Pop-up Institute for
Social Prescribing

Social prescribing

Case studies and insight *from practitioners in the South West of England*

www.swahsn.com/institute-for-social-prescribing

South West
Academic Health
Science Network

The Institute for Social Prescribing is hosted by the South West Academic Health Science Network with the aim of informing the adoption and spread of social prescribing across the South West region and beyond.

The South West Academic Health Science Network was established as one of 15 Academic Health Science Networks (AHSNs) across the country by NHS England. It works to bridge gaps and connect NHS and academic organisations, local authorities, charities and industry to spread good practice.

Informed by the work of the Institute for Social Prescribing over the year to September 2020, this report shares learning and insight about the conditions which enable social prescribing to take place. Eight building blocks for social prescribing in practice are presented to enable further spread and adoption of this work.

February 2021

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About social prescribing

For the Institute, social prescribing is a process that enables healthcare professionals to introduce people to a range of practical, social and emotional support to boost their health and wellbeing.

Others may understand social prescribing as community connecting, care navigating or other similar terms. Whatever terminology is used, at its heart social prescribing is about relationships – between patients, their carers and the professionals that support them, and between the organisations in the places we live and work. When these relationships work well, social prescribing builds resilience – in individuals, in the health and care workforce and in our communities.

The Institute recognises that social prescribing is not new. Whilst the Institute starts from the perspective of healthcare professionals in primary care, it recognises that approaches that build relationships and resilience, and motivate and link people into community-based activities and support, take place in a range of settings.

Supporting individuals and communities

Social prescribing is what well-functioning communities do in a geographical place, but the approach is also commonly found within other communities, for example in youth work, prisons, housing associations, leisure centres and workplaces as well as the various health and care settings.

In health and care, social prescribing seeks to address ill health by looking at a person's whole life rather than just their immediate issues or medical condition. It is rooted in an approach that considers the impact of social, economic and environmental factors on people's ability to live as well as they can. As such, social prescribing looks to find ways to encourage and enable individuals to take up opportunities to socialise and get involved in things that interest them as well as connect with offers of practical and emotional support to address issues that affect their health and wellbeing.

Varied and diverse approaches

Being highly personalised in nature, the support that people are introduced to through social prescribing is varied. It can include almost anything – from joining informal social groups, getting help at home, taking tailored exercise classes or attending peer support groups for particular health conditions. It also often involves linking people into more formal one-on-one services like benefits advice, counselling or employment support programmes.

There are different approaches taken to social prescribing in different places, and often for different individuals within the same scheme. These differences reflect the variation in local communities, individual circumstances and other services available.

Some schemes use tools to help collect information or sign post to community activities. For others it might involve their GP or another professional inviting them to meet with someone, often called a link worker, who works with them one-on-one to identify what support and activities will work for them.

Many schemes also include a community builder who works within communities to help ensure relevant support is available locally to meet people's needs. There can also be a wide range of people in the local community involved, acting as advocates or offering suggestions on ways people can connect with what is available.

Some social prescribing schemes cover the general population and offer universal access to anyone who thinks they might benefit. Others are more specialised and targeted at, for example, young people, older isolated adults or those with more complex needs.

The diversity in social prescribing is part of its strength, but it also presents a challenge - for practitioners who want to learn from each other, for researchers who want to study the impact and for policymakers who want to protect the personalised nature of the approach whilst enabling the development of a common standard nationally with equity of access for all.

Identifying, understanding and sharing insight to help overcome these challenges has been central to the work of the Institute for Social Prescribing.

Policy context

In line with NHS England and Improvement, the Institute for Social Prescribing sees social prescribing as contributing to personalised care, which is a tailored way of providing care for individuals, rather than a 'one-size-fits-all' approach.

Universal personalised care is a central plank of the **NHS Long Term Plan**, which was published in 2019 and made an immediate commitment to recruit over 1,000 new NHS social prescribing link workers – one for every Primary Care Network, which are new structures that group GP practices into networks covering local populations of 30,000 to 50,000 people. These Primary Care Network social prescribing link workers are one of a number of new roles in primary care – including health coaches and wellbeing advisors – that join the existing social prescribing workforce based in different settings across localities.

COVID-19 has undoubtedly disrupted plans for the rollout of NHS social prescribing link workers as it was originally intended, as well the face-to-face elements of existing social prescribing activity. However, with their position within and between health and care services, communities, and the voluntary sector, many established social prescribing teams found themselves uniquely placed to identify and support vulnerable individuals during the initial phase of the pandemic. Consequently, in many places, local social prescribing teams have been front and centre of the community response to COVID-19.

Recognising this, in August 2020, NHS England and Improvement offered additional funding so that Primary Care Networks can recruit up to four social prescribing link workers in total. Whilst part of the NHS response to COVID-19, this announcement is in line with the original ambition to expand social prescribing teams so that 900,000 people will benefit from social prescribing in England by 2023/24.

> At the time of writing an estimated 1,300 NHS-funded social prescribing link workers are now in place across England.

▶ QUICK REFERENCE

See page 23 for more about research into social prescribing.

About this report

This report shares learning and insight, to help inform what is needed for the adoption and spread of social prescribing in the South West and beyond.

What this report provides

- Case studies summarise the experience of five test beds who worked with the Institute for Social Prescribing in the year to September 2020.
- Eight building blocks are presented as the common elements which have been observed from studying the test bed's social prescribing in practice.
- Ideas are suggested for how social prescribing can support the development of new models in health and care. This includes reflections on the development of Primary Care Networks.
- Learning from COVID-19, including the rapid innovation seen in the social prescribing test beds is set out.

Social prescribing case studies

Social prescribing case studies from the five test beds working with the Institute for Social Prescribing detail how things are done in practice along with what can be achieved and how challenges can be overcome. These case studies are published in full at the end of this report. Whilst all the case studies are different, common elements have been observed.

Research process

The research methods included a mix of desk research, semi-structured interviews and group discussions.

With the arrival of COVID-19 at the same time as the project was due to commence, there was a need for flexibility in the approach the research took. Insights were collected through an iterative and reflective learning approach, coordinating across other regional research projects and responding to developments in the external environment.

This publication follows a short interim report published in July 2020.

Who this report is for

The primary audience for this report is social prescribing practitioners (in the NHS, and VCSE sector), GPs and other healthcare professionals as well as Primary Care Networks, Integrated Care Systems and commissioners in the NHS and local authorities – in the South West and further afield.

The wider background and learning about how to spread good practice and the contribution social prescribing can make to national ambitions to transform health and care services may be of interest to other Academic Health Science Networks and their regional partners including service providers, policy professionals, national bodies, funders and other research teams.

▶ **QUICK REFERENCE**

See from page 12 for insights and learning from the Institute for Social Prescribing.

Key lines of enquiry
for the research

The Institute for Social Prescribing	How does social prescribing work and what has it achieved?
	Can the community learning model be replicated in other areas of health and care?
Social prescribing practice	How do the test beds deliver social prescribing and what they are learning?
	What innovation is there that could be spread to other areas?
Social prescribing policy	What can the practical learning tell us about the future of social prescribing?
	Are there particular policy themes this learning is most relevant for?

About
The Institute for Social Prescribing

Why and how was it set up?

The South West Academic Health Science Network has historically supported the spread of social prescribing as an innovation in health and care. In 2016 it provided match funding and professional support to two Life Chances Fund bids – one in Devon and one in Somerset – to explore the feasibility of social investment as a funding route to achieve social prescribing at scale. Working with regional public health bodies it also conducted a mapping exercise of social prescribing practice across the South West at a similar time.

The South West Academic Health Science Network learnt from this previous work that there was a lot of good social prescribing practice in the South West. However, they also observed that many communities across the region did not benefit from such approaches, including some of the places that need it most, where levels of ill health and health inequalities are highest.

In response, in 2019, the Institute for Social Prescribing was set up under the leadership of Dr Michael Dixon, a long-term advocate and practitioner of social prescribing, from his own practice in Devon. Sir Muir Gray provides oversight as President of the Institute along with advisors from around the UK as Visiting Fellows.

The South West Academic Health Science Network provides funding to the Institute as well as a secretariat function through their programme management and administrative staff. Other in-kind support enables the Institute to connect with the wider work of the South West Academic Health Science Network and benefit from its data analytics, patient engagement, event management, communications, website and other functions.

> By supporting the Institute, the South West Academic Health Science Network hopes to enable the spread of social prescribing across the region and further afield. By doing this, it hopes to contribute to the improvement of population health and the reduction of health inequalities across the region.

The Institute for Social Prescribing key personnel

President

Sir Muir Gray
previously Director of Knowledge (NHS) and a pioneer of the National Library for Health and Cochrane Centre

Chair

Dr Michael Dixon
Chair of College of Medicine, Co-Chair of National Social Prescribing Network and Clinical Champion for Social Prescription NHS England

Visiting Fellows

Sir Sam Everington London

Dr James Fleming Lancashire

Dr Richard Kimberlee Gloucestershire

Dr Ulrike Harrower Public Health England

Marie Polley Social Prescribing Network

Dr Catherine Calderwood Scotland

Sir Mansel Aylward Wales

Tony Doherty N. Ireland

Dr David Robinson Eire

How does it operate?

Practical and place-based

The Institute's approach to learning is fully grounded in practice. It is working with five local social prescribing teams as test beds.

The Institute launched with four test beds initially – in Cullompton, Frome, Ilfracombe and St Austell. Each test bed was provided with funding to create capacity for them to work with the Institute and each other. Between them the four test beds represent the region geographically. A further fifth test bed, in Kingsbridge, Devon, subsequently joined the Institute in January 2020.

Given one of the core aims of the Institute is to spread social prescribing, all test beds were given a place on the **2020 Spread Academy** – an immersive training programme focused on designing and leading large-scale change – run by the South West Academic Health Science Network in partnership with the **Billions Institute**. The aim is to provide the Institute test bed teams with additional tools and capacity to spread change.

▶ QUICK REFERENCE

See page 26 for summary case studies from South West health and care systems.

Institute for Social Prescribing Test Beds in the South West

Location	Population
Cullompton	10,000
Frome	30,000
Ilfracombe	13,000
Kingsbridge	6,000
St Austell	34,000

The Institute for Social Prescribing

Testing and exploring different models for supporting test beds

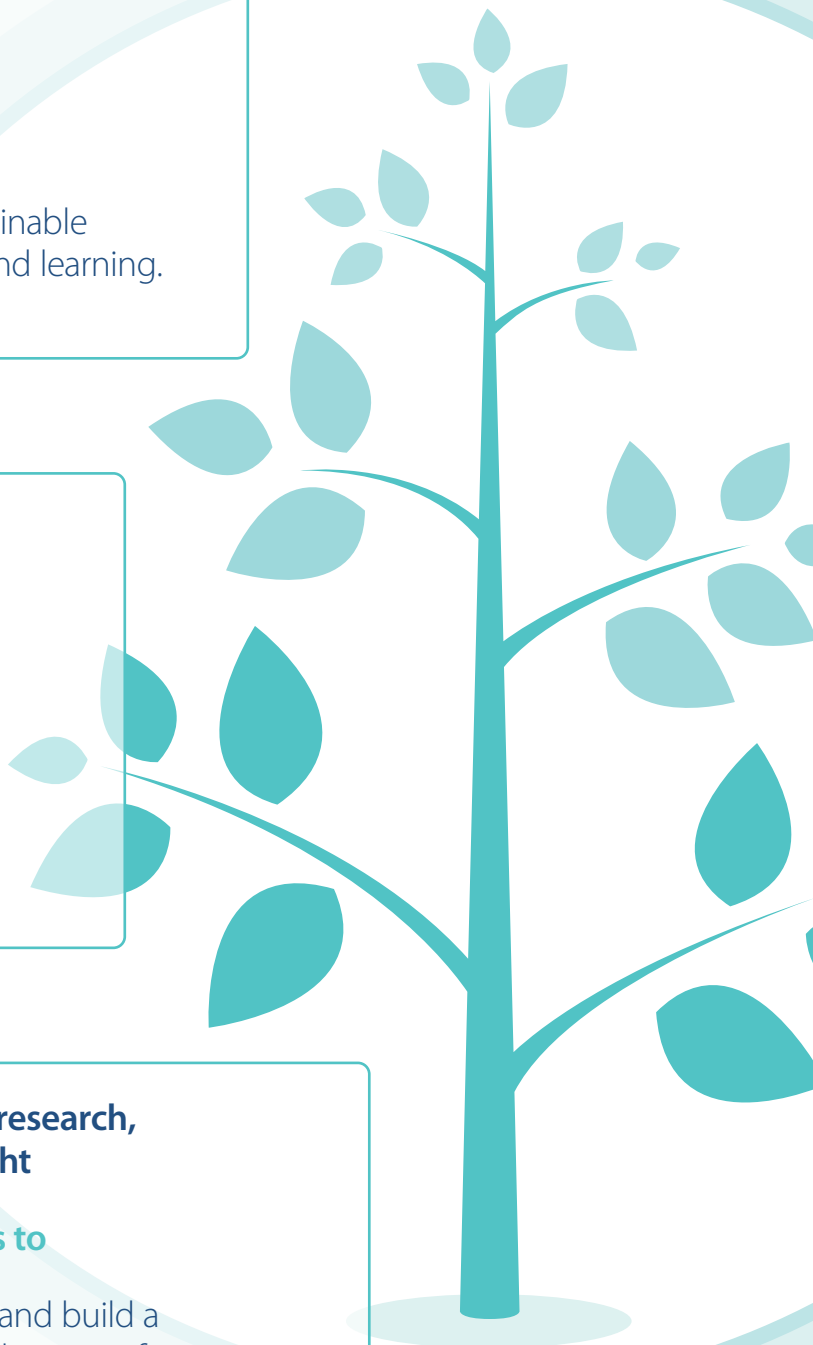
The Institute works to

find the most empowering and sustainable model for spreading good practice and learning.

