rolled out and the other existing services already available to receive referrals.
- Managing expectations of what social prescribing can deliver is critical – for prescribers, commissioners and participants. The purpose of a social prescribing intervention is not necessarily to get a problem fixed, but rather to building a network that enables individuals to feel confident and empowered to address problems for themselves. Equally, the patient may have an expectation of receiving a medical prescription; a non-medical solution may take time for patients to adjust to.
- Creating safe and accessible spaces is important. In Bromley-by-Bow and Cullompton, the social prescribing service is called 'the café'.

No social prescribing service label was applied, and people were reportedly engaged.

- Primary care computer systems (such as EMIS) were identified as a potential route to prompt GPs to think about individuals' needs and for link workers to add notes and feedback to GPs. Flags or alerts can be set up when a patient presents with particular characteristics. This depends on getting coding systems right. It was noted that having a link worker based in surgeries, and using the same computer system allowed for enhanced communication between healthcare professionals within the practice and the link worker.

CASE STUDY: Social prescribing: integrating GP and Community Assets for Health – University of East London

"Teamed me up with an old boy with Alzheimer's and we go and do a bit of gardening in our local park in winter we do cooking it gets me out. Before that I was just sitting indoors doing my medical procedures." **Unknown social prescribing client**

Tai La is an active member of the Chinese Vietnamese community in Hackney. She was referred to the Public Health Team through the borough's GP Social Prescribing pilot. Due to the closure of a local community centre where she arranged social activities, her Wellbeing Co-coordinator suggested that she was at risk of becoming socially isolated. Hackney Council in partnership with Hackney Homes offered Tai the use of an under-used community centre where she held a ballroom dancing taster event in July 2014, as a result of the success of the taster session, a weekly dance class has now been funded which attracts 20+ residents.

Workshop 3: Regulation and standards

Facilitators: Dr James Fleming and Dr Karen Pilkington

This group discussed what standards and regulations could be applied to social prescribing services and what would be both appropriate and acceptable.

- The group discussed different proposals, including:
 - a. A social prescribing rating for non-statutory services for commissioners and referrers
 - b. A standardised, non-biased system for measuring outcomes involving CCG data
 - c. A minimum standard of entry to be included as a recognised link worker
 - d. Opportunities for patients to be involved in the design and running of services
 - e. Opportunities for local services to contribute to community social assets
- The group recognised that the momentum behind social prescribing as a concept means it will come under greater scrutiny; there is therefore a need to review the current regulations and standards in place for all components of the social prescribing model (model described in Figure 1).
- Social prescribing initiatives may encounter barriers to commissioning if standards are not in place, or there is a perceived lack of standards. Standards and ratings, if robust, would help inform the commissioning process.
- It was also agreed that standards are needed rather than additional levels of regulation that could stifle innovation in the sector.
- The implementation of professional standards is a possible solution to quality assurance. A Faculty of Social Prescribing was suggested with potential powers of accreditation and Continuing Professional Development, so the profile of those working in social prescribing is recognised. Organisations could then choose whether to be accredited and to work to agreed guidelines.
- There is also a view, particularly from the voluntary sector representatives, that stringent professional standards already exist so there is no need to re-invent and create new standards, if current standards will suffice. It would make it easier, however, if a recognised and specific social prescribing standard or rating was accessible through the proposed Faculty of Social Prescribing.

Workshop 4: Great quality provision

Facilitators: Alyson McGregor and Lev Pedro

This session provided insights into what high quality social prescribing services look like and the barriers to high quality provision. Participants considered the necessary prerequisites, qualities, knowledge, values, skills and experience necessary to provide and inform the commissioning of high quality services. The conversation largely focused on the link worker and the service within the GP practice.

The features of a high quality service:

