Overview and Scrutiny

Social prescribing

March 2018

Membership of the Healthier Communities Select Committee in 2017/18:

Councillor John Muldoon (Chair)
Councillor Susan Wise (Vice-Chair)
Councillor Paul Bell
Councillor Peter Bernards
Councillor Colin Elliot
Councillor Sue Hordijenko
Councillor Stella Jeffrey
Councillor Olurotimi Ogunbadewa
Councillor Jacq Paschoud
Councillor Joan Reid

Social prescribing in Lewisham

Chair's introduction

Social prescribing has received considerable media coverage in recent months. Radio 4's "Today" programme reported how South Dakota's Department of Health national park prescription scheme aimed to provide access to the physical, mental, and social benefits of exercise in nature.

Theodore Zeldin, the academic who established the Oxford Muse Foundation and who twice visited Lewisham, has paid much attention to questions such as how we may find more inspiring ways of spending each day and what roles there could be for those who feel isolated or different, or misfits. His thoughts on the future of work ask what roles there will be for the many of us who live to be 100 years old. Suggestions such as mentoring younger people and other ways of transmitting skills and experience will benefit many, on both sides of the arrangement. This is not, I submit, social prescribing.

Social prescribing involves a referral, by a primary care clinician, of a patient with social, emotional or practical needs to an appropriate non-clinical resource, with an identified desired outcome, involving that patient's wider health and wellbeing.

Even the most ardent advocates of social prescribing would concede little is known of long-term outcomes. There have been few systematic reviews on the effectiveness of social prescribing on health. There is little recent evidence to support the cost-effectiveness of social prescribing compared to that of traditional primary care, although there may be cost savings when considering referral to specialist and secondary care.

This review endeavours to examine local forms of social prescribing, to assess the beneficial impact on those in receipt of it, and recommend potential future developments.

Councillor John Muldoon (Chair of the Healthier Communities Select Committee)

Executive Summary

1.1 Social prescribing is a way of enabling GPs, nurses and other primary care professionals to refer people with social, emotional or practical needs to a range of local, non-clinical services. Typically provided by local community and voluntary sector organisations, social prescriptions often include activities such as volunteering, gardening and arts activities.

1.2 Interest in social prescribing has increased in recent years as the NHS looks for ways of caring for an ageing population with an increasing number of long-term conditions. The NHS England General Practice Forward View also highlighted social prescribing as a mechanism to reduce demand on stretched primary care services.

1.3 There is emerging evidence that social prescribing can lead to a range of positive health and well-being outcomes, and that getting people involved in community life, keeping them active and improving social connections is good for both health and wellbeing. There are now more than 100 schemes across the UK, a quarter of which are in London.

1.4 In Lewisham, the use of social prescribing is part of the wider shift by health and care providers towards prevention, early action and enabling people to look after themselves. Key social prescribing initiatives in Lewisham include *Community Connections*, which supports vulnerable adults to access a range of community groups, and *Lewisham SAIL*, which is specifically targeted at older people (60+).

1.5 There is also a wide range of voluntary and community-sector organisations in the borough involved in the provision of or referral to social prescribing activities. During the course of the review, the Committee heard from, among others, Sydenham Garden, Lewisham Carers, Lewisham Speaking Up, Bromley and Lewisham Mind, and Lewisham Disability Coalition.

1.6 There is good evidence of the effectiveness of a number of social prescribing interventions in Lewisham. For example, in 2016/17, 68% of those supported by *Community Connections* and 79% of those supported by Bromley and Lewisham Mind's Community Support Service reported an improvement in their wellbeing.

1.7 Witnesses told the committee, however, that more consideration needs to be given to how social prescribing interventions are evaluated and that more services should have clear outcome measures so that evidence on the effectiveness of interventions can be shared more easily.

1.8 The majority of social prescribing activity in Lewisham is targeted at specific groups and there remains a variety of unmet need in the borough. This includes provision for the under 60s, men, people unable to leave their home and, in particular, people with learning disability and mental ill health.

1.9 GPs in Lewisham would like to see more social prescribing – 35-40% of consultations relate to social issues, such as debt, family and general wellbeing problems. However, awareness of social prescribing among GPs needs to be improved and social prescribing referral pathways need to be quick, easy and effective for GPs to continue to use.

1.10 The committee has carefully considered the evidence put before it and has made a series of recommendations to improve the evidence base for social prescribing interventions and address the gaps in social prescribing provision. The committee's recommendations are set out in full in the following section.