Involving real people that have benefitted from social prescribing

The Institute works to

ensure that innovation is grounded in reality, that professionals elsewhere understand benefits for patients, and that the public can more easily learn about social prescribing.



Bringing together research, evidence and insight

The Institute works to

prevent duplication and build a whole greater than the sum of its parts to inform change and policy.

Building on structures and systems of the South West Academic Health Science Network

The Institute works to

keep its administrative and office requirements low, enabling it to be more sustainable while dynamic and responsive to internal developments and external events.

Creating a safe space to test ideas and highlighting multiple routes to success

The Institute works to

empower practitioners to learn from each other and lead the spread of learning.

Networked and explorative

As well as engaging with each test bed individually, the Institute brings the test beds together monthly to share learning, support each other and find collective solutions to common challenges. The agenda is guided by latest events and the learning that the test beds want to share as well as topics that arise from other research teams and the study of the test beds' practical work. This enables relationships to develop and for the test beds to learn from each other.

In early 2020 the test beds were invited to identify people who had benefitted from social prescribing to join the Institute as Resident Fellows. This was in recognition of the important role that people themselves have to play in the development and spread of social prescribing by acting as partners and advocates with ideas for how to maximise its effectiveness and share experiences first hand.

The Institute plans to grow a network of around 20 Resident Fellows and support them through media and other training to work alongside the Institute's Chair and test beds. COVID-19 restrictions put these plans on hold, but the Institute is exploring how co-production can be made to work successfully online.

Alongside the test beds, the Institute also brings together research teams in the region monthly. This enables the sharing of insights and research activity, helping to ensure the Institute complements rather than duplicates existing research efforts. It also helps keep test beds at the cutting edge of research and increases the opportunity for those that think and those that do to learn from each other in real time so that people can benefit from innovation quicker.

A further nine experts from the across the UK are Visiting Fellows to the Institute. These advisors, along with wider networks of policy leaders, share findings from the work of the test beds on the ground with wider networks to guide policy and practice beyond the South West.

▶ QUICK REFERENCE

See page 23 for more on current research in social prescribing

Insights and learning

In its first year, the Institute for Social Prescribing has developed an explorative and practical place-based network of networks to share learning about social prescribing and spread good practice.

By working alongside its test beds and studying the work of clinical champions and social prescribing practitioners (including link workers, community builders, charity staff, and volunteers) the Institute has learnt a lot about the way social prescribing works in practice. This includes how challenges can be overcome and where social prescribing presents opportunities for bringing about change in health and care more generally.

Whilst this was not known to be the case from the outset, each of the Institute's test beds shines a light on different aspects of social prescribing. This, and the fact that social prescribing looks and feels different in each of the test beds, has served to strengthen the Institute's belief that there are multiple routes to success.

Yet this local flavour, whilst a strength, also means that insights and learning from local practice do not neatly translate into a linear blueprint or step-by-step how-to guide for social prescribing. However, the Institute hopes that by organising and sharing the breadth of practical experience from the test beds through detailed case studies it can help others find answers to the questions they have in relation to their own practice.

Different aspects of social prescribing practice in each test bed

- **How can social prescribing become an agent for community development and system change that improves local health?**

  > See **Ilfracombe** case study

- **How can social prescribing alter the pattern of local GP and primary care provision?**

  > See **St Austell** case study

- **How can we use social prescribing to spread community activism and build a more sustainable model of healthcare?**

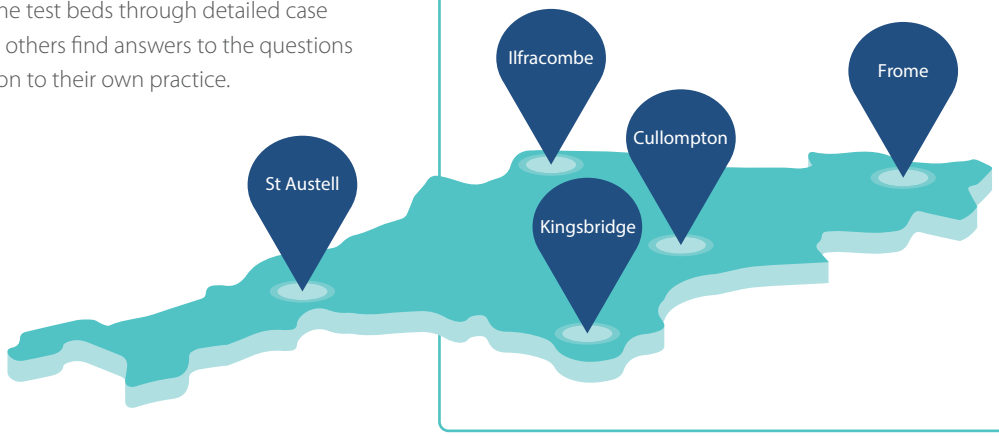
  > See **Frome** case study

- **How can social prescribing contribute to the development of communities?**

  > See **Kingsbridge** case study

- **How do you use social prescribing to improve the health and wellbeing of children and young people?**

  > See **Cullompton** case study



Learning across the South West region

Stepping back and looking across the detail, different learning themes emerge.

- **Learning from the COVID-19 response**
- **The experiences and skills of social prescribers**
- **Developing long lasting innovations at pace**
- **Drivers for different approaches to social prescribing**
- **Eight building blocks of social prescribing in practice**
- **Common solutions to overcome challenges**
- **Learning from other other research**
- **How to spread good practice**

The COVID-19 pandemic has obviously been a big feature in the first year of the Institute's work. Clearly COVID-19 caused disruption to local and national plans for developing social prescribing. At the same time, the Institute saw in its test beds how social prescribing is well placed to rapidly respond during a crisis and meet the health and wellbeing needs of its population.

The Institute also saw an acceleration in innovation during this time with the development of new tools and approaches, many of which stand to strengthen the social prescribing on offer over the longer term.

From the study of the test beds before and beyond the initial COVID-19 crisis, highlights that whilst social prescribing looks and feels different everywhere, it is possible to identify common elements or building blocks.

> By organising the practical learning and challenges overcome by the test beds into building blocks, the Institute has seen how certain factors can help social prescribing achieve its potential to improve the lives of people everywhere.

The approach of the Institute and its test beds to spread good practice could be scaled or replicated elsewhere. This section includes reflections on where this learning applies to policy ambitions for wider reform of health and care services, related to but wider than social prescribing on its own sake.

Learning from the COVID-19 response

Established social prescribing is ready prepared for rapid change

During the initial phase of the COVID-19 pandemic, the Institute worked to rapidly capture learning about how the social prescribing teams in Frome, Ilfracombe and St Austell were responding to COVID-19. Findings were presented in detailed case studies published on the **Institute web page**.

Ilfracombe

The social prescribing team supported the delivery of volunteer support through the organisation of individual street-level volunteer coordinators.

St Austell

They rapidly repurposed their existing Help at Hand app, systematically prioritised need in the population and worked in partnership with voluntary sector groups to meet the needs of vulnerable people in the community.

Frome

The social prescribing team, website, community connectors and know-how about wellbeing was redirected to contact thousands of people on the phone or by letter and support the community response where gaps were identified.

Whilst each response was different, the Institute concluded there were common underlying reasons why these well-established social prescribing teams were ready prepared for rapid change and could respond quickly during a time of crisis.

The experiences and skills of social prescribers

Have the skills and confidence to deal with **uncertainty and complexity**. It is 'their normal' as they work to help people navigate complex lives within a complex health and care system and diverse communities.

Continually **build relationships and work collaboratively** across sectors in a supportive and safe environment.

Offer the community an additional trusted resource, a piece of **social infrastructure**, with systems and processes and people that solve problems and offer practical solutions.

Are used to rolling up their sleeves, looking for ways to remove organisational boundaries and work creatively to unblock challenges. They act flexibly and are **adaptable** to the needs of individuals, communities and professional.

Build resilience – within health and care teams, with the individuals they support and within communities.

By organising the practical learning and challenges overcome by the test beds into building blocks, the Institute has seen how certain factors can help social prescribing achieve its potential to improve the lives of people everywhere.

Developing long lasting innovations at pace

During the initial COVID-19 response, the Institute also witnessed how additional tools and skills were developed within the test beds at pace. Many of these continue to be relevant and useful in the short term, but the test beds also report the benefits they see from building on these innovations over the longer term. These include:

- Rapid development and adoption of new **digital approaches** that give teams the ability to switch between face-to-face, phone and video consultation dependent on the personal preference of individuals and help overcome access issues. For example, in Frome there are now 50 digital connectors that work with people in the town to show them how they can communicate, book appointments, order prescriptions and join support groups online.

- Increased experience of coordinating and managing **volunteers**, coming from local and national, and informal and formal sources, in the community, voluntary sector, public sector and business, often with different backgrounds and training. For example, in Ilfracombe their quick call out and coordination of street level volunteer coordinators to help marshal the COVID-19 community response is hoped to benefit longer term initiatives to help people home from hospital.

- **New processes, internal guideline and protocols** for teams and local partnerships to follow. For example, in St Austell the team developed deep understanding of the different working practices of the pharmacists in the town which is now available in a document for all practice staff.

- **Risk assessment of whole populations** by social prescribing teams, often working together with others in GP surgeries, local councils and voluntary sector organisations to pool data and intelligence and follow up proactively to gather and share information on needs within the community. All the test beds hope to find ways to make use of this new information about their communities to target resources in a way that helps address health inequalities to improve health and wellbeing across the whole population.

The development of social prescribing over time

For those that have worked in or studied social prescribing for some time, the fact social prescribing teams were well placed to respond during a crisis like COVID-19 is no surprise. It is also no surprise that the responses all looked different. Even in the small number of the Institute's test beds, social prescribing practice differs in a multitude of ways, like individuals and communities do. However common elements can be observed.

Drivers for different approaches to social prescribing

The Institute has observed six drivers which result in different approaches within the five social prescribing test beds. These should be taken into consideration when looking to incorporate good practice into the design of new local social prescribing schemes:

1. **Starting point** – in some cases social prescribing came out of necessity due to wider pressures in primary care or from GPs that wanted change. Other social prescribing started in the community or by leaders in the local council.

2. **Stage in the journey** – social prescribing has been going for a number of years in some cases, others are just starting out on their journey.

3. **Local context** – some of the social prescribing test beds work in towns with one large GP surgery, whilst others are more rural or in coastal tourist hotspots.

4. **Population** – some have a high proportion of older isolated people, others have more children and young people.

5. **Inequality** – some have areas of significant deprivation with health inequalities across the population, others are in more affluent areas.

6. **Maturity of relationships across the health and care system** – some are embedded within well-developed place-based systems involving health and care alongside other local services and the voluntary and community sector. Other systems are still developing community-wide relationships in line with the vision for new structures like Primary Care Networks in health and care.

Eight building blocks of social prescribing in practice

Buy-in and access

Social prescribers identify and work with people locally that may have few other places to turn. For this to happen people need to know that social prescribing is on offer. In essence this is about finding ways of making healthcare more approachable so that people want to engage with it at times before and beyond ill health.

Effort is needed, especially at the outset, to publicise the approach with individuals, professionals and organisations in an area. This can be done by making it easy to refer people, having previous beneficiaries recommend it to their peers and champions that engage their healthcare colleagues. Case studies (such as those captured in this report) can be a helpful tool.

Many of the test beds have used a combination of approaches, changing focus of effort over time as relationships develop and different groups in the community are reached.

Kingsbridge: the GP champion regularly shares social prescribing success stories with colleagues.

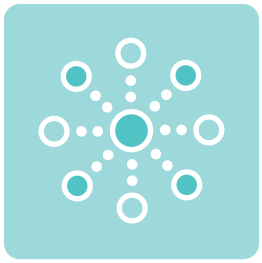
- St Austell: GPs are alerted to people that might be suitable for social prescribing through flags on patient records. Many of the local volunteers leading the practice walking groups were themselves previous beneficiaries of social prescribing support.
- Frome: many beneficiaries go on to support others as community connectors.
- Ilfracombe: self-referral is made easy with a simple leaflet that people fill in and drop off in the GP practice or the office in the community.

Personal conversations and time

Lack of time for a proper conversation is a common issue cited by patients when talking about their local health and care service. Access to a professional who listens and has time for an expansive conversation about their life is what is often most appreciated by individuals when they engage in social prescribing.

In practice, this conversation often looks to identify a person's existing support network and future goals. This can follow the approach of a 'guided conversation' or 'motivational interviewing'. In some cases the conversation may result in a formal care plan. In many cases the simple act of having a named individual to ask questions is what makes the difference.

- Kingsbridge: link workers have access to conversational prompts to guide the conversation.
- St Austell: individuals develop an action plan which is then printed on a simple card to act as a reminder during daily life.
- Ilfracombe: one of the link workers is well known throughout the town and the numbers of self-referral are high, as people recommend her to their peers.
- Cullompton: the link worker has a background in motivational training.



Relationships and collaboration

When social prescribing works best, the approach is rooted in collaborative working between individuals, with professionals and in communities. Relationship building between local authorities, primary care and the voluntary sector is critical to the adoption and spread of social prescribing. In practice, this relationship building is done in different ways according to the stage of development, what already exists and where there is a need.