- Co-produced and non-paternalistic. Good link workers value the knowledge and experience of the people they are working with, and do things 'with' not 'to' or 'for' the patient.
- Accessible and highly visible to people through a wide range of routes. Patients should be able to access the social prescribing service directly as well as through referral, and everyone in the GP practice should be an advocate and a navigator to the service.
- Social prescribing services need to be described to patients in a language that is meaningful and understandable. Currently, many examples of services named by professionals as SP services are described differently to patients.
- Good feedback mechanisms are necessary to all potential referrers in order to close the loop and encourage more referral. For example, a link worker could contribute to patients' notes, or inform the GP about improvements if that patient was referred to them from the surgery.
- Skills of the link worker should include empathy, listening skills non-judgemental, share a common language ability to provide practical knowledge and support, people skills, an understanding of coproduction and shared decision making, understanding of theories of behaviour change, networking skills, ability to organise and share information, one to one motivational interviewing and coaching skills and an ability to work as partners in enabling patients to come up with solutions that will work for them.
- Social prescribing offers an environment where patients can articulate what matters most to them and enables them to explore options about how they might best be supported.
- Link workers need a good knowledge and understanding of the local area and resources available to support people as well as good relationships between the people working in these community and voluntary sector organisations.
- Social prescribing interventions need to be designed to meet the needs of patients - not based on a 'one size fits all' service.
- There was no consensus at the conference on the issue of standardisation of

service models. For the purposes of influencing policy at a national level and for the purposes of comparing outcomes at a national level, it was acknowledged that standardisation would allow this, but this contrary to what is known to work at a local level, where different ways of working are appropriate to different local conditions.

- Link workers should seek and pay attention to feedback from patients about their experiences using the social prescribing services. Data and evidence should be collected to this end.
- Ability to draw on a vast range of formal and informal support offers from within the statutory and voluntary sectors and the wider community.
- Linked to commissioning support services, e.g. Rotherham have developed a sophisticated model which commission for community needs.
- Service needs to embed key measurements of changes to the local health economy that could be attributed to the presence of the social prescribing scheme, which provides evidence of financial effectiveness.

Barriers to high quality social prescribing provision identified by the group included:

- Underfunding of support services delivered in the voluntary and community sector.
- Lack of understanding, value and support from the GP practice particularly where the ideology within the GP practice is rooted in the medical model.
- Unrealistic expectations from commissioners based on a lack of understanding of the approach. For example, value being placed on patient throughput, rather than the outcomes delivered. Other examples included contracting processes being inappropriate and disproportionate to resources within smaller organisations that were less able to bid to provide valuable skilful support.
- Bureaucracy and risk adversity within the GP practice and from local commissioners around health and safety and standards.
- The complexities of the social determinants of health and wellbeing, which can take time and many different support services to fully tackle.
- A lack of attention to the actual capacity and capability of frontline providers to receive referrals and deliver appropriate interventions - not just in terms of their ability to handle client numbers, but also internal management processes, and the complexities of dealing, for example, with spot purchasing of their service.

CASE STUDY: Arts on Prescription – Cultural Commissioning Programme at NCVO

“It’s what the community wants. The activities are very much led by what the people accessing them would want to learn.” Catherine Richardson, Public Mental Health Lead, Durham County Council

Colour your Life is a social prescribing service on offer across County Durham. Commissioned by the Public Health Team in Durham County Council, it is delivered by a consortium of seven third sector organisations. The Consortium’s offer, aimed at improving the mental health and wellbeing of the people of Durham, ranges from arts and learning on prescription, to ecotherapy, and supported volunteering. Consortium members receive referrals from a variety of organisations including GPs, Voluntary and Community Sector groups and Job Centre Plus. Individuals can also self-refer. Those who are referred receive ten weeks on the programme on a fully funded basis. After this, they can join a membership scheme and pay a weekly donation to continue on the programme. Key outcomes as a result of the programme included reduced reliance on antidepressant or tranquiliser medications and reduced amount of GP contact time devoted to people experiencing mental wellbeing issues.

Workshop 5: Research

Facilitators: Dr Marcello Bertotti and Dr Marie Polley

Delegates in this session explored the barriers and possible solutions to collecting data and designing appropriate research studies on social prescribing. There was manifold and rich discussion from a mixture of stakeholders. The groups acknowledged that there is a diverse amount of research and evaluation that has been carried out in social prescribing, but it is of varying quality and hard to compare like for like.