Recommendations

Community and voluntary-sector organisations

1. *Given the importance of those involved in social prescribing, both prescribers and providers, building a better understanding of the usefulness and effectiveness of different referrals and interventions for different people and different needs, the committee recommends that following up on referrals and gathering feedback from all parties becomes a compulsory part of the Community Connections referral process. This would allow GPs and other organisations better understand each referral and better target social prescribing interventions.*

Evidence of effectiveness

2. *The committee notes that there is evidence of the effectiveness of social prescribing interventions in the borough. However, given that there is still a significant lack of a coherent body of evidence, generally and locally, the committee recommends that officers look into ways of building a more comprehensive database of evidence and feedback. This should include statistical analysis of wellbeing outcomes where available, but it should also include patient-reported feedback and case studies.*

3. *In order to build a more comprehensive database of statistical data the committee also recommends that officers look into the possibility of drawing up a set of clear outcome measures for social prescribing interventions, which could be reported on and shared with health and care partners, particularly GPs and services users. The committee suggests that it may be helpful to link this information to the Lewisham health and social care directory of services so that prescribers, providers and service users can view it when searching for services.*

Gaps in provision and awareness

4. *Given the evidence the committee has received on the loneliness rates among people with learning disability and the rates of mental ill health among young adults, and the long-term health impacts of these, the committee recommends that Lewisham health and care partners pay particular attention to addressing the gaps in support for young adults with learning disability, men's groups and those experiencing mental ill health.*

5. *There is evidence that existing services in the borough need more support with capacity building, and the committee recommends that Lewisham health and care partners continue to help with this, but the committee also recommends that officers also explore appropriate opportunities to work with national and neighbouring borough services.*

6. *Given that lack of awareness and knowledge of social prescribing among GPs appears to be acting as a barrier to its wider use, the committee recommends that Lewisham health and care partners focus on raising awareness of social prescribing, including evidence of effectiveness, among GPs and the wider clinical community as a priority.*

7. *One measure that should be further explored is locating more social prescribing representatives in key GP practices. Without high levels of awareness among the GP community, people will miss opportunities to access activities and support which could help them. And without high levels of awareness and use by GPs, officers will be unable to accurately assess local gaps and the effectiveness of particular interventions.*

8. *The committee also notes the concern that organisations which signpost people can end up adding an extra step to the patient's journey and recommends that Lewisham health and care partners ensure that any social prescribing mechanism developed is as quick and easy-to-use as possible, for both prescribers and service users.*

The purpose and structure of this review

4.1 At its meeting on 25 April 2017 the Healthier Communities Select Committee agreed to hold an in-depth review of social prescribing.

4.2 At its meeting on 13 June 2017, the Committee agreed the scope of the review.

4.3 The key lines of enquiry were:

The extent of social prescribing in Lewisham: Who are the partners and organisations currently involved in the development and provision of social prescribing services? What types of activities and interventions are provided, and how many people are being referred? What types of problems is social prescribing commonly used for, and which groups of people tend to be most commonly referred?

The plans for social prescribing in Lewisham: What is the potential for expanding social prescribing in Lewisham? For which problems and groups of people could it play more of a role? What further partners and organisations could be involved in the development and provision of social prescribing? What is the capacity of local partners and organisations to provide more services?

The effectiveness of social prescribing in Lewisham: For which problems and groups of people has social prescribing been used most effectively? How are the outcomes of activities and interventions captured and measured? How is the effectiveness and efficiency of social prescribing schemes evaluated?

The gaps in social prescribing coverage: For which problems and groups of people is social prescribing coverage lacking? What further help and support do providers and other local organisations need to reach more people? What help and support do providers and local organisations need to improve the way they work more generally?

4.4 The timetable for the review was:

First evidence session – 20 July 2017
Council officers, Lewisham Clinical Commissioning Group (CCG), Community Connections, Lewisham Safe and Independent Living (SAIL).

Second evidence session – 7 September 2017
Lewisham Disability Coalition, Rushey Green Time Bank, Sydenham Gardens, Lewisham Local Medical Committee, Healthy Living Centre, the Big Group.

Report – 1 November 2017
Committee to consider the final report presenting all the evidence and agree recommendations for submission to Mayor and Cabinet.