- Kingsbridge: social prescribing link workers attend multi-disciplinary team meetings with GPs, other healthcare professionals and social workers.
- St Austell: relationships between primary care and the voluntary and community sector were strengthened when leading charities took up office space in the practice building.
- Frome: the social prescribing team make themselves available and approachable for people in the town to strike up conversation and build relationships through regular Talking Cafes (now online) and Talking benches where a member of the team sits on the same bench at the same time each week.
- Ilfracombe: where social prescribing came out of a local town partnership, relationships with primary care were strengthened when link workers moved their physical base to the GP surgery.
- Cullompton: where local relationships across and within health and care and the local community are emerging, new collaborative partnerships have developed around a shared vision to develop better outcomes for children and young people in the town.

Local and place-based

The national drive to spread social prescribing is largely welcomed in local communities. Many are appreciative of central efforts to share learning and develop guidance around specific roles and recruitment.

At the same time, flexibility for local areas to design and deliver their social prescribing in a way that suits their needs is appreciated. The knowledge of professionals about their populations can be helpful. Data can also be used – sometimes as part of a process known as population health management.

Place-based design can be done by actively involving local people and organisations in a process – often called co-production - to determine how nationally funded roles and finite resources are used to best meet the needs of local communities.

Many different approaches can be used in parallel and this can change over time as more is understood about the local population and their health and wellbeing needs.

- St Austell: during the COVID-19 pandemic patient lists were triaged according to a range of different health indicators.
- Frome: local GPs could see the impact of social isolation on the health and wellbeing of their older patients and this led to their focus to connect people back into their personal and community networks.
- Cullompton: the approach to develop social prescribing for children and young people started with the building of a Youth Forum which centres young people at its heart.

Connections to community support

Social prescribing link workers often play the lead role in connecting people into relevant support in the community, voluntary sector and other local services. The Institute's test beds offer their link workers and a range of tools to find out about activities and support in their area. Some of these are also available to the public. In many cases link workers rely on community development workers, voluntary sector infrastructure bodies, support providers and volunteers in the community to share relevant information.

- Kingsbridge: a database of support is available for the link workers that is maintained by a partner organisation's community development worker.
- St Austell: a digital app, **Help at Hand**, contains information of their local community support and services. The leaders of one group offer to have tea with new joiners coming from the link workers.
- Frome: the **Health Connections Mendip directory** of local services is both public facing and directly linked into the GP IT system.

Funding to build community resilience

For social prescribing to reach its full potential, there has to be activities and support in the community for social prescribers to link people into.

Research by **New Philanthropy Capital** shows that the areas that need it most, where ill health and health inequalities are highest, usually have less community and voluntary sector activity than more affluent areas.

In the test beds, community development is often a core part of the social prescribing team, or there are close partnership working arrangements between organisations with aligned objectives. However, funding for activities and development in the community is often short term in nature and not secure.

- Kingsbridge: there is an arrangement where community builders from organisations with aligned objectives work in partnership with the link workers.
- Frome: social prescribing taps into community activism, thousands of community connectors ensure that all the existing assets in the town are accessible.
- Ilfracombe: the community building element of social prescribing is done by a dedicated community development worker working within the same team as the link workers.
- Cullompton has a partnership in place with the local Council for Voluntary Service (CVS).

Appropriate and relevant measurement

The primary aim of social prescribing is to help people to live their lives as well as possible. Managers of social prescribing teams understand the importance of measuring their impact on individuals. Many take a variety of routes in order to achieve this, with a focus on the individual outcomes. This includes the use of different wellbeing surveys and measures.

The Institute's test beds all measure wellbeing, but not always using the same tool. The test beds also collect stories from individuals, professionals and organisations involved. Healthcare professionals, commissioners and national policymakers are often also interested in measuring the knock-on effect of social prescribing on things like GP appointments and hospital admissions and social care, and the associated cost savings of this.

As is well documented, there are challenges in measuring the impact on services from specific interventions in complex systems like health and care, especially where there are challenges in joining up datasets and having multiple interventions in place. There are, however, lessons to be learned from a variety of approaches that have been tried.

- Frome: have produced data that shows a reduction in hospital admissions at the same time as social prescribing being put in place.
- Ilfracombe: has used the **New Economics Framework** for cost-benefit analysis.

Leadership and workforce development

Recognising that the work of social prescribing teams can be difficult, the right leadership and professional support is important. All of the Institute's test beds have inspirational and enthusiastic leaders involved, but these have developed or been nurtured in different ways.

In many of the test beds there is a support system for dealing with complex cases. This can involve working with other professionals, practitioners and organisations over a larger area helps to create a professional support network where there is a recognisable shared experience. These networks, and other peer support, can help give social prescribers confidence to test and develop new approaches and partnerships.

- Kingsbridge: there are newsletters circulated with news of positive success stories and new activities and events locally.
- Frome: GPs and social prescribers host support groups jointly for specific patient groups where knowledge and learning is shared, with participants but also between GPs and social prescribers.
- Ilfracombe: link workers have access to professional support meetings to confidentially discuss difficult cases with a range of other professionals (including in the police, local council, health, social care and the community). Effort is also made to educate GPs and other healthcare professionals about the successes and challenges social prescribers face.
- Cullompton: local volunteers were given free rein to develop the support on offer through the Life Hub attached to the practice.

Learning from other research
what is common across social prescribing practice?

Whilst the Institute's learning about the building blocks of social prescribing comes from studying its five test beds, it builds on the findings of previous research that identifies the essentials or core components of social prescribing. This includes research from the Richmond Group of Charities **Doing the Right Thing Programme**, the **NHS England guide on social prescribing** and **London South Bank University.**

Common solutions to overcome challenges

The test beds, like many other social prescribers, have and continue to overcome multiple challenges in the course of their work. Whilst practitioners and clinicians will often need to find solutions particular to their context, looking across their test beds, the Institute has observed trends.

- **Inspirational, generous and trusting leadership** helps social prescribers to apply their skills, knowledge and experience to work with people in a motivational way that builds their health and wellbeing through practical, social, economic, environmental and other means and generates a change in culture in how organisations and professionals in a place work together.
- Capacity for **community development,** alongside link workers, plays an important role in enabling the development or expansion of community groups, voluntary sector support and more formal services to fill gaps in local provision. This includes tapping into a wide range of different funding sources.
- **Professional support networks** for link workers coming from a wide range of settings across an identifiable local area, like a district or similar parts of a county, helps to build resilience and offers a place for social prescribing professionals to turn to for advice.
- **Involving people** that benefit from social prescribing in the design and delivery of social prescribing ensures it builds on what is already there in communities, responds to the realities of life and is what people actually want.
- Working to **build relationships** with a wide section of local partners and agencies ensures that social prescribing is genuinely place-based and builds additional social infrastructure within the community
- **Using systems that already exist** to collect data and measurement tools that make sense to link workers and people and collecting stories make it useful.
- Developing **understanding of the local population** helps to determine demand for more specialised social prescribing for certain groups, including those harder to reach or in areas of inequality.

Learning from other research
what challenges do social prescribers have to overcome?

Many of the challenges that the Institute's five test beds have overcome are consistent with the challenges that have been identified through other research. It is hoped that the practical learning from the test beds will help local practitioners and policymakers to find solutions to overcome these challenges and achieve their ambitions to make social prescribing as effective and impactful as it could be over the long term.

In July 2020 the National Association for Link Workers published findings of a members' survey in their **Care for the Carer** report. This research is from the perspective of link workers and includes recommendations to boost support and training to link workers as part of their role, as well as their employers, commissioners, and system partners.

In August 2020 The Conservation Volunteers published findings of two surveys exploring the issues of VCSE sector funding for social prescribing – one from before the outbreak of COVID-19 and the second not long after the first peak had passed. Their report **Enabling the potential of social prescribing** makes a number of recommendations to overcome funding issues in the voluntary, community and social enterprise (VCSE) sector, improve collaboration in the design of Social Prescribing locally and provide link workers and individuals the tools and skills they need to interact face-to-face or online if needed.

In early September 2020 National Voices – a coalition of charities working in health and care in the UK – published the findings of research to capture the VCSE perspective on the NHS roll out of social prescribing link workers through Primary Care Networks. Many VCSE organisations are involved in social prescribing as providers of link workers and the social, practical and emotional support and activities in communities.

The report **Rolling out Social Prescribing** identifies five key challenges to the ambitions of the national rollout. These relate to the link worker role, measurement, funding for the VCSE sector activities and support identified by social prescribing, inequalities and collaboration and partnership.

In mid-September New Philanthropy Capital hosted a policy roundtable on social prescribing. The discussion, outlined in their **summary blog** of the event, focused on how to support the further rollout of social prescribing in light of the inequalities laid bare by the COVID-19 pandemic; the need for better funding for VCSE organisations involved; and things to consider in relation to measurement of social prescribing.

Later in September the Westminster Health Forum hosted a half day conference on social prescribing. Presentations were heard from a range of speakers including practitioners, commissioners, researchers, national bodies and policymakers. A number of opportunities and challenges were highlighted, including how to develop resilience in the workforce, make social prescribing accessible to all and capture and spread good practice from local areas.

Learning about how to spread good practice

The Institute has identified four elements to consider when trying to spread good practice. Much of this is specific to social prescribing, but it can also apply to other interventions to improve health and wellbeing and further afield.

During its first year the Institute has worked to build a learning community that enables practitioners, thinkers and policymakers to enhance each other's work, spread change, inform local and national approaches and policy.

While a future evaluation over a longer time period will be needed to truly determine the success of the approach, there has already been a lot that the Institute has learnt, or confirmed, through its work.

1. Place practitioners in the driving seat and empower them to lead change

The Institute has created a safe space to test ideas and open-up debates. Sharing information is a key part of this but in each other the test beds are also able to share their inspiration and enthusiasm for what they are doing with a supportive group of like-minded others. The Institute is testing various routes to creating capacity for practitioners to participate fully. This includes through the funding of time and expenses, organising the network and regular meetings, collecting learning from the test beds by observing them in action and aligning researchers around a common cause.

With the Institute's conferences, online meetings and events, and publications it provides a platform for the test beds to share learning amongst themselves, and with others. This is making a tangible difference to the practitioners involved. For Hannah McDonald, One Northern Devon's Partnership Manager, whose work includes the Ilfracombe test bed:

"being part of the Institute is an amazing opportunity for us. Presenting at the first regional social prescribing conference was an easy way to tell our story and share our learning with hundreds of others in the region. Overall it is hugely beneficial for us."

By learning with their peers and having an easy mechanism to identify opportunities for collaboration, the test beds are finding ways to short cut the process to solve their challenges. For Daisy Robinson, social prescribing lead for the Culm Valley Primary Care Network and GP in the Cullompton test bed:

"being able to join the Institute and learn from others trying to similar things has helped us to move forward at a much faster pace than if we were going it alone."

2. Find an identifiable footprint that enables the spread of good practice at scale

The challenge of how to spread good practice comes up frequently in policy discussions in health and care. National platforms whilst undoubtedly helpful for many practitioners and rich for research purposes can be overwhelming in volume to some on the front line or not specific enough to their own local circumstances. At the very local level historical relationships and a competitive commissioning environment can make it harder than it might otherwise be for professionals to coalesce and learn from each other.

The Institute's regional footprint has proven helpful in this regard. The region, the South West peninsular of Devon, Cornwall and Somerset, is identifiable to its residents and professionals. This helps to avoid the 'that won't work here' argument against learning from others elsewhere. The region is also large enough that issues of personality and politics can be overcome to enable the spread of innovation at scale.

The Institute's position - between local and national partners, and with practitioners and academics - means it can play a role in bringing about change more widely by acting as a bridge between the different perspectives, collating and sharing its learning in a way that is accessible for different audiences.

3. Remain institutionally agile to adapt to external events and change focus when it is needed to keep learning relevant

With low overheads and a dynamic approach to developing its work priorities in partnership with the test beds and in response to external events, the Institute was able to rapidly refocus its efforts on gathering insights during COVID-19. Whilst this may prove to have been a unique moment in time it is likely that the longlasting impacts will mean there is ongoing need for rapid adaptation in health and care over the medium term. By developing a learning community built off the back of another institution rather than developing new infrastructure has been instrumental in helping this happen.

Going forward many of the test beds are starting to focus on the issues of inequalities, which have been thrown into sharp relief by COVID-19. This is rightly also rising in importance in national policy circles. The responsive and iterative approach of the Institutes means it is able to adapt and evolve its focus. This includes with a focus on inequality through social prescribing, but this could evolve further as learning develops.

4. Understand and promote the relevance and learning from this specific practice across to wider policy ambitions

For the Institute the primary purpose of social prescribing is to improve the lives of people with health issues. As shown through the case studies this is achieved by helping individuals to find ways to address a range of non-medical issues that impact on health and wellbeing - including loneliness, physical inactivity, work and money problems. Others in the community - in other local services and the community and voluntary sector – are integral to this and therefore supporting the development of strong and resilient communities by working in partnership with the voluntary and community sector and other local services is another important route to success. This again is shown throughout the work of the test beds.

But for the Institute, starting from the perspective of primary care, social prescribing is also about the health service. Social prescribing represents how many doctors, especially in general practice, would like health care to be. Rather than the overwhelming experience of high levels of demand from patients with complex issues that medication alone cannot resolve, many instead want to be able to offer the holistic care that social prescribing offers to resolve the root causes of ill health. Yet in the past, for GPs doing this as lone agents in primary care it has sometimes felt like an uphill challenge.