The following points summarise the main discussions of the group:

Barriers:

- Without an agreed definition of social prescribing, the appropriate outcomes to measure social prescribing cannot be fully ascertained, nor can different data sets be easily compared.
- There is an increasing amount of data on social prescribing being collected but the outcome measures used are varied. Quantitative outcome measures may not fully capture all the relevant outcomes and benefits of social prescribing.
- There has been a lack of academically informed and agreed research and evaluation methodology around social prescribing. Many social prescribing projects have not counted on the necessary resources or relationships with academic organisations to carry out academically supported evaluations. Both these factors have limited the ability to produce and share academically robust data and to compare the impacts of different social prescribing projects.
- Social prescribing stakeholders cannot get any data from the current IT system, locally or nationally, about referrals made by healthcare professionals to social prescribing, as there are no relevant read codes (or equivalent) to record which patients are being referred to social prescribing or why.
- It can be hard to identify baseline measures or to validate interventions with control conditions. Further work is needed to identify how best to measure and evaluate the social prescribing pathway.
- Research currently focuses on those who are using social prescribing, however little research or evaluation has been carried out on the patients and citizens who may have been referred but did not take up social prescribing.
- There is a lack of research that has used multi-site interventions or collected large-scale data. Therefore, we are currently unable to evaluate the efficacy of specific SP models when delivered across different geographical areas by a variety of staff.

Potential solutions:

- Carry out research and evaluation using an agreed definition of social prescribing to facilitate a more accurate comparison of social prescribing related data.

- Map all the benefits of social prescribing to ensure that all relevant core outcomes can be measured. Within this it is important to research the health benefits for the healthcare professionals working within a social prescribing environment.
- Develop agreed outcomes to measure for social prescribing, which can be embedded within IT systems for healthcare practices and also ways of measuring benefit within the voluntary and community setting. Further and more detailed outcomes can be collected via discrete research projects to understand aspects of social prescribing more thoroughly.
- Use a mixture of qualitative and quantitative measures to ensure the full breadth of experience and outcomes of social prescribing are collected.
- Investigate/develop the different approaches to providing control groups in research design for social prescribing.
- Develop a set of read codes (or equivalent) to ensure that the numbers of patients and reasons for referral to social prescribing are recorded. These data will provide a more accurate understanding of the scale of social prescribing required and the type of services needing to be offered to best meet the needs of service users.
- Use the Social Prescribing Network to develop collaborations that enable regional and national research collaborations.
- It is useful to collate all evidence, no matter what level it is at, so that an initial mapping of the state of existing data and evidence can be carried out.
- Data could be collated at a variety of levels – individual, community, population, and system. Further discussion is needed to determine the utility, practicality, and costs for these.
- Clinical activation or ‘buy-in’ to social prescribing could be an interesting area to explore for measurement, since healthcare professionals’ opinions and service connectivity are central to the success of social prescribing.
- It is beneficial to focus research on all patient groups, including those who might not be engaged by social prescribing: we need to understand who these people are and how to reach them, which includes adapting current social prescribing approaches.

The Social Prescribing Network: next steps

Delegates were asked to discuss in what format the Social Prescribing Network should continue and to prioritise the goals. It was clear that participants are acutely aware of the growing crisis in primary care, including increasing annual adult attendance at GP surgeries despite limited resources, as well as GPs' concerns about standards of care in a demand-led service. There was also consensus that social prescribing provides untapped potential to reduce pressures on health and care services through referral to non-medical, and often community-based sources of support.

Delegates were keen that the Social Prescribing Network, which was formally established at this conference, continues beyond the conference – creating a community to share information, make practical recommendations for action and for stakeholders to work together to achieve common goals. It was agreed by delegates that the provision of social prescribing can be a simple process within a GP practice where a patient is referred to a link worker, or it can be a wider provision where citizens self refer into social prescribing. To provide a focus on immediate efforts, delegates agreed that the Social Prescribing Network should concentrate on the former model, social prescribing within the GP practice, initially.

The information gathered on the day of the conference and via the preconference survey was considered by the Steering Committee to determine how best to harness, channel and support enthusiasm and commitment of the conference participants. Many suggestions emerged from the day to be taken forward as a matter of priority:

- Extending the survey to include more participants including those unable to attend the conference, to build a more detailed national analysis of social prescribing provision, perceptions and experience. (At the time of writing this report, we now have 172 responses.)
- Expanding and consolidating the Social Prescribing Network, to drive local and national discussions on embedding social prescribing in the NHS.
- Facilitating regional events to understand members' experiences of social prescribing and support members to grow as a community and share best practice.
- Creating a standards group to support the quality of social prescribing nationally. The group will review the existing standards and regulations in place within all parts of the social prescribing model, and bring findings and recommendations back to the Social Prescribing Network for further consultation.
- Translating the core principles of social prescribing into a framework for commissioning so that potential commissioners can determine what good quality social prescribing provision looks like.