Introduction and policy context

5.1 Interest in social prescribing has increased across the UK primarily because of the increasing burden on the NHS of long-term conditions and the growing crisis in general practice.[1] The challenge of caring for an ageing population and supporting people with long-term conditions is one of the most important the country faces – chronic illnesses consume approximately 70% of the health budget.[2]

5.2 Professor Sir Michael Marmot's 2010 review, *Fair Society, Healthy Lives*, pointed out that the majority of health outcomes are attributable to social-economic factors. In fact, it is estimated that around a fifth of visits to GPs are for a social problem rather than medical one.[3] It is also acknowledged within primary care that around 30% of all consultations and 50% of consecutive attendances concern some form of mental health problem, usually depression or anxiety.[4]

5.3 Given the increasing pressure in primary care, the fact that there is often no cure for many long-term conditions, and that GPs are not necessarily equipped to handle all the social and psychological burdens that patients present, some health experts argue that it is necessary to look beyond the traditional clinical model the NHS offers and develop new approaches, including social prescribing.[5]

5.4 Some commentators believe that, by connecting people with local community services and activities, we can help improve the health and wellbeing of large numbers of people. Social prescribing, and a more holistic approach, is increasingly being seen as a potential solution to the burden of managing long-term conditions and repeat attendees in surgeries.[6]

5.5 Social prescribing was highlighted in NHS England's General Practice Forward View as a mechanism to support more integration of primary care with wider health and care systems to reduce demand on stretched primary care services. The south east London Sustainability and Transformation Plan (STP), in common with all of London's STPs includes a commitment to self-care and social prescribing. (officer report)

5.6 Industry experts recognise, however, that links between primary care and third sector organisations are often underdeveloped, and that there is currently little robust evidence demonstrating the effectiveness and efficiency of social prescribing schemes.[7]

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[1] Kimberlee, R. (2015) What is social prescribing? *Advances in Social Sciences Research Journal*, 2 (1), p102
[2] Local Government Association, *Just what the doctor ordered: social prescribing – a guide for local authorities*, May 2016, p2
[3] *ibid*
[4] Kimberlee, R. (2015), p102
[5] *ibid,* it is anticipated that consultation rate will increase by 5% over the next 20 years.
[6] Kimberlee, R. (2015), p102
[7] *ibid*

What is social prescribing?

6.1 Social prescribing, or "community referral", is a way of enabling GPs, nurses and other primary care professionals to refer people with social, emotional or practical needs to a range of local, non-clinical services. Social prescribing, recognising that people's health is determined by a range of social, economic and environmental factors, seeks to address people's needs in a holistic way, and to support individuals to take greater control of their own health.[8]

6.2 Social prescribing schemes can involve a variety of activities, which are typically provided by voluntary and community sector organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports. It can also involve simply putting people in contact with services that can provide help and advice with issues such as debt, benefits and housing.[9]

6.3 Social prescribing and similar approaches have been used in the NHS for many years, with several schemes dating back to the 1990s. The Bromley by Bow Centre, for example, one of the oldest and best-known social prescribing projects, was established in 1984 (see case study below). However, interest in social prescribing has increased over the past decade or so, with more than 100 schemes now running across the UK, more than 25 of which are in London.[10]

Social prescribing in Lewisham

7.1 In Lewisham, the use of social prescribing is part of the wider shift by health and care providers towards prevention, early action and enabling people to look after themselves – by finding information or making connections in the local community, for example. Lewisham health and care partners said that social prescribing is not necessarily a medical model; it is more concerned with supporting an individual's wider health and wellbeing including any underlying issues such as social isolation.

7.2 Social prescribing is also a key focus of the four Neighbourhood Care Networks being developed in the borough (a central part of the wider integration of health and social care in Lewisham), and a number of tools have been developed at a neighbourhood level to support social prescribing.[11] This includes Neighbourhood Community Teams,[12] Multi-Disciplinary Meetings and Neighbourhood Co-ordinators,[13] and Lewisham's Single Point of Access.[14]

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[8] King's Fund, *What is social prescribing? (webpage)*, February 2017 (accessed May 2017)
[9] Local Government Association, *Just what the doctor ordered: social prescribing – a guide for local authorities*, May 2016, p4
[10] King's Fund, *What is social prescribing? (webpage)*, February 2017 (accessed May 2017)
[11] Lewisham's Neighbourhood Care Networks aim to provide more integrated, higher quality, more timely, and cost-effective community-based care by bringing together, at a local level, the different organisations, individuals and agencies involved in a person's health and care. They also aim to establish connections with other local support available, such as that provided by local voluntary and community organisations or by housing, welfare or education providers. (Source: Health and adult social care integration, HCSC in-depth review final report, March 2017)
[12] virtual teams of district nurses and adult social care staff
[13] to support health and care staff to improve multi-disciplinary working
[14] To provide general health and care information and advice