Some GPs have overcome these challenges as shown through the work of Dr Stewart Smith and Dr Helen Kingston in St Austell and Frome. In these cases, primary care services are offered at scale through one large practice. Recognising the success of these larger practices NHS England is now investing heavily in Primary Care Networks to act as agents of change in the health service. Based on accepted evidence from the King's Fund about the optimal population size for the delivery of health and care being between 30,000 and 50,000 people and building on the practical work of the National Association for Primary Care and Primary Care Home, Primary Care Networks are the operational route for the delivery of the vision in the 10 year plan.

In some places, like St Austell and Frome, the Primary Care Networks are already highly functioning and effective, because this is how they already operate. In many other places though, Primary Care Networks are still in the early stages of development, especially in areas where GPs do not yet work closely with each other or have been set up to compete in the past. The experience of the test beds shows the important role that developing and delivering social prescribing can have in helping this process. Data from St Austell shows that social prescribing reduces workload on clinicians. The experience in Kingsbridge demonstrates the rich experience that clinicians feel when the root causes of their patients' health and wellbeing problems are addressed.

> The experience of the test beds also show that healthcare practitioners and staff – whether GPs, practice managers, receptionists, physios, nurses and more – are united in their desire to improve health and care.

Practitioners are also united in the fact that they are inherently practical. By working together to implement social prescribing across bigger footprints, including Primary Care Networks and beyond, can itself help to kickstart the process of Primary Care Networks becoming the agents of change they are hoped to be in health and care.

In Ilfracombe the breadth and depth of the collaborative relationships that social prescribing has built across and within health and care services and the community, the understanding of the local population and the impact of social, environmental and economic factors on health and wellbeing it has built is influencing the system as a whole.

In Cullompton coalescing around a shared ambition to improve life for children and young people has built new working relationships and understanding of the issues in the town for the first time ever. In this sense social prescribing is itself a test case for how to practically transform health and care, which for the Institute makes it an even more important approach to understand and champion.

Summary of case studies

Case studies of the Institute's five test beds set out how social prescribing is approached in different ways across the South West of England. The case studies detail the history and local context as well as the approach and impact for people, communities, professionals and commissioners as well as challenges overcome.

Cullompton
developing social prescribing for children and young people

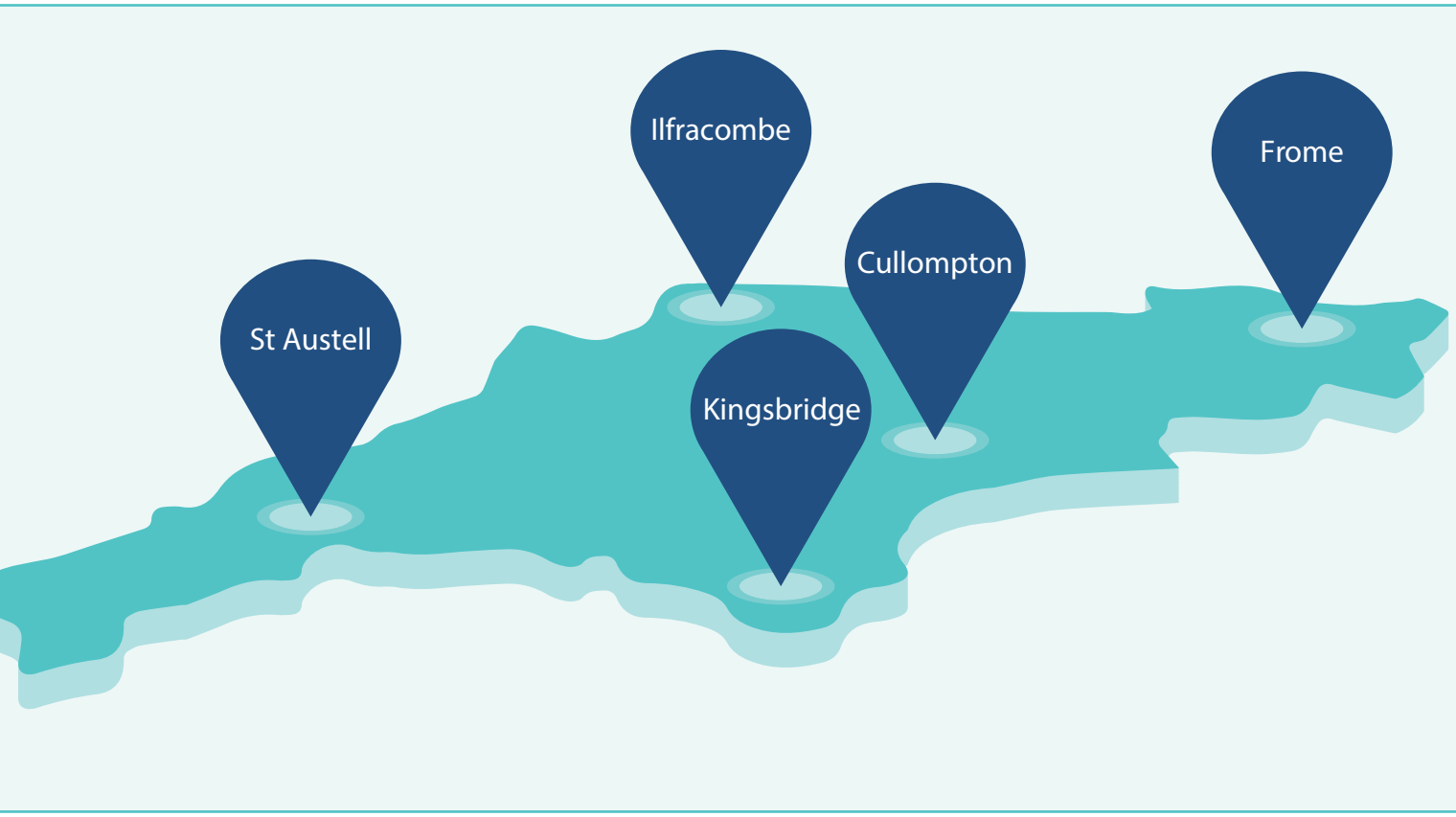
Social prescribing for adults has been in place in Cullompton since 2007. This is now evolving to operate as part of a wider social prescribing framework across the Culm Valley Primary Care Network.

In 2019 the GP practice realised that more needed to be done for children and young people in the town. They led the development of a Youth Forum, bringing together young people with other local agencies and charities. New initiatives and activities have been developed in the town along with a process for enabling partners to work together. This is laying the ground for a new social prescribing link worker for children and young people to link into once they are in post.

Frome
connecting community activism with social prescribing

In Frome social prescribing is the inner core of a wider approach to empower the local community to lead change. A central team of health connectors based out of the GP surgery provide one-on-one support to around 1,500 complex cases a year and link them into one of 400 groups, activities or other support services in the town. But it is the ripple effect of the community connectors, signposting thousands more residents to local support, that have the biggest role.

By creating an onion with layers of support, local GPs report the complete rejuvenation of their practice. The ambition is that in 20 years' time social prescribing need not exist as the community itself will know how to find out where they can access the support they need to manage their health and wellbeing.



Ilfracombe
taking a place-based partnership approach to social prescribing

In Ilfracombe, social prescribing has been in place since 2015. It was started by the town partnership – One Ilfracombe – that tackles local issues. Link workers, now attached to GP practices, offer personalised support to individuals and work in partnership with community builders. 1,500 people have been supported so far but the impact reaches far beyond these individuals.

By embedding themselves in the community and building relationships with a range of local partners, all residents and services know they can go to One Ilfracombe for help and support should they need it. This is demonstrated by the high proportion of local people that refer themselves directly to the social prescribing link worker.

Kingsbridge
building community assets with social prescribing

A group of people in Kingsbridge with an interest in wellbeing first put social prescribing in place in 2018. A small team of voluntary sector link workers contracted by the Primary Care Network supports individuals to help them identify their ambitions and opportunities available.

There is a close working relationship with a community developer in the town and new initiatives to boost wellbeing are developed in partnership with local and national organisations. The numbers of people being supported through social prescribing continues to grow as more people and professionals become aware of what it is and the potential it offers.

St Austell
transforming general practice through social prescribing

Social prescribing was put in place in 2016 when three GP practices merged to form St Austell Healthcare. It has now been on offer to patients of the GP surgery for over four years.

A team of practice-based link workers and volunteers, working in partnership with other healthcare professionals and local charities, link people into activities and support in the community to boost wellbeing. The 1,400 people that have benefitted since 2016 have been linked into a range of activities and support often with a strong focus on physical activity and nature. GPs report a transformational effect on their approach to managing their workload as social prescribing has developed.

Photo © Derek Harper

Cullompton
developing social prescribing for children and young people

Summary

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In 2019 the GP practices realised that more needed to be done for children and young people in the town. They led the development of a Youth Forum, bringing together young people with other local agencies and charities. New initiatives and activities have been developed in the town along with a process for enabling partners to work together. This is laying the ground for a new social prescribing link worker for children and young people to link into once they are in post.

Local context

Cullompton is a market town in relatively rural mid-Devon. The population of around 10,000 people is growing at a rapid rate and the development of a new village bordering Cullompton, the Culm Garden Village, is currently underway. Situated about 13 miles north of Exeter, around a fifth of Cullompton residents commute there for work.

Whilst Cullompton has an ageing population in line with the rest of the South West, over 19% of residents are under the age of 16 and the birth rate is one of the highest in Devon. There are relatively good levels of health and wellbeing in the town, although young people report a lack of mental health support and levels of self-harm are higher than the national average.

The town is served by two GP practices – College Surgery and Bramblehaies Surgery. These are both part of the newly defined Culm Valley Primary Care Network along with two other surgeries in the area. Spread over a long, thin geography in a rural area, there has historically been little cause for partnership and coordination between the four GP practices. But with new opportunities for shared resources, relationships are developing to create shared goals and partnership working across the Culm Valley as a whole.

What was done?

In 2008, the College Surgery in Cullompton creates an integrated health centre – the Culm Valley Integrated Centre for Health – offering complementary therapies, gardens and a café. People looking to make changes to their life to improve their wellbeing and older isolated patients from both GP practices in the town are seen by health facilitator Ruth Tucker, a practice-based link worker, who works full time to connect individuals into the activities and support that is right for them.

In 2015 a team of older volunteers attached to the practice set up the Community LiFE Hub. This offers a range of activities including diabetes support groups, community gardening and exercise classes on social prescription as well as support from other organisations like Age UK and DAS.

In 2017 wider pressures on the practice mean funding for social prescribing has to be reabsorbed and Ruth takes up a new role managing the reception in the practice. The volunteer-led activities and support in the Life Hub continue and are publicised directly to people in the town and in the surgery.

In 2019 as practice pressures subside, Ruth is reinstated in her role as social prescribing link worker but part time. GPs and other healthcare professionals in the town start referring patients to her again whilst the Life Hub continues to run itself through the support of volunteers in the town.

When NHS England groups GP surgeries together to form Primary Care Networks, College Surgery becomes part of the Culm Valley Primary Care Network along with Bramblehaies, Blackdown, Sampford Peverell and Wyndham House Surgeries. Like all other Primary Care Networks they are offered funding for a social prescribing link worker and discussions begin locally about how to make best use of this given all the practices have their own established schemes. College Surgery also brings Involve, the voluntary sector infrastructure body, into the discussions.

In Cullompton, given the relatively high proportion of young people in the town, and the existing provision for adults, College Surgery proposes an expansion of social prescribing to focus on children and young people across the Primary Care Network.

From the outset it is apparent to the local champion for children and young person's social prescribing, Dr Daisy Robinson, that this work cannot just be attached to the practice.

"We know that young people traditionally don't engage with the GP unless they really have to, and that many others in the town – in the education system and community more widely - play a much bigger role in shaping the health and wellbeing of children and young people."

This awareness of young people often being out-of-reach of GP services, drives the approach to develop a local place-based partnership first, rather than starting with the recruitment of a link worker.

In September 2019, to get things off the ground, College Surgery works with the town council, the heads of local schools, the police, charities like the YMCA and the Teen Yoga Foundation as well as young people themselves to develop the Cullompton and Culm Valley Youth Forum. The aim is that the Youth Forum will enable the building of new community provision for children and young people in the area, supported by a joined up system of professionals and organisations, that current and future social prescribing link workers can connect with.

For the first six months there is a relatively informal approach taken to building the forum. The initial focus is on bringing people together, building relationships, and exploring opportunities to do things together and share information. Within time work is undertaken by the council, Primary Care Network and voluntary sector to agree the vision, set priorities and take projects forward. This starts with discussions with young people to identify what already exists and what more could be built.

There are priorities to develop more places to go, more youth volunteering opportunities as

COVID-19

In March 2020 COVID-19 means that all the existing face-to-face complementary and volunteer-led activity for older people at the surgery has to stop. Practice-based link worker Ruth works with local voluntary sector organisation Involve to support the local community response to COVID-19.

Ruth contacts over 500 patients being advised to shield to see whether they need additional support to manage their health and wellbeing, including the delivery of prescription medication and food, and opportunities for social contact.

At the same time the Youth Forum enables the involvement of young volunteers to be part of the effort and its further development continues. A charter is put together, the launch of new activities is agreed, and professionals meet monthly, but online instead of in-person.

Seeking to support the Primary Care Network to take up the offer of additional resources for social prescribing from NHS England, Dr Daisy Robinson begins to discuss with the Clinical Director how the area could move towards a more coordinated approach for adult social prescribing too. Working closely with voluntary sector partner Involve, a discussion begins with the existing volunteer-led social prescribing practice-based teams to explore how to bring everything together collaboratively to make the best use of the additional resources for the area.

well as a Yoga Ambassadors scheme for 11-16 year olds and an initiative to train Wellbeing Ambassadors within the workforce of people that work with children and young people. For primary school children parent cafes that host activities around healthy eating and other activities are suggested.