- Developing further understanding and documentation of the range of benefits of social prescribing, and developing more appropriate research and evaluation designs for social prescribing. The long-term aim is to build a research and evaluation toolkit for social prescribing approaches that will encompass not just health and wellbeing, but the social and economic determinants of health.
- Mapping the economic benefits of social prescribing and the associated outcomes, and to explore pros and cons of different economic models to better understand the economic case for social prescribing.
- Ensuring we have a process for patient and citizen involvement in all of our discussions.

Organisations represented at the conference:

- AbbVie
- Age UK (Lewisham and Southwark)
- Altogether Better
- Bridges FM
- Bristol CCG
- Bromley by Bow Centre
- Bromley by Bow Health Partnership
- Centre for Primary Care and Public Health
- Colchester Community Voluntary Services
- College of Medicine
- College Surgery
- Community Action Southwark
- Devon Health Ltd
- Edberts House
- Family Action
- Hackney Social Prescribing Service
- Hart Voluntary Action
- Health Connections Mendip
- Hillingdon and North West London CCG
- Hope Citadel Healthcare, Community Interest Company
- Jewish Volunteering Network
- Kensington & Chelsea Social Council
- Leeds Beckett University
- Locality
- London Voluntary Service Council
- Low Commission
- Mid Essex Social Prescribing Project
- National Association for Voluntary and Community Action
- National Council for Voluntary Organisations
- Newham CCG
- NHS Alliance
- NHS City and Hackney CCG
- NHS Herts Valleys CCG
- NHS Tower Hamlets CCG
- NHS Wales University Health Board
- Oxford Terrace and Rawling Road
- Medical Group
- Penny Brohn UK
- Peterborough Council for Voluntary Service
- Rotherham CCG
- Royal College of General Practitioners
- Sense
- South Yorkshire Housing Association Limited
- Southmead Development Trust
- Stennack Surgery
- Sussex CCG
- Sussex Community Development Association
- SustainCare Community Interest Company
- Sydenham Garden
- Team Around the Practice
- The Care Forum
- The Green Dreams Project
- The Haven
- The Institute of Cultural Capital
- The Reading Agency
- The Tavistock and Portman NHS Foundation Trust
- The Work Foundation
- Timebanking UK
- University College London
- University of East London
- University of Exeter Medical School
- University of the West of England
- University of Westminster
- Voluntary Action Camden
- Voluntary Action Rotherham
- Volunteering Matters
- Ways to Wellness
- Wellcome Trust
- Wellspring Healthy Living Centre

Social prescribing initiatives

The following are examples of social prescribing initiatives underway in the UK and Ireland:

Bromley by Bow Social Prescriber, London

The Bromley by Bow social prescriber offers initial and follow up face to face sessions of up to an hour including motivational interviewing and coaching to increase patient activation and access to services. The work started in 1997 and currently serves a network of five GP practices with 35,000 patients.

For more information please contact:

Dan Hopewell

E: dan.hopewell@bbbc.org.uk

T: 07545 255 095

www.bbbc.org.uk



@bromley_by_bow



BromleyByBowCentre

City and Hackney Social Prescribing Service, London

City and Hackney Social Prescribing supports clients to: have improved self-esteem and confidence; experience a reduction in social isolation; visit the GP or hospital less through better self-management; and have an improved sense of community well-being through mutual support.

For more information please contact:

Dr Patrick Hutt

E: patrick.hutt@nhs.net



@patrickhutt

Emel Hakki

E: emel.hakki@family-action.org.uk

Gulden Sural

E: gulden.sural@family-action.org.uk

T: 020 72498109

www.cityandhackneyccg.nhs.uk

www.family-action.org.uk

Connect Well, Mid Essex Social Prescribing Project

Connect Well is a multiagency collaboration which connects local residents to their community and sources of non-medical support through a mixture of empowered signposting and direct behavioural change coaching support.

For more information please contact:

Sian Brand

E: sianbrand@livingsafeandwell.co.uk

T: 07724 396670



@ConnectWellME

Crawley Social Prescribing Partnership

Crawley Social Prescribing Programme developing social prescribing to support people living with long-term conditions, mental health and wellbeing.

For more information please contact:

Malcolm Bray

E: Malcolm.bray@westsussex.gov.uk

T: 07590457959

Creative Alternatives, Sefton

This programme supports better mental health by enabling people to engage in creative activities that offer opportunities for fun, socialising, skills development and playful expression in a safe and non-judgemental environment.