7.3 An overview of some of the other key initiatives related to social prescribing in Lewisham is set out below.

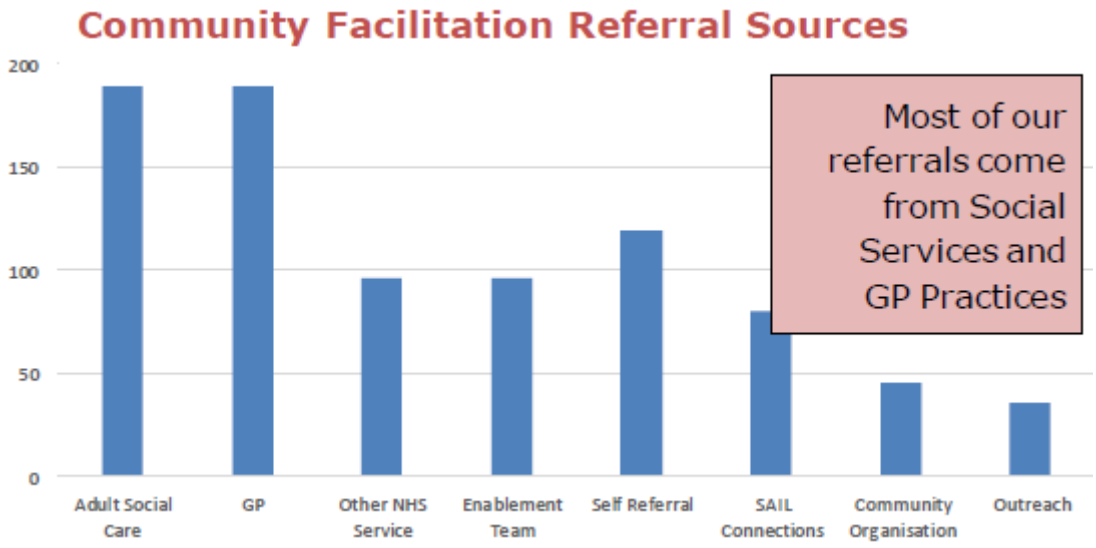
Community connections

8.1 Established in 2013 by a consortium of voluntary sector organisations led by Age UK Lewisham and Southwark, *Community Connections* is a community-development programme with the aim of decreasing social isolation and improving mental wellbeing.

8.2 The programme helps vulnerable adults access community-based groups and activities, such as lunch clubs, befriending services and community learning, and it supports local voluntary and community-sector organisations to build capacity and develop services to meet local needs.

8.3 *Community Connections* was commissioned to provide greater access to social prescribing activity, in recognition that social isolation and loneliness can be bigger predictors of ill health than smoking and obesity.[15]

8.4 In 2016/17, *Community Connections* received more than 900 referrals. This included 200 from adult social care, 200 from GPs, 120 self-referrals, and 40 from outreach work. 690 of these received a person-centred support plan following a home visit from a Community Facilitator. 57% of people supported were over 65 years old.[16]



Source: Community Connections Annual Report 2016/17

8.5 The needs that people are most often referred for include social isolation, mental ill health, dementia, access to activities and groups, and information and advice. The support people are most often referred to include social activities, groups for those with learning disabilities, volunteering opportunities, men's groups, and mental health support.

[15] UK must tackle loneliness, says Jo Cox Commission report, *BBC News*, 14 December 17
[16] Community Connections Annual Report 2016/17, p9

Neighbourhood Community Development Partnerships

9.1 With one in each of the four neighbourhood areas in the borough, Neighbourhood Community Development Partnerships (NCDPs) work with local community groups and organisations to help them to connect to statutory providers and build capacity by recruiting, supporting and training local volunteers. In 2016/17, community-development workers developed 55 organisation-support plans, working with various community groups and organisations to develop new projects and increase the capacity of existing projects.

9.2 Each Neighbourhood Community Development Partnership will be responsible for producing a Neighbourhood Community Development Plan. This will use the findings from Community Connections' analysis of gaps in local services in order to identify key priorities for the neighbourhood. A grant of £25k per partnership will be available to deliver local solutions to the local priorities identified. Health and care partners stated that NCDPs have the potential to expand the role of the voluntary and community sector in social prescribing.