Current situation

In September 2020 Cullompton's link worker Ruth is continuing to work in partnership with the voluntary sector infrastructure body, Involve, to link older isolated patients into the COVID-safe support that is in place in the community and the Life Hub. There are around 5 new referrals a week and connections are made with a variety of online exercise classes, befriending and other support on offer from the likes of Age UK, Carers Direct, One Small Step and Talkworks.

Building on the experience of the social prescribing team in St Austell shared during an Institute meeting, Ruth is starting to work with developers to populate a local Help at Hand app with information about community support that is available. Other GP surgeries in the Primary Care Network are keen to develop this together and it becomes a project for the Culm Valley more widely.

The work with the Primary Care Network to develop a social prescribing pathway for the area that builds on the existing practice-based activity is now near completion.

All three practice-based volunteer-led social prescribing, including the Life Hub, are keen to work together collaboratively as a social prescribing workforce for the Culm Valley Primary Care Network.

Work is underway to develop a framework to support data collection and ensure consistency across the area. Local voluntary sector partners, Involve, are supporting this process and their community development worker, who is funded by the Devon Sustainability and Transformation Plan until April 2021, is feeding in their intelligence about gaps in the community and where a an additional Primary Care Network social prescribing link worker can be best targeted over and above existing link workers to meet the needs of the local population.

The Autumn plans to launch the priority activities identified by the Youth Forum are underway, supported with funding from Devon County Council to support the development of community groups. The Primary Care Network has also agreed to start the process to recruit a specific children and young person's social prescribing link worker from a relevant provider of youth services in the area.

How it works

GPs and nurses in the two practices in the town introduce older isolated people to Ruth, who has her own room in College surgery and is a well-known presence locally. Individuals and their carers are also able to introduce themselves by contacting Ruth directly through the practice reception desk or phone number.

Ruth, who has a background in motivational training, follows up the introduction with a conversation with the individual to determine what activities or support they might like to connect with. She then links people into relevant activities and support within the community and voluntary sector, in the Life Hub, and the surgery itself. This includes things like gardening, craft and walking clubs as well as support groups for people with specific conditions like diabetes and fibromyalgia.

The ten volunteers at the Life Hub oversee the groups and manage the centre but are closely linked with the GPs and Ruth. Ruth collects data on individual wellbeing from new referrals using the ONS Subjective Wellbeing Measure. This follows experimentation with a variety of measures over the years.

The Cullompton and Culm Valley Youth Forum holds meetings every two months or so, with a discussion guide and agenda set beforehand. Minutes are taken at each meeting and key outputs are shared in easy to digest posters. These include information about different partners activities, the views of children and young people, issues that are raised and questions discussed by the group. Agreed actions are also set out with named individuals to lead and timelines. Action group meetings are held more often to progress specific projects.

Taking an asset-based approach, the forum first focussed on mapping what is already on offer for children and young people in the town and seeking the views of the young people themselves. Over ten proposals for new children and young people initiatives in the town are proposed and Devon County Council and Sustainability and Transformation Partnership funding for the development of community groups is available for redirection towards the proposals coming out of the Forum. The Forum discusses proposals and comes to decisions as a group.

What has been achieved?

The Cullompton and Culm Valley Youth Forum is the first time all agencies in the area have united around the common goal of improving life and opportunities for young people. In under a year, including the six months of COVID-19 restrictions, the Forum has built a close working relationship between key agencies in the town as well as leading charities and young people themselves.

> The Culm Valley Youth Forum have identified what could be built on in the town and a way to agree next steps and fund an expansion of provision.

With the range and number of partners involved securing agreement on next steps could be a challenge, but with all united around the goals and ambitions of the young people, and open and transparent management of the meetings this has not occurred. There is buy-in from young people, health, education and the police.

Crucially the Forum also acts as a support network for professionals. This was especially helpful during the COVID-19 lockdown. It enabled increased sharing of intelligence about children and young in the town and the creation of new assets. All of this together has resulted in a commitment from the Primary Care Network to invest in a social prescribing link worker for children and young people.

For adults, prior to COVID-19 and when Ruth was funded full time approximately 12 people a week were supported back into activities to improve their health and wellbeing. Over time Ruth has built strong relationships with many different charities, community groups and the local council. Her role is recognised as one that straddles both health and the community. This has helped the process to bring together disparate groups across the Primary Care Network. The ten volunteers in the Life Hub are self-sustaining and are a key part of the community for older people. Whilst operating largely virtually for now, the Life Hub hopes to get up and running again as soon as safely possible.

What challenges have been overcome?

Funding

In the first decade of social prescribing in Cullompton funding for social prescribing was a continual challenge. At certain times it operated month-to-month and the scheme even had to close for a couple of years. This uncertainty is something that the staff and practice has had to endure. With central funding coming from NHS England to Primary Care Networks for social prescribing the practice hopes this problem will be a thing of the past and that social prescribers will become and accepted and expected part of all primary care teams.

Development of new structures in primary care

More recently the key challenge that social prescribing in Cullompton has had to overcome is in relation to the creation of Primary Care Networks. For the Culm Valley, partnership across the area did not have a history. In the past there has even been a feeling of competition between the practices.

Recognising though the potential for sharing resources, intelligence and learning with other colleagues Cullompton worked hard to identify issues of common purpose. By focusing on children and young people, and undertaking a process to develop a community in the town around children and young people, the Primary Care Network were able to see how it could benefit all the practices to develop social prescribing for children and young people on this larger footprint.

This focus on a more specialised form of social prescribing has been shown to be helpful when there is more general social prescribing already in place. Understanding that the Primary Care Network had to focus on more urgent issues around care homes, they were kept informed of developments. As time allowed this enabled the Primary Care Network to quickly focus on the issues and make a decision on how to proceed.

What does the future hold?

Cullompton is hopeful that very soon the Primary Care Network will look to appoint new social prescribing link workers. There is a commitment to employ three additional social prescribing link workers for adults, to work in collaboration with the existing local link workers.

There is also a commitment to recruit a part time social prescribing link worker for children and young people to be homed in the youth sector. They see that this will have a transformative effect on the delivery of health and care services across the area, and help to deepen relationships across primary care.

You can learn more about the Cullompton Youth Forum by contacting Dr Daisy Robinson, College Surgery **daisy.robinson@nhs.net**.

Frome
connecting community activism with social prescribing

Summary

In Frome social prescribing is the inner core of a wider approach to empower the local community to lead change. A central team of health connectors provide one-on-one support to around 1,500 complex cases a year and link them into one of 400 groups, activities or other support services in the town. But it is the ripple effect of the community connectors, signposting thousands more residents to support, that have the biggest role.

By creating an onion with layers of support local, GPs report the complete rejuvenation of their practice. The ambition is that in 20 years' time social prescribing need not exist as the community itself will know how to find out where they can access the support they need to manage their health and wellbeing.

Local context

Frome is a town in the Mendip area of Somerset, 13 miles south of Bath. The needs of the 30,000 residents are served by a politically independent and active town council, the Frome Medical Practice and a diverse voluntary, community and social enterprise sector. The town has a vibrant arts scene and a considerable number of independent shops. Almost half the working population commutes to bigger cities for employment.

While older than average, Frome has one of the younger populations in Somerset with more people aged under 16 than over 65. Life expectancy is above the national average. However, there is inequality and pockets of deprivation with a higher proportion of residents claiming benefits than for Somerset as a whole. One in 20 residents live in parts of Frome that are amongst the 20% most deprived areas in the country and one in ten households live in fuel poverty. People in the area are at increased risk of social isolation and loneliness and digital exclusion.

The Frome Medical Practice is also the Frome Primary Care Network, which is working alongside the Mendip Primary Care Network and the West Mendip Primary Care Network to improve population health as envisioned in the NHS Long Term Plan.

What was done?

In 2013 Frome Medical Practice, with funding from the Somerset Clinical Commissioning Group, begins development of a new model of care that connects people with health problems into social networks and community-based support. As a first step they employ someone to map what activities and support already exists across Mendip.

In 2015 Frome Medical Practice launches Health Connections Mendip. The directory of mapped local activities, groups and other support is publicly available on a website and linked into the GP's IT system. People can also learn what is available from one of the community connectors. These are local citizens who have been trained by Health Connections Mendip to proactively signpost people into what is available.

Frome Medical Practice employs a team of five health connectors on behalf of the ten GP practices to work one-on-one with people with more complex needs. There are also three part time Area Leads in post to manage the health connectors and undertake community development across Mendip to fill identified gaps in local provision.

In 2019 Health Connections Mendip expands further to include the social prescribing link workers funded by the Frome and Mendip Primary Care Networks. The team now includes the equivalent of 8 full time one-to-one health connectors. There are also over 1,000 community connectors in Mendip and the website directory includes details of over 400 groups, activities or support services available.

Current situation

In September 2020, the health connectors had one-on-one sessions over the phone with nearly 1,100 people. This is nearly four times more than the 300 face-to-face sessions in September 2019.

COVID-19

When the COVID-19 crisis hits the UK in March 2020, the Health Connections Mendip team feels confident the community will lead the response locally. Informal aid groups spring up at street, village and town level almost overnight. and Health Connections Mendip supports this by providing additional capacity and tools when gaps are identified.

Health Connections Mendip publicises what is available locally on their website, make thousands of wellbeing calls to the most vulnerable, provide GPs with a template letter with details of the local support available to go out to all patients that are being advised to shield. They also deliver a booklet on local support for maintaining wellbeing to every household.

Building on the success of the community connectors, Health Connections Mendip also train people as digital connectors so they can support others to get online on and point them towards digital support available. Details of the Health Connections Mendip response to COVID-19 between March and June 2020 is available in an earlier case study published on the Institute for Social Prescribing website.

With the majority of conversations still taking place over the phone the health connectors are able to see more people in a day than they would be able to face-to-face. At the same time demand is higher especially as the lack of face-to-face groups due to the ongoing COVID-19 restrictions means that more needs to be done one-to-one.

Some local groups, like the Somerset Activity Sports Partnership health walks, are back up and running but the majority are not. Where they can, the health connectors have developed new ways for people to connect in groups. Talking Cafes, an informal way for people and organisations to come together during the week to chat in a café, are now taking place online and outside when the weather allows.

Some of these existing groups have developed into friendship groups and support networks independent of Health Connections Mendip. This is positive for the people involved but it is not something that Health Connections Mendip can direct new joiners towards. A new initiative, Talking Benches, is helping the team stay connected to people in the community that might need support. During a set half hour each week, members of the team are known to be available on one particular bench in the town for people to come and talk to them.

Other more specific support is also being delivered online. For example, the Healthy Lifestyles Programme which is available for anyone that would like to tackle issues related to weight, physical activity, sleep and more, is now taking place on zoom. GP group consultations for specific conditions, such as diabetes and arthritis, where GPs and health connectors work in partnership are now also taking place online.

How it works

The way in

Health Connections Mendip want to reach as many people as possible and as such there are multiple points of access. Anyone in the town can look for information, advice and support using the Health Connections Mendip phone number, email, website contact form or by speaking to one of the community connectors.

The community connectors are often identifiable by a badge and come from all walks of life including hairdressers to taxi drivers, and supermarket staff to sixth form students as well people who formally volunteer for other organisations or run support groups.

Once in there are a range of options that people are pointed towards. It can be as simple as a signpost to a particular organisation or activity or a recommendation to join a group. Or it may be an offer of training to become a community connector or a connection with the Ideas Cafes for people that have ideas of new things for the community but need a bit of help to get going.

For people with more complex needs they can ask to see a health connector for a one-on-one session. GPs and other healthcare professionals can also introduce their patients to one of the health connectors via a referral form on their IT system, EMIS.

One-to-one support

When someone is introduced to a health connector they start with a conversation based round 'What Matters to You?' A range of avenues are explored in this conversation including the mapping of personal networks, goal setting or the exploring of self-management techniques. When face-to-face is an option then health connectors offer to meet individuals either in their home, the GP practice, hospital or care home.

Once life goals and ideas for self-management and how to connect into personal networks have been identified then the health connector and individual work together on a plan. Known as My Life Plan, this plan is held on the GP IT system. Information about the onward support that people are connected into is recorded by the health connectors on the My Life Plan, which is then available for all those involved in the health and care of an individual to see. Other health and care professionals can then add to this, for example with hospital discharge notes or about preference for end of life care.

The health connectors attend multi-disciplinary team meetings with other professionals, whether it is the hospice, district nurse team, adult social care, the police or housing department. This way there is an ongoing conversation across all professionals involved with an individual which ensure coordination and continuity of care.

Measuring impact

During one-to-one sessions the health connectors ask a range of questions to enable them to assess an individual's progress against the Patient Activation Measure, the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) and the Office for National Statistics four subjective wellbeing questions (ONS4). They also regularly survey GPs and other practice staff to judge their impact as a team.

What has been achieved?

Before COVID-19 the health connectors in Mendip were seeing 1,500 people a year for an average two or three appointments each. 81% of individuals reported an improvement in their wellbeing and 94% said they felt more able to manage their health and wellbeing.

Sue, an older lady with long term health conditions is an example of how Health Connections Mendip can help. On her own after her grown up children moved away, Sue was feeling the health impacts of loneliness. By visiting her and putting her in touch with a befriender she is now happier and more able to manage her health and wellbeing. "Health connections gave me confidence that there is some good in the world. It's the best thing that ever happened to me" Sue said.

This impact on individuals has not gone unnoticed by healthcare professionals.

92% of GP practice staff see their patients benefit from Health connections Mendip and a similar proportion feel that it adds value to the service they provide patients.