For more information please contact:

Karen Lauke

E: karen@creativealternatives.org.uk

www.creativealternatives.org.uk

Doncaster Social Prescribing

Doncaster Clinical Commissioning Group and Doncaster Metropolitan Borough Council has commissioned South Yorkshire Housing Association and Doncaster CVS to run a social prescribing service across the borough.

For more information please contact:

Phil Parkes

E: p.parkes@syha.co.uk

www.syha.co.uk/doncastersocialprescribing/



@SYorksHA



South Yorkshire Housing Association



vimeo.com/112684357

Donegal Social Prescribing for Health and Wellbeing, Ireland

This programme was initiated in six sites across the county in 2013. In each area the Primary Care Team established a local working group which feeds into the Steering Group who provide support and a standardised approach. Each project is tailored to local needs.

For more information please contact:

Triona Stafford

E: letterkennysp@yahoo.ie

T: 07491 23078 or 0831 335700

East Sussex Welfare Benefits Project

Sussex Community Development Association coordinates access to specialist advice to help people at risk of homelessness, older people and people with long term health conditions.

For more information please contact:

Kirsti Godson

T: 01273 519142 or 07796 869 390

www.sussexcommunity.org.uk

Focussed care, Oldham

Providing specialist professional support to chaotic and hard pressed patients in economically challenged areas, unpicking the complexity of the whole problem to allow social and clinical transformation.

For more information please contact:

Laura Nelson

E: laura.neilson1@nhs.net

Health Connections Mendip, Somerset

Health Connections Mendip sets up peer led groups, offers one-to-one appointments with 'Health Connectors' and trains our volunteer 'Health Champions' to signpost people as well as awareness raising initiatives for local services and charities.

For more information please contact:

Jenny Hartnoll

E: j.hartnoll@nhs.net

T: 01373 468366

www.healthconnectionsmandip.org

Hillingdon Health and Wellbeing Gateway, London

Five local third sector groups – Age UK, MIND, Hillingdon Carers, Harlington Hospice and DASH – have come together to provide a single point of access and coordination for a social prescribing service. This service will be provided for 4000 people over the age of 65.

For more information please contact:

Trevor Begg

E: trevorbegg@hotmail.com

www.hillingdonccg.nhs.uk

Improving Dementia Care Through Social Prescribing

With growing numbers of patients receiving a dementia diagnosis, it was becoming increasingly challenging to manage their needs. A Primary Care Navigator role was developed to find and support patients, their families and carers.

For more information please contact:

Sheinaz Stansfield

E: sheinaz.stansfield1@nhs.net



@sheinazs



Oxford Terrace and Rawling Road

Making Connections, Hampshire and Surrey

Making Connections Project Co-ordinators will be linked to five Locality integrated care teams (Aldershot, Farnborough, Farnham, Fleet and Yateley) to provide personalised support to patients aged 18+ to enable them to engage in lifestyle changes. This is a new pilot operating from April 2016.

For more information please contact:

Caroline Winchurch

Hart Voluntary Action, Civic Offices, Harlington Way, Fleet, Hampshire, GU51 4AE

www.northeasthampshireandfarnhamccg.nhs.uk/local-health-services/farnham-making-connections

Macmillan Social Prescriber, London

The Macmillan Social Prescriber Service aims to improve patient experience by meeting the specific needs of those living with and beyond cancer. It increases the level of non-clinical support for them and promotes integrated care, supporting self-care and management.

For more information please contact:

Dan Hopewell

E: dan.hopewell@bbbc.org.uk

T: 07545 255 095

www.bbbc.org.uk



@bromley_by_bow



BromleyByBowCentre

Museums on Prescription, London and Kent

Museums on Prescription is a three-year research project to investigate the value of museum encounters in social prescribing by connecting lonely older people at risk of social isolation to partner museums.

For more information please contact:

Professor Helen Chatterjee

E: h.chatterjee@ucl.ac.uk

www.ucl.ac.uk/museums/research/museumsonprescription

My Social Prescription, Essex

My Social Prescription is a community-based scheme led by Colchester Community Voluntary Services to connect community members to voluntary and community services and volunteers to improve health and wellbeing.

For more information please contact:

Louise Willsher

E: msp@ccvs.org

www.ccvs.org



@colchesterccvs



Colchester CVS

Reading Well Books on Prescription, across England

Reading Well Books on Prescription helps people manage their mental health and well being by providing accredited self-help reading through public libraries.