Helen Kingston, GP partner at Frome Medical Practice and original driving force behind the establishment of the scheme has said "the joy of all this is that I can see the impact it has on individuals turning their lives around by being given back a sense of being part of a community again. It has rejuvenated the practice."

The value of the health connectors is also recognised outside their impact on the individuals. By working in partnership many of the GPs have come to recognise the unique and complementary skills of the health connectors. For Dr Robert Taylor, a GP partner at Frome Medical Practice that runs a diabetes education group with Jo, one of the health connectors, being able to work together as a team is invaluable. "It has been really valuable to run a diabetes education group with Jo, one of our health connectors.

Jo has been able to work alongside me with her expertise and knowledge in nutrition but also in her excellent ability to facilitate the groups and support patients with positive ideas and goal setting and encouraging behaviour change. These are aspects that GPs don't traditionally have the time or the expertise to do," he said. With COVID-19 these groups have gone online, increasing the numbers able to access them up to 60 a month.

The impact of the one-on-one support is just the tip of the iceberg. With their focus on enabling and empowering anyone and everyone in the community to get involved Health Connections Mendip has managed to scale their impact, in a ripple effect, to reach thousands more with the involvement of over 1,500 community connectors and 50 digital connectors.

With each connector having an estimated 20 conversations a year this amounts to a total 30,000 signposting conversations to activities and support in the town.

The Health Connections Mendip website directory gets nearly 75,000 hits a year from individuals and healthcare practitioners use the website over 7,500 times for signposting.

This ripple effect is strongly felt in the community with the support given to others that want to set up health-related groups as well as the 250 groups that Health Connections Mendip run themselves throughout the year.

What challenges have been overcome?

Enabling the spread of good practice

In some ways social prescribing in Frome has been a victim of its own success. The demand from people across the UK and internationally to learn from their work is high. In just a two week period during the summer of 2020 the team had ten requests for assistance from others, at least three of which were overseas.

For Health Connections Mendip Manager, Jenny Hartnoll, this interest is clearly a good thing. "We want to be able to share with others and spread what works because we can see what a great impact it is having in our town," she said. At the same time, for Jenny it is not without it's challenge. "Trying to keep up with the demands to share our learning with others whilst also trying to keep up the day job can be hard," she said.

Wanting to help, Jenny and the team have created many different ways they can share learning with people in a sustainable way. They hold regular conferences to share learning, sell their website template and community connector training packages, and provide bespoke early stage support to people interested in developing social prescribing. Being part of the Institute for Social Prescribing is also providing a route to enable the spread of learning within the South West region.

Ensuring long term sustainability

Since it began Health Connections Mendip has been funded by the local Clinical Commissioning Group as part of its test and learn approach to new models of care. More recent additional funding from NHS England to Primary Care Networks has enabled further expansion of the team. This means there are now currently three funders given there are multiple Primary Care Networks across the footprint of Health Connections Mendip.

Going forward the Clinical Commissioning Group is pursuing a strategy to securely fund social prescribing across the county on a long-term basis. The Clinical Commissioning Group and Primary Care Networks have agreed a shared funding approach to achieve this. For Jenny such a move would be welcome as it would enable her to give the team certainty in their positions, ensuring that their expertise is not lost if they need to seek financial security elsewhere.

What does the future hold?

Going forward the team are focused on building on their work in the past five years with an expansion of their Let's Connect approach to include new Warm Homes Connectors, Healthy Lifestyles Connectors and others. Over the longer term it is hoped that this approach will empower the community to lead.

For Dr Helen Kingston this is entirely consistent with the original vision which is to create intrinsic strength in the community rather than additional capacity in the practice. "Ultimately our aim is that in 20 years time social prescribing in Frome is redundant because all the signposting to community support happens in the community rather than coming through the surgery," she said.

You can learn more about social prescribing in Frome **here** or contact mendip.**healthconnections@nhs.net**.

Ilfracombe
taking a place-based partnership approach to social prescribing

Summary

In Ilfracombe, social prescribing has been in place since 2015. It was started by the town partnership – One Ilfracombe - that tackles local issues. Link workers, now attached to GP practices, offer personalised support to individuals and work in partnership with community builders. 1,500 people have been supported so far but the impact reaches far beyond these individuals.

By embedding themselves in the community and building relationships with a range of local partners, all residents and services know they can go to One Ilfracombe for help and support should they need it. This is demonstrated by the high proportion of local people that refer themselves directly to the social prescribing link worker.

Local context

Ilfracombe is a coastal town in North Devon with a population of around 13,000 people. It is a largely rural area with holiday appeal due to its sandy beaches and surf. However, parts of the town are in the top 10% most deprived areas of England. There is an ageing population in North Devon and nearly 23% of residents are over 65, compared to 18% nationally. Social isolation and loneliness is commonly reported as an issue for residents in the town.

There are relatively high levels of ill health in Ilfracombe and higher prevalence of diabetes, heart disease and mental issues compared to the national average. Life expectancy in Ilfracombe is the lowest in Devon, with people dying an average seven years earlier than the national average and 15 years earlier than those in more affluent areas of the county.

There is one GP practice – Combe Coastal Practice – that serves a population of 20,000 people across Ilfracombe and neighbouring Woolacombe, Combe Martin, Lee and Berrynarbour. Combe Coastal Practice is part of the North Devon Coastal Primary Care Network (PCN) along with the South Molton Medical Centre, Lyn Health and Caen Medical Centre in Braunton. The Ilfracombe Centre is a one stop shop in the town that houses the offices of the town council, One Ilfracombe, Citizens Advice and various other voluntary sector organisations.

What was done?

In 2013 public sector partners in the town form One Ilfracombe, a not for profit company which brings together residents, the councils, health and emergency services, schools, social housing, charities and businesses to create better health, economic prosperity and a higher quality of living for the people of Ilfracombe.

In 2014 conversations between One Ilfracombe and older residents highlight issues from social isolation and the need for improved access to practical support in the community. In response One Ilfracombe employs a community connector from the voluntary and community sector with funding from Devon County Council and the Clinical Commissioning Group. Shortly afterwards GPs begin referring patients to the community connector as part of a social prescribing service.

In 2016 a collaboration of public and voluntary sector partners working across the whole of North Devon – One Northern Devon - is established to improve quality of life in the area. It operates on different levels – directly with people, with towns and villages and with the systems that design and deliver services. One Ilfracombe is joined by other local town partnerships in Barnstaple, South Molton, Bideford, Braunton and Torrington. Community development workers form an important part of the One Northern Devon team.

In 2018 One Northern Devon sets up a community development and social prescribing network which includes all those with similar roles in the area. This includes the town partnership community connectors, the Primary Care Network social prescribing link workers, the six community developers employed by One Northern Devon, link workers at Encompass and Wiser Money, and the police diversion support team. Through the network, professionals get support from peers, receive training, and share innovative solutions they have found to help their clients.

In July 2019 the Ilfracombe community connector becomes an NHS social prescribing link worker contracted by Combe Coastal practice with dedicated funding for the Primary Care Network.

COVID-19

In March 2020, as the COVID-19 crisis hits the UK, the social prescribing team in Ilfracombe reacts quickly given the substantial number of older people and significant hidden deprivation in the town. The team organises the delivery of volunteer support, through a sustainable and self-organising structure with volunteer coordinators for individual sections and streets of Ilfracombe. One Ilfracombe also develops a work plan to coordinate logistics overall. This means that assistance from One Ilfracombe exists alongside informal structures and networks of community volunteers.

One Northern Devon supports One Ilfracombe and other local town teams with tools – like a template workplan – and opportunities to connect at a daily operations meeting. A process for cascading cases up and across the district – including when local volunteers could not be found – aims to ensure that no one in North Devon needing support during the initial phase of the COVID-19 crisis is missed. Details of the One Northern Devon response to COVID-19 between March and June 2020 is available in an earlier **case study** published on the Institute for Social Prescribing website.

Current situation

In September 2020, staff from One Ilfracombe are still operating from home as the GP surgery is only hosting their core team onsite. However face-to-face appointments, where needed, are available at the Ilfracombe Centre. With COVID-19 restrictions ongoing, referral rates for social prescribing are slightly lower than the previous year. In September there were 19 referrals, compared to 22 in September 2019.

Some community activities and groups are starting to get up and running in the town but a lot of people, especially those at risk from COVID-19 are still wary about returning to group activity. A lot of voluntary groups run by older people, and the community car service for example, have yet to restart.

One area that has returned to normal more rapidly, or a 'new normal' at least, is physical activity. Supported by Active Devon several initiatives are in place to help encourage people back into physical activity – including an exercise voucher scheme to help people to pay for the gym. Outdoor activities, like Park Run, are scheduled are scheduled to restart shortly.

In other areas, like mental health and financial advice, the One Ilfracombe team are working with partners and sharing their intelligence from the community to see how any additional need for these services identified through social prescribing can be met. This includes working with the local Citizens Advice Bureau to feed information from the social prescribers into a mapping exercise to understand the financial advice that is on offer locally.

How it works

The way in

There are a variety of ways that people are referred to the social prescribing link worker Miriam in Ilfracombe but the two most common are self-referrals and referrals from the GP or other healthcare professionals. The self-referral process is straightforward – people fill in a leaflet and drop it at the GP surgery or in the Ilfracombe Centre.

If GPs think that something other than medication might help a person they complete a 'referral form' on their IT system – System One – which is then printed out and signed for people to take to the social prescribing office hatch in reception. The use of a hard copy form is intentional as prior experience showed that people are more likely to take up the offer if it is made on an NHS-branded form, signed by the GP, which has to be physically handed in.

Connecting to community support

Once a person is referred they meet with the Miriam Turner, the link worker, who has a conversation with the person to help them identify activities and support that would help achieve what they want in life. The level of involvement from Miriam varies. For some people, after an initial conversation, Miriam signposts them into an activity in the town straight away. For others there might be a number of conversations before the individual identifies the support that's right for them. At the other end of the spectrum Miriam undertakes more in depth one-on-one casework over time to help identify the right support.

Social isolation is the most frequent issue that people raise with Miriam when they meet but this is closely followed by issues with benefits, money and debt and support to live at home independently. For the most common issues Miriam has well established relationships with relevant local partners like Citizens Advice and Navigate. To keep on top of the full range of what is available locally Miriam maintains her own directory of services. She also works closely with the One Ilfracombe community development worker, Charmain, who has a database of social groups in the town.

NHS funding for social prescribing in Ilfracombe covers Miriam's post but there is no additional funding for the activities or support that Miriam links people into.

However through the community development worker, One Ilfracombe is able to creatively find ways to fund new or expanded community-based support and activity when social prescribing identifies a need.

Collecting data to measure impact

Miriam asks each new client a benchmarking set of two questions about their situation and wellbeing. These are based on the Measure Yourself Concerns and Wellbeing (MYCaW) tool and are followed up at each subsequent meeting. They include questions like 'how do you feel about the issue you have come in with today' and 'how would you rate your general feeling of wellbeing?'.

Data is also collected on age, referral source, the issue presented with and whether the person has had a home fire safety visit (which is a priority issue in Ilfracombe). This data combined with the initial responses to MyCAW is stored on a large spreadsheet.

What has been achieved?

In the past five years, One Ilfracombe social prescribers have supported over 1,500 residents. On average 75% of clients report an improvement in their wellbeing following their involvement with Miriam.

The support given to one client is typical of the impact One Ilfracombe has. He suffers from depression and anxiety and takes medication to help with this. In his first meeting with One Ilfracombe he talked about his interest in walking and was subsequently introduced to two local walking groups which have made a big difference to his life.

"Being able to talk to other people and knowing that you are not going to be judged or ignored has meant such a lot to me. I feel so much more positive in myself now and have more strength to face my demons and get my life back on track."

For some people, the support from One Ilfracombe can literally be lifesaving. Another client said:

"I had absolutely nothing and had no idea where I could get help. With the help of One Ilfracombe contacting the right people I could get a bed in my flat and food vouchers whilst I was waiting for my benefit to be sorted."

However, the benefits go far beyond the impact on individuals. With the starting point of social prescribing in Ilfracombe coming from an existing town partnership, the approach has been collaborative from the outset has grown to include relationships across nearly all organisations in the town.

As a locally commissioned service initially, partners were keen to understand the financial impact on local services. A cost-benefit analysis was undertaken for two years running. This was done using the New Economics Foundation process for cost-benefit analysis, a commonly used approach. This estimated a cost saving to the public sector of nearly three times the investment in the scheme.

Since then the scheme has grown from strength to strength. GPs in particular have benefitted from the closer links with social prescribing since 2019 when Miriam was based for a set number of hours at the surgery each week. The volume of referrals from primary care doubled almost overnight and required additional link worker capacity.

Miriam has also seen the benefits of being co-located in the GP surgery. Outside of COVID-19 restrictions she can discuss patients with GPs more easily, as well as take part in practice meetings. A strong relationship has been built with the practice manager in particular but all staff are now much more aware of social prescribing and how the Link worker can be a valuable asset.

Further testament to Miriam's work over the past five years is the high number of people that now self-refer to the service for support, often

following a recommendation from a friend or neighbour. On average over 60% of referrals now come directly from individuals, compared to under 40% when social prescribing began and this has remained constant even whilst GP referrals have increased.

For Hannah McDonald, the One Northern Devon Partnership Development Manager, "the high level of self-referrals for social prescribing really shows the success of Miriam, and it is a referral route we've been keen to keep up even though she is now based in the GP surgery.

When social prescribing was first developed in Ilfracombe it was about meeting the needs of the organisations first, and so demand came from them. But now it is about directly meeting the needs of the people in the town and referrals from other organisations have fallen. For me this is a good thing and what we should be most proud of in Ilfracombe. If Miriam wasn't doing a good job then people would not recommend her directly." As a result whilst One Ilfracombe spent time in its first few years promoting the service to partners in the town now this is no longer needed.

As well as Miriam the other important part of the social prescribing jigsaw in Ilfracombe is Charmain Lovett, the community development officer. Charmain works to build local community assets as needs are identified by Miriam. She also has capacity to identify and develop new funding streams to fill gaps.

One such need identified was to help over 50s get back into exercise. Miriam had identified a number of people that could benefit from personal training and Charmain worked with Active Devon to bring in funding to subsidise this support so that it was affordable for the people that need it. Another example included working with a private pilates studio to offer subsidised classes for people identified through social prescribing. Having a community developer working alongside a link worker is instrumental in making this happen.

By building community assets and social capital through its work, social prescribing has itself become a key part of social infrastructure in the town. During the first phase of the COVID-19 crisis the strength of this was apparent. Having dedicated personnel, understanding of the community and working relationships across and within all sectors of the community not only enabled the team to respond rapidly but it also gave an additional level of reassurance to the community and the other local services in place.

The close working relationship with the town council and health at the same time was especially important and saved time in developing the response as relationships and ways of working already existed. This degree of place-based coordination is not unique to Ilfracombe but the strength of local relationships and trust that has built over time in the social prescribing team is certainly something that others can learn from.

What challenges have been overcome?

Creating feedback loops

One challenge has been the sharing and processing of information about patients between GPs, other healthcare professionals and the social prescribing team. Miriam is employed by the local authority through One Ilfracombe so is not an NHS employee therefore does not automatically have the necessary permissions to access the GP's IT system 'System One', despite the post now being funded by the NHS.

Whilst a workaround reporting system was developed this took more time than it should and was not as comprehensive as it could be. However, with the strong relationship developed with the practice manager this is about to change and Miriam will have access to the GP's IT system, restricted to the areas that she needs, so that she can record notes and information about patients she sees. It is hoped that this will enable easier monitoring of impact and the building of a shared view across the local authority and GP practice about clients.

Measuring impact on local services

Whilst One Ilfracombe undertook a cost-benefit analysis for two years running this was not without its challenge. Despite using a tried and tested process from the New Economics Foundation there were still some local agencies that did not trust the process as placing a value on much of the work social prescribing does is largely subjective. A victim of its own success the high level of self-referrals made it even more difficult as there was no one organisation making lots of referrals so it was difficult to prove the prevention angle. The process was also incredibly time consuming, and costly for local partners.

Now that funding has started to flow as part of a national policy for social prescribing this complicated element of measurement no longer falls on the shoulders of the social prescribing team. This is not only a game changer for the team in terms of time but also in terms of acceptance of the benefits of the approach with other local partners.

Supporting link workers

Recognising that the social prescribing link worker role is difficult and can sometimes feel a lonely place, One Northern Devon's Social Prescribing Network has designed a system of collective problem solving to enable link workers from across the patch to support each other alongside professionals. Team meetings are held where link workers can present particular cases and seek advice. Representatives from the police often attend along with a GP, a district nurse and any other relevant professionals including link workers from other areas.

Miriam recently used this approach to build a team around person to get advice from others about an individual that had become increasingly dependent over 18 months. Miriam sought ideas on how to approach this situation and get this person to overcome her barriers and engage in the services that she was signposted to instead of expecting the link worker to solve the problems for her.

What does the future hold?

Building on the COVID-19 response to target inequalities

Over the past five years, and in a more intense way over the last six months, One Ilfracombe has learnt a lot about its community and the residents. This is particularly true in relation to health inequalities, which have been thrown into sharp relief by COVID-19. But it also includes greater understanding of the assets within the community, which were clear for all to see with the volunteer response during lockdown.

Based on this intelligence One Ilfracombe is now entirely focused on trying to decrease inequalities and helping to support the new networks to flourish and grow. Ongoing encouragement to people to look to their neighbours first for help, and to offer it.

Digital inclusion was shown to be a real problem – there are broadband issues in North Devon given the rurality so the team are looking at this. Recognising that the inequalities driven by COVID-19 manifest in multiple ways – firstly given the disproportionate effect of the illness on BAME communities and those on lower incomes, but also the unequal impact of the restrictions on those in lower paid manual jobs, One Northern Devon are also doing a lot around employment inequalities.

Focussing on mental health and young people

Mental health, especially for young people, has been an area that One Ilfracombe has wanted to focus more resources to. Again, with the COVID-19 pandemic exacerbating mental health issues for many people One Ilfracombe has decided now is the time to act. They are currently exploring a joint project with the Devon Community and Mental Health Partnership, the NHS body responsible for mental health services in the area. The focus of this is to try and identify ways that social prescribing can help bridge the gaps between statutory mental health services and support in the community.

Applying the social prescribing approach in acute medicine

The social prescribing team in Ilfracombe are now working with a wider North Devon team in partnership with the hospital in Barnstaple to see how they can bring a social prescribing approach to managing people's return to home from hospital. Building on their experience to coordinate local volunteers during the COVID-19 lockdown the hospital has now employed a multi-service volunteer coordinator to act as a link worker between the hospital, the social prescribing link workers and support in the community.

Taking the step from what was originally a primary care community-based approach, One Ilfracombe see the next natural step to spread the approach into other parts of the health and care system. The structure of One Ilfracombe being part of a bigger whole across the North Devon area is enabling that as it is more suited to working across the footprint of hospital and mental health services in the county.

You can learn more about social prescribing in One Ilfracombe **here** or by contacting Hannah McDonald, Partnership Development Manager at One Northern Devon **Hannah.McDonald@northdevon.gov.uk**

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Kingsbridge
building community assets for social prescribing

Summary

A group of people in Kingsbridge with an interest in wellbeing first put social prescribing in place in 2018. A small team of link workers supports individuals to help them identify their ambitions and opportunities available. There is a close working relationship with a community developer in the town and new initiatives to boost wellbeing are developed in partnership with local and national organisations. The numbers of people being supported through social prescribing continues to grow as more people and professionals become aware of what it is and the potential it offers.

Local context

Kingsbridge is a small town situated on an estuary in the South Hams area of rural south Devon. With its proximity to the coastline it is popular with visitors and second homeowners. Kingsbridge has around 6,000 residents, with nearly 30% of people over the age of 65.

The South Hams area consistently records high levels of happiness in national surveys and there are good levels of health generally. However, the risk of loneliness in parts of Kingsbridge is judged to be very high and headline figures mask rural poverty and youth unemployment.

Norton Brook Medical Centre is the GP surgery that serves the primary care health needs of just over 10,000 people in the town and surrounding area. The surgery is part of the South Hams Primary Care Network along with four other surgeries in neighbouring areas of Dartmouth, Ivybridge and Salcombe. Spread over quite a large rural area, relationships are developing across the new network.

What was done?

In 2018 a group of local people set up the South Hams Area Wellbeing (SHAW) Community Interest Company to improve wellbeing in the area. They start by exploring the development of a social prescribing scheme for GPs and other healthcare professionals in three of the local GP surgeries.

In 2019 SHAW secures short term funding from Live Well South West and employs two community-based link workers to introduce individuals referred by GPs and other healthcare professionals into activities and support in the community to boost their wellbeing.

In March 2020 the South Hams Primary Care Network uses its NHS England funding to contract four part time social prescribing link workers through South Hams Council for Voluntary Services (CVS). The SHAW link workers become part of the South Hams CVS link worker team, which is based across the five surgeries. SHAW redirects its resources to employ a community builder that works in partnership with the link worker team to ensure existing support in the community is understood and easily accessed, and that gaps can be filled if they are identified.

Current situation

In September 2020 referrals for social prescribing have picked up to a point where capacity is almost being reached. The majority of consultations are still taking place on the phone although some face-to-face appointments are happening but in community spaces rather than in the GP practice.

In the town there are few community-based activities and services operating face-to-face but there are opportunities to connect with nature or do outdoor physical activity through walking groups for example The SHAW community builder continues to play a leading role in helping to secure funding for new activities in the town, as well as working with others to improve the natural assets, like the parks.

COVID-19

When the COVID-19 crisis hits the UK, the GPs and the new social prescribing link workers in Kingsbridge rapidly contact all patients they feel to be vulnerable and offer to make connections to support in the community where needed. Time is spent developing relationships between the South Hams CVS link workers and the SHAW community builder who makes connections to emergency support from the Kingsbridge Town Council, food bank and local pharmacies.

Throughout the rest of lockdown, as the team is new and referrals for social prescribing are low, there is a focus on training and development delivered virtually by the practice teams through video consultation.

How it works

People are currently referred for social prescribing by GPs and nurses in primary care along with healthcare professionals, like physios, from other settings. Healthcare professionals make a decision on who to refer based on their sense of who might benefit rather than set eligibility criteria. There are no exclusion criteria other than for those with severe mental illness.

There is a simple referral form for professionals to complete which gets emailed to the social prescribing link worker. This is usually followed up within a week with link workers offering flexible options to meet at a convenient time, including early evening to suit people's working hours. The majority of the meetings are currently being offered on the phone but in the past were almost exclusively in person.

At this first meeting the link worker holds a guided conversation to help the individual identify what support and activities might help improve their wellbeing. The link workers try hard to create a relaxed atmosphere, with no time pressures set. As Claire Jeffreys, one link worker, explains, "when face-to-face is possible we invite the individual to meet with us, either in a meeting room or in their own home if mobility or transport is an issue. On average a first meeting might be an hour to an hour and a half."

"The meetings are very relaxed with no strict boundaries on time as we want to be able to give the individual our full attention and for them not to feel rushed."

In more complex cases link workers develop a plan of action together with the individual. In all cases the tone of the conversation is based on goals rather than needs. According to link worker Rosie, "within the meeting we invite individuals to talk about what is happening in their lives at present and to see what goals (if any) they have for the future. We encourage the individual to tell us what is important to them." At this initial meeting the link workers also attempt to capture data to measure a person's wellbeing following the Warwick Edinburgh Mental Wellbeing Scale.

People are then introduced to new opportunities for social contact or other activities and support. The most common introduction is to physical activity with yoga, pilates and the local walk and talk group as the most popular activities. People also commonly seek financial and benefits advice or support with housing issues. These are referred directly to Kingsbridge Citizens Advice who have the relevant expertise. Helen, SHAW's part time community builder has a database of local support, which the link workers help to keep up-to-date.

While NHS England funding now covers the costs of the link workers contracted through South Hams CVS, SHAW funds the community builder through their own fundraising. However, this funding is short term and not secure and there is no funding to cover any costs of the activities or support given. There are free walking groups and exercise classes funded by the council and NHS. In some cases individuals are able to cover small costs themselves – for example for yoga or pilates classes but not everyone is able to do this.

What has been achieved?

Whilst referral rates were slow initially, in the ten months between February and December 2019 the SHAW link workers saw 100 people. Historically over two-thirds of referrals are female and nearly a half are retired. By summer 2020, even with the new team and ongoing COVID-19 restrictions the expanded link worker team hosted by South Hams CVS saw 31 people over July and August.

The experience of Mrs BC is typical of the impact social prescribing in Kingsbridge has. She is registered blind and has a number of health issues that left her feeling very isolated. By spending time with her and connecting her to different organisations in the town Mrs BC has learnt about lots of different ways to improve her day-to-day life.

"Meeting with the link worker has made me realise that there are people out there that care and that they are willing to take the time to listen, to what is important in my life and what matters to me. The connector has given me hope that I can improve my independence."

Another person that has been helped is Mr AG. He is an army veteran that struggles with his mental health. The link workers introduced him to a volunteering opportunity with the National Trust that has had a transformational impact on his life. He said 'once I started going to the National Trust meetings as a volunteer, I suddenly felt a sense of purpose again which helped my self-esteem and gave me confidence in life again. The National Trust have been really understanding and welcoming of me and the 'Combat Stress' day at Overbecks was really useful to be part of and contribute."

Local GP champion of social prescribing, Dr James Mottram, sees the impact on his patients when the link workers really get to the underlying causes of people's health and wellbeing issues. For him this is clearly a good thing for patients, but he also sees the positive impact on his day-to-day work.

"It adds a lot of pleasure to the role of being a GP when you can really find a breakthrough that addresses the root causes of people's problems, even if they are not medical."

Having a dedicated community builder working alongside the link workers makes a big difference to the breadth of non-medical support the team can offer, particularly with ongoing COVID-19 restrictions. One recent success from this partnership approach is the launch of a free ten-week wellbeing programme at Slapton Ley field centre. In the last nine months the SHAW community builder has helped to get this up and running, funded by a range of national and local government sources. There are now over 20 people a week taking part in the course, which offers people suffering from issues like chronic pain, anxiety and depression the opportunity to be physically active in nature with like-minded people.

What challenges have been overcome?

Creating capacity for community building

In the early days the link workers found it a real challenge to keep abreast of what was going on in the community as all their time was focused on trying to meet the demands for individual assessments. They also found that it required a very different skillset.

In response, as additional funding was made available through NHS England for link workers the decision was made locally to continue to invest the resources that had been available social prescribing into a community builder to be able to undertake this work.

For Claire, "it is imperative that this role works hand in hand with the assessor to provide the best outcome for the individual." As such there has been a real focus in 2020 on building close relationships across the organisations and between the individuals doing the assessments with individuals and the community building.