For more information please contact:

Debbie Hicks, The Reading Agency

E: Debbie.Hicks@readingagency.org.uk

Ciara Eastell, Society for Chief Librarians

E: Ciara.Eastell@devon.gov.uk

www.readingagency.org.uk/adults/quick-guides/reading-well/

Southwark Safe and Independent Living (SAIL), London

SAIL is a quick referral pathway that allows any vulnerable, 50+ resident in Southwark, London, to access a range of services to help them maintain their independence.

For more information please contact:

Rachel Henry

E: rachel.henry@ageuklands.org.uk

T: 07542 592181

www.ageuk.org.uk/lewishamandsouthwark/sail/

Start in Salford

Start in Salford is funded by Salford Clinical Commissioning Group to support people facing mental health challenges back into the community through arts activity and training.

For more information please contact:

Bernadette Conlon

E: bernadette.conlon@startinsalford.org.uk

Sydenham Garden, London

Sydenham Garden is a wellbeing centre in South London which runs three adult mental health projects and a dementia project.

For more information please contact:

Tom Gallagher

E: info@sydenhamgarden.org.uk

T: 0208 2911650

www.sydenhamgarden.org.uk



@sydenhamgarden



sydenhamgarden

Ways to Wellbeing social prescribing service, Bristol

Ways to Wellbeing provides a free and confidential social prescribing service to anyone over the age of 18 living in and around the greater Fishponds area of Bristol.

For more information please contact:

Debbie Howitt

E: debbiehowitt@thecareforum.org.uk

www.thecareforum.org.uk



@thecareforum

Ways to Wellness – social impact bond, Newcastle upon Tyne

Ways to Wellness is the prime contractor for a social impact bond delivering social prescribing at scale to 17 general practices in West Newcastle.

For more information please contact:

Tara Case

E: info@waystowellness.org.uk

T: 0191 208 6555

www.waystowellness.org.uk



@ways2wellnessUK

Wellspring Health and Wellbeing Project, Bristol

Wellspring Healthy Living Centre is a community building which hosts a number of services including a GP surgery, dentist, complementary therapies, arts projects, a learning kitchen and garden. Social prescribing is practiced here and aims to link local people to the community.

For more information please contact:

David Martin

E: david.martin@wellspringhlc.org

T: 0117 3041432 or 07904 155992

www.wellspringhlc.org

Steering Committee biographies

Dr Marie Polley

Marie is a Senior Lecturer in Health Sciences and Research at the University of Westminster. Marie has a PhD in molecular carcinogenesis and started her research career as a biomedical scientist. Marie has also been a Reiki Master for the past 20 years. Using her experiences in different health paradigms, Marie has spent many years researching how to combine different healthcare approaches to provide effective patient-led care. Marie has played a central role in developing Measure Yourself Concerns and Wellbeing (MYCaW), an internationally used PROM which allows patients a voice to nominate and score their primary concerns thus capturing all relevant information when patients are receiving holistic care. Marie has chaired the British Society for Integrative Oncology for the past 2 years and is collaborating internationally with integrative medicine clinicians and healthcare professions to develop global guidelines for measuring patients' outcomes in integrative oncology. Marie collaborates with several charities to evaluate the impact of their work. Amongst other things, Marie is Principal Investigator on a project in collaboration with Michael Dixon, using a social prescribing approach to supporting patients with prediabetes and Type 2 diabetes.

Dr Michael Dixon

Michael is a general practitioner at Culm Valley Integrated Centre for Health, Devon, widely regarded as a prototype for general practice of the future. The practice uses a health advisor to support and advise patients, referred from their GPs, to make lifestyle improvements. A recent mixed-methods evaluation of this service has shown how this social prescription approach can make fast and sustained improvements in how patients with prediabetes and Type 2 diabetes manage their health.

Michael has held numerous national leadership roles including: the first chair of the NHS Alliance, a leader of the GP/clinical commissioning movement, acting president of NHS Clinical Commissioners, special advisor on Practice Based Commissioning to Lord Darzi, member of the National Stakeholder Forum, the National Steering Group and the National Strategy Group for Clinical Commissioning. He is also a member of the NHS Sustainable Development Unit National Advisory Group. He holds honorary positions at the University of Westminster, University College, London, HSMC (University of Birmingham) and Peninsula Medical School, Exeter.

Dr Karen Pilkington

As an information specialist with advanced searching and appraisal skills, Dr Pilkington is based at the University of Westminster and will oversee the design and conduct of the mapping exercise. She will specifically focus on the identification of existing social prescribing projects, and extraction and collation of relevant information. Dr Pilkington has considerable experience of conducting systematic reviews and so will also provide guidance and input on the review of the wider literature. Her research focus on chronic health problems and effectiveness of complex interventions matches the focus of this project while experience of supporting the implementation of evidence in practice in the NHS is also relevant to this project. Dr Pilkington will draw on experience of effective collaborative work with a range of health and social care professionals and across organisational boundaries in contributing to the development of this project and the proposed network. Knowledge of the practical challenges involved in changing practice will inform the approach used in this project and will be important in contributing to the success of the project in achieving its aims.

Professor Damien Ridge

Damien Ridge is Professor of Health Studies, and specialist in patient experience, at the University of Westminster, London, previously of the Health Experiences Research Group (HERG) at the University of Oxford, where he first began to flesh out what recovery from depression entailed for patients. In 2010, the UK-wide National Institute for Health and Care Excellence (NICE) adopted his research extensively into their guidance on the management of depression in adults in the UK. In 2014 his broad depression programme was singled out for its “outstanding reach and significance” in the results of the UK-wide Research Excellence Framework 2014. In 2015, his work in originating the Atlas Men’s Wellbeing pilot programme for distressed men in primary care was shortlisted for the BMJ Award (primary care). He is a sociologist who has published over 60 academic papers and one sole authored book. He has broad interests in patient experiences of health problems, HIV, depression, distress, recovery, masculinity, sexuality and men’s wellbeing. He also provides psychotherapy in the community, and is passionate about translating research into wider patient benefit.

Dr Nicholas Herbert

Nicholas Herbert is the point of contact for the Social Prescribing Network and he has run the day-to-day evaluation of a novel social prescription service offered to patients with diabetes and prediabetes at Culm Valley Integrated Centre for Health, Devon. This project involved the collection and analysis of quantitative (physiological and self-reported health measures) and qualitative (interview) data, to map patient outcomes and experiences of the service over a five-year period. He has first-hand experience of working in the NHS as a clinician and has completed a PhD in Audiology (specialising in behavioural outcomes). Nicholas previously worked on two projects aimed at improving experiences and outcomes of NHS patients, in the School of Healthcare at the University of Leeds.

Alyson McGregor

Alyson has 30 years experience working in a range of roles and sectors that meet the health and well-being needs of patients and communities. She is currently Director of Altogether Better, a NHS national network organization with an award winning evidenced based approach, working with over 21,000 volunteer health champions who draw on their own assets and resources to improve health & wellbeing and service outcomes. Alyson believes a sustainable solution to the challenges faced by the NHS lies in improving the quality of our relationship with people in communities. Altogether Better is working with over 60 practices in 16 CCGs across the country (as well as internationally) to prototype a radical attempt at system change, introducing an intervention designed to enable primary care and the population they serve to co-evolve. She was voted one of the top 50 inspirational women leaders in the NHS in 2013 and commended by the judges who said: Community empowerment is going to be important in the NHS and Alyson is a visionary.

Professor Chris Drinkwater

Professor Chris Drinkwater was an inner city GP in Newcastle for many years and is now emeritus Professor of Primary Care Development at Northumbria University. He was the President and Public Health Lead of the NHS Alliance until 2014. He is the Chair of HealthWORKS Newcastle, and a Trustee of the Northumberland, Tyne & Wear Community Foundation. Until recently he was chair of the Newcastle West CCG Partnership Forum and he also chaired the Newcastle NESTA funded People Powered Health programme. He now chairs Ways to Wellness (www.waystowellness.co.uk) a charitable foundation responsible for the development and delivery of a social impact bond (SIB) for social prescribing for long-term conditions in Newcastle upon Tyne - the first SIB in health. Prof Drinkwater has considerable expertise and knowledge of social impact bonds and social prescription. Ways to Wellness has been commissioned by Newcastle and Gateshead CCG Alliance with financial support from the Big Lottery Commissioning for Better Outcomes Fund, the Cabinet Office Social outcomes Fund and Bridges Ventures Social Investment Funds.