Sharing information between professionals

Another concern that link workers had in the early days was around the level of complexity in the cases they were taking on, especially around mental health, where they did not feel equipped or prepared to deal with the severity of some people's problems. In many cases this was resolved with referrals including more specific background details about issues so that link workers could adequately prepare. In other cases, sometimes the conversations with link workers were the first time such issues had been brought up.

To make sure that there is an opportunity to refer people back for more specialist support a new process where link workers report back by letter to the referring healthcare professional was established. This helps to ensure that patients get an onward referral for more specialist support if they need it. It is also helping to build relationships between link workers and healthcare professionals and ensures that GPs can easily learn more about their patients once they have been seen by a social prescribing link worker.

The need for education

Whilst the idea of social prescribing has started to become much more widely known nationally, the link workers in Kingsbridge have found that this is not necessarily the case across much of their area. Quite often link workers find they have to spend much of the first conversation trying to explain what social prescribing is, especially in comparison to other services that people may have also been referred to.

In other instances, link workers have found that individuals see the meetings with link workers as a counselling session. In response the team are now developing a leaflet that GPs can give to individuals to explain what social prescribing is. They are also creating opportunities for other social prescribing teams and GPs to share their successes with the local Primary Care Network so that healthcare professionals really understand it and can explain it directly to patients.

For link worker Claire the need for more education is understandable given it is a relatively new approach for the area. "Hopefully, within time, and more talk within the media and everyday chat, social prescribing will become an easily accessible service, which is known by all."

What is happening now?

While social prescribing has been underway in Kingsbridge for over two years now it is a new thing for the team to be based within primary care. Work is underway to really embed the link workers into the wider practice team and make sure that others are aware of what the link workers do along with the other new health coach and wellbeing adviser roles being put in place by the Primary Care Network.

There is also a lot of effort being made to try and enable more physical activity programmes that would have historically taken place in gyms and leisure centres but want to move outdoors. Most recently SHAW has received funding from Sport England via their local strategic partner Active Devon to help boost what is on offer locally to support people to be more active, including those that may find accessing traditional groups and classes more difficult because of disability, learning difficulties or existing health conditions.

You can learn more about social prescribing in Kingsbridge **here** or by contacting Dr James Mottram, South Hams Area Wellbeing **jmottram@southhamsareawellbeing.co.uk.**

St Austell
transforming general practice through social prescribing

Summary

Social prescribing was put in place in St Austell in 2016 after three GP practices had merged to form St Austell Healthcare a year earlier It has now been on offer to patients of the GP surgery for over four years.

A team of practice-based link workers and volunteers, working in partnership with other healthcare professionals and local charities, link people into activities and support in the community to boost wellbeing. For the 1,400 people introduced to social prescribing in St Austell since 2016 there has a strong focus on physical activity and nature. GPs report a transformational effect on their approach to managing their workload as social prescribing has developed.

Local context

St Austell is a market town in south Cornwall, close to the coast and tourist attractions like the Eden Project. It is one of Cornwall's largest towns, with around 20,000 residents. There is significant deprivation and parts of St Austell are in the top 10% most deprived areas in England. Life expectancy in these areas is reduced by up to nine years. Higher levels of obesity are recorded in the population than the national average. 23% of people in St Austell have a life-limiting long-term health condition, compared to 18% nationally.

Like the rest of Cornwall, St Austell has a higher proportion of people identifying as socially isolated than the national average. The risk of loneliness is estimated as 'very high' in many parts of the town.

There is one GP practice, St Austell Healthcare, serving the primary healthcare needs of residents in the town and the surrounding area. St Austell Healthcare is also the Primary Care Network for the area.

What was done?

In 2014, one of St Austell's four GP practices collapses, triggering a merger of the remaining three practices in the town. The newly formed practice, St Austell Healthcare, is able to maintain and develop primary care services for the local population. However, a shortage of GPs nationally means a process begins to redesign how primary healthcare is provided to the 32,000 practice population.

In 2015, following discussions with patients, GPs prioritise creating stronger links to community-based support that can help address a range of non-medical issues that impact on health and wellbeing. The initial focus is on people that are socially isolated and would benefit from physical activity.

In 2016 the practice invests in a social prescribing facilitator to work with patients referred by clinicians to identify the right community support for them. Walking groups, diabetes support groups, horticulture therapy and other activities are set up by volunteers recruited by the practice or by partners like the Eden Project.

In 2018 the social prescribing facilitator starts working with developers on a mobile app, Help at Hand, to provide link workers and people in St Austell with an up-to date directory of services in the community. Other organisations also start working in partnership with the social prescribing facilitator and share a physical base in the surgery. This includes staff from local charity Volunteer Cornwall and two lifestyle support workers from Healthy Cornwall, a Cornwall Council initiative to encourage health and wellbeing.

In 2019 social prescribing in St Austell continues to expands to include a full-time manager and three part-time link workers.

Current situation

In September 2020 the social prescribing link workers in St Austell continue to provide appointments with new and existing clients on the phone, or through video consultations. Face-to-face is also now on offer in some situations. Referral rates, whilst reaching 38 in September, are still lower than the 53 referrals for the same month last year. The GP practice as a whole is seeing a big increase in demand from people with mental health issues. These are being triaged between the specialist mental health practitioners and the social prescribing team according to need.

Many local groups and activities have not yet been able to return given government guidelines. At the same time many people, especially in higher risk groups, are understandably cautious about rejoining certain activities. However physical activity is one area where some normality has returned. The social prescribing team has been working closely with Active Cornwall to enable local physical activity providers to keep going during COVID-19 by, for example, starting new classes online. They have also been able to re-launch three of their walking groups, with online walking challenges, access to pedometers and a newsletter and Facebook page.

COVID-19

In March 2020, as COVID-19 hits, the resulting lockdown significantly reduces face-to-face activities and support in St Austell pretty much overnight. In the GP practice concern rises for local residents who rely on face-to-face community groups and volunteer-led services for their health and wellbeing. In response the social prescribing team rapidly repurpose their Help at Hand app to show the support on offer during lockdown. They also systematically prioritise need and make personal approaches to people deemed at risk from COVID-19.

By working in this way and building on their existing partnerships, the St Austell social prescribing team are able to create an effective and rapid response to the crisis and meet the needs of vulnerable people in the community. Further details of the St Austell response in the early days of the COVID-19 crisis is available in a previously published case study on the Institute for Social Prescribing website.

How it works

The way in

During COVID-19 the GP surgery's approach to risk assess their entire practice population identified many older, isolated people that have benefitted from regular contact from the social prescribing team in recent months. At the same time the standard process for identifying patients suitable for social prescribing has continued. GP and other staff members in the practice are able to refer people they think suitable for social prescribing through the clinical IT system, System One.

Referrers complete a short referral form and check the relevant codes for social prescribing referrals. The referral form includes a reminder of people that might be suitable for social prescribing – for example people with long-term conditions, or those suffering from anxiety or at risk of loneliness and isolation. There is also a reminder of a small number of criteria that people must meet, including whether they are ready to make a change to their life to benefit their health and wellbeing. Reporting from the social prescribing back to GPs and healthcare professionals is also done through the same IT system.

Connecting to community support

Once a person is referred through System One they are automatically added to the social prescribing waiting list and one of the link workers follows up with a call. During this first call the person is either signposted to the support they are looking for or invited to meet for a session with a link worker.

During the first session the link worker guides the conversation depending on the person in front of them, supported by prompts on the relevant page of the IT system if needed. These prompts include questions about activities that

the person currently or previously enjoyed and any reasons why they are not now doing them, their support network, dietary history and weight, employment situation and the goals that people may be looking to achieve.

During the conversation, and any subsequent follow-ups, the link worker works with the person to develop a personal action plan centred around their goals. This is then printed out for the person and further referrals, connections or signposting made accordingly.

The support that people are connected into depends on the individual's goals highlighted in their session with link workers. Over 40% of connections made are with opportunities to undertake physical activity. This is followed by weight management (18%), mental health support (15%) and social groups (10%).

There are a number of popular walking groups, some for people with specific conditions and others more general. Other activities include support for healthy eating and cooking and maintaining a healthy weight, counselling and horticulture therapy, and social groups including lunch clubs. Some group leaders and providers of support will meet with people before they join if they are lacking in confidence. The leader of the Men's Society for example will often meet new joiners beforehand for coffee and walking group leaders will often act as a buddy for someone's first time.

Between them St Austell Healthcare and NHS England cover the costs of the link worker team and their manager but there is no funding for activities and support that people are referred into. Therefore the team have identified free or cost effective options in the local area and developed arrangements with partners for reduced costs for referrals where appropriate. The Help at Hand App has a filter function on it related to cost so that these activities can be easily found.

Collecting data to measure impact

In the initial conversation new clients are asked a series of questions from the Warwick and Edinburgh Wellbeing (WEMWBS) scale, which is commonly used measurement tool for social prescribing. Individuals are asked to rate how they have been feeling in the previous two weeks about difference things like the future, closeness to other people and usefulness. People's Body Mass Index is also measured. These combined measures form the baseline for comparing individuals progress before and after social prescribing.

Recognising that data is not the only way to measure impact, the social prescribing team also periodically collect and publish case studies of how their work affects the people involved, often in partnership with others like the Eden Project.

What has been achieved?

The social prescribing team has now received referrals for over 1,400 people in total and 900 in the last two years alone. There are almost twice as many women referred as men and a spread of ages. 20% of referrals are aged over 70 and nearly 25% are aged under 40.

Vanetta's story is a good example of what is achieved in St Austell. After being diagnosed with type two diabetes in 2016 she wanted to take steps to turn around her diagnosis without medication. Following an initial session with link worker Hayley Burgoyne she joined the diabetes walking group at the Eden project. With the walking, along with other exercises, Vanetta lost over 2 stone and her blood sugar levels returned to a normal level. Whilst the improvement in her health has been very important to Vanetta there have been other longlasting knock-on benefits, including training to become a walk leader and making new friends, all of which has improved her life and overall wellbeing.

As well as its impact on individuals the social prescribing team has also built a number of new community activities, like its walking groups and relationships with over 20 community partners that it regularly refers people into. A number of these relationships, especially with Volunteer Cornwall and Healthy Cornwall – were intensely strengthened during the first phase of COVID-19 further helping to build social capital within and between the community and health sector partners.

After involvement with the social prescribing team over 71% of people report an increase in wellbeing and 76% of people record a reduced Body Mass Index.

However, it is the impact that the local GPs see that is perhaps the most transformational. Data collected and analysed for 2017 showed that 6 months after meeting with a social prescribing link worker there was a 48% reduction in GP appointments for the patients studied.

For Dr Stewart Smith, GP partner of St Austell Healthcare and Clinical Director of the Primary Care Network, the impact goes far beyond just the numbers. He said "data from Health Education England shows that younger doctors have different career aspirations to older generations, they are less motivated by money, want to work less hours, have more flexible portfolio style careers and are more driven by social and environmental ideas. Anecdotally we have found that practices with flourishing social prescribing schemes find recruiting younger doctors easier. It seems to re-ignite the simple reason that many of us became doctors in the first place – to help people."

What challenges have been overcome?

Tailoring support to individuals

In the early years all people referred for social prescribing were seen face-to-face in a one-to-one meeting. But over time the social prescribing team has come to understand that not everyone wants or needs this level of support.

Some people are just looking to be pointed in the right direction to support they have already identified would be beneficial. For others more indepth one-to-one work is needed to help identify what their goals are in life and how they can achieve them. As a response the social prescribing team now ask referrals to include details of the level of support they think might be needed, for example signposting or more indepth one-to-one support. The team then tailor their initial response accordingly.

Building practical knowledge of working practices

Given people can be referred into a wide range of support in the community it can be daunting for link workers to know how to do this, especially as there are different processes and preferences for different organisations.

As a relatively large and growing team of link workers manager Hayley Burgoyne knew that it did not make sense for each link worker to hold all this information themselves. "Whilst the Help-at-Hand App is helpful in terms of finding support out there, the public facing resource does not contain all the relevant information that a social prescribing link worker might want to know" said Hayley.

In response Hayley started to pull together all this information for the team including details for how to link someone into the support. For example, there are some that need an official referral form completing, like Healthy Cornwall, and submission of this might be online or by email. Others request an email to say a new member may be joining and others like to talk with new joiners beforehand.

This information about the referral process is now stored in the back office function of the App. his back office function also gives the surgeries full access and control of the data so that the team can, at any time of day or night, update, add or hide a service. It also enables the team to include 'referral only services' that the team can see but are not displayed publicly.

What is happening now?

The social prescribing team is working in partnership with Patientcards Limited (the Help at Hand developers) to develop an integrated patient management system for social prescribing that integrates with the App/directory of services. The aim is to develop a streamlined, intuitive, user friendly platform that will save surgeries time and money as well as provide a powerful tool for evaluation

St Austell Healthcare have become ever more aware that many disadvantaged young people in the town are likely to be further disadvantaged as a result of the covid-19 pandemic. They are therefore looking to expand their social prescribing team to include a specialist link worker for young adults aged between 16 and 25 years in the team.

To help inform the priorities of the new link worker St Austell Healthcare are undertaking work in parallel to work with young people in the town to better understand what life is like for them in St Austell, what challenges they face and what would make a difference to them. They are also engaging widely with colleagues in the voluntary and community and other local agencies to identify the priority themes where coordinated local action could make a difference. Supported by the South West Academic Health Science Network, the team are drawing on learning from the Culm Valley and Cullompton Youth Forum, Luton and Streetgames more widely.

You can learn more about social prescribing in St Austell **here** or by contacting St Austell Healthcare's Head of Social Prescribing, Hayley Burgoyne **hayleyburgoyne@nhs.net**.

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