Dr James Fleming

James is a GP with considerable knowledge as a social prescription provider and GP in Padiham, near Burnley. In 2010 he set up a social enterprise, The Green Dream Project CIC, to provide solutions for patients with social problems impacting on their physical and mental health. Patients needed multi-agency support but were unable to coordinate the various self-referral mechanisms. The project tackles many issues such as isolation, long unemployment, clinical dependence, social exclusion and more through providing one-on-one support, marrying health and social care and by investing in community social assets. The service has won multiple awards, is recognised nationally as an innovator in Primary Care and serves 30% of the county's population. It is commissioned by East Lancs CCG and has expanded to provide specialist Nurse Practitioners for the over 75s living in

Nursing Homes in Burnley District. Throughout all our work there is a strong focus on the work being meaningful to the client, on real outcomes that are measurable, and on clear governance and safety protocols.

Caroline Frostick

Caroline has recently moved from the Psychology Department at UEL to the Institute for Health and Human Development (IHHD) where she has just finished working on the evaluation of a large-scale social prescribing project with City and Hackney CCG. During her time at the Institute for Research in Child Development (IRCD) she worked for several years on a variety of studies with infants, mothers and adolescents; most notably project managing the evaluation of the adolescent component of the Well London Programme; a ground-breaking, holistic community development approach to health. She has also worked as a counsellor with a South London based charity for women experiencing post-natal depression. Her research interests include the evaluation of alternative treatment pathways for improving mental health outcomes and person-centred approaches to mental health recovery. In a previous life, she spent almost a decade working as a freelancer in the television industry.

Dr Richard Kimberlee

Richard graduated with a first class Sociology/Psychology BA honours degree from Lancaster University in 1983. His MSc. Politics (Distinction) was gained from UWE in 1996, followed by a PhD in 2000. He has taught at Liverpool (John Moores) University, Bradford University and Bath Spa University. His current research interests include evaluating complex community and health interventions. This evaluative work includes analysis of SRB, Big Lottery, NRSI, Sport England and EDF programmes. He has worked with a plethora of third sector organizations in the UK and across Europe to develop the capacity of the sector to profile their work. He has many years experience of both quantitative and qualitative methods and in recent years he has undertaken SROI analyses of a broad range community initiatives including community transport, LinkAge, Thomas Pocklington Trust, Healthy Living Centres and Social Prescribing. He recently reported to Bristol Clinical Commissioning Group on social prescribing activity across the city and made policy recommendations on sustaining and expanding holistic social prescribing practice.

Dan Hopewell

Dan Hopewell is Director of Knowledge and Innovation at the Bromley-by-Bow Centre and was previously the Director of Strategy and Director of Services. Prior to arriving at Bromley by Bow Dan taught art at Barnet College. Before that he worked in Esteli in Nicaragua for 15 years developing highly effective programmes for street children and young people based around public art.

Dr Marcello Bertotti

I apply conceptual frameworks from multiple perspectives to research community health, with particular focus on the effectiveness and cost-effectiveness of non-clinical interventions that may contribute to improve individual and community health and wellbeing. I use innovative evaluation methodologies and methods to solve health issues and tackle health inequalities. I held research grants from the Arts and Humanities Research Council (AHRC), Economic and Social Research Council (ESRC), Netherland Organisation for Scientific Research (NWO), Health Foundation (Shine) and completed consultancy projects for Public Health England, and Newham Clinical Commissioning Group.

With the support of a grant from the Health Foundation, I recently led a large-scale evaluation of social prescribing in collaboration with City and Hackney Clinical Commissioning Group and Queen Mary University of London. I also led research on homelessness and mental health pathways, and alternative community currencies (e.g. Time Banks), all of which focus on developing asset-based approaches to health and wellbeing. I also lead on the setting up of the first university based time bank in the UK.

Lev Pedro

Lev works in the policy and public services team at the National Council for Voluntary Organisations (NCVO). He works to ensure that voluntary organisations have access to commissioning opportunities, and the skills to compete. Previously Lev worked for eight years at Kensington and Chelsea Social Council where his role included organisational development for local health improvement projects, and running a strategic forum for voluntary sector health organisations. Lev has worked in senior roles in the charity sector since 1987, including CEO of Immune Development Trust. He has also sat on boards of the BME Health Forum, Adverse Psychiatric Reactions Information Link (APRIL) and his local residents' association.

The University of Westminster is a charity and a company limited by guarantee.
Registration number: 977818.
Registered office: 309 Regent Street, London W1B 2UW.
7794/02.16/RD/