Social prescribing review group

10.1 The Social Prescribing Review Group was established in December 2016 to develop a system-wide approach to the development of social prescribing in Lewisham. The group includes representation from secondary care, primary care, public health, social care and *Community Connections* and aims to review the activity in the borough that might be considered social prescribing, identify gaps in provision to improve targeting of activity, and consider a more coherent social prescribing model. The review is considering the infrastructure and capacity of the local voluntary and community sector and whether social prescribing is always an appropriate and reliable resource. There will be a particular focus on projects where there is a link worker in place (as per the Social Prescribing Network definition).

The three key components of a social prescribing scheme:

- a referral from a healthcare professional,
- a consultation with a link worker, and
- an agreed referral to a local voluntary, community and social enterprise organisation.

Social Prescribing Network (January 2016)

10.2 There will also be a particular focus on the mechanism by which social prescribing referrals are made and what support the council can provide to ensure this operates as effectively as possible. Health and care partners stated that while there is considerable data on individual interventions, there is much less on the different referral mechanisms in use.

10.3 As well as those who may need support face-to-face or over the phone, health and care partners stated that it is important to consider how to support those

who are able to navigate the health and care system themselves, for example, by making online information easier to access.

10.4 Given that the evidence on social prescribing shows that the most effective social prescribing schemes are targeted at particular groups, the review will also consider whether the appropriate groups are being targeted. Officers noted that Healthy London Partnership has recently carried out analysis of GP practice data in Lewisham in order to work out which groups, if targeted, could benefit most from social prescribing.[17]

Lewisham SAIL

11.1 Fully launched in 2017, Lewisham SAIL (Safe and Independent Living) is intended to provide a quick and simple way of accessing local services to support older people (60+) with their independence, safety and wellbeing.

11.2 Lewisham SAIL has formed partnerships with a range of organisations to provide referrals for support with, among other things, health and wellbeing, mental resilience, social Isolation, financial inclusion, fire safety, home security, safeguarding and personal safety and security. Anyone can make a SAIL referral by completing the one-page checklist (see appendix).

11.3 Between July 2016 and March 2017, Lewisham SAIL received 194 referrals from more than 50 different organisations, including GPs, adult social care, the police, fire brigade, local NHS trusts, and various voluntary sector and community groups. 25% of referrals came from GPs.[18]

[17] The Healthy London Partnership advocates the increased use of social prescribing and has been working to identify, using existing data sets, the numbers of people who may benefit in London from social prescribing. It also intends to calculate the return to the NHS in London on investment in implementing social prescribing initiatives over a five year period to March 2021.
[18] Lewisham Safe and Independent Living (SAIL) Connections Impact Report July 2016- March 2017, p2

11.4 The service is targeted at those aged 65 and over because older people are more likely to have more than one long-term condition, to become socially isolated, to need help finding support, and less likely to have access to the internet. But SAIL will "do everything [they] can to help people access the services required even if they don't fit perfectly onto the checklist". The average age of those who have use SAIL is 78.[19]

11.5 SAIL works closely with *Community Connections* and the Neighbourhood Community Development Partnerships in order to maintain its knowledge of the various groups and providers in the borough.

11.6 Lewisham health and care partners are planning a review of the SAIL initiative. This will evaluate the early stages of the programme and consider gaps and recommendations for improvement.

Lewisham health and social care directory

12.1 The development of the Lewisham health and social care online directory of services is closely linked with the future development of social prescribing in the borough. The online directory will allow people to search by postcode for a broad range of services and activities. Improvements are currently being made to the content and functioning of the site, including the development of a screening tool, in the form of a questionnaire, which will be linked to the services in the directory.

Community and voluntary-sector organisations

13.1 In Lewisham, there are a wide range of voluntary and community-sector organisations involved in the provision of or referral to activities that could be described as social prescribing. During the course of the review, the Committee heard from a number of these organisations including: Sydenham Garden, Lewisham Carers, Lewisham Speaking Up, Bromley and Lewisham Mind, Lewisham Disability Coalition, and the Lewisham Local Medical Committee.

13.2 Sydenham Garden provides fixed-length social and creative activity for people experiencing a wide range of mental ill-health. They also provide similar activities for people recently diagnosed with dementia. This is Sydenham Garden's core provision and all of their "co-workers" (the name they give people who access their services) are referred by health professionals. In 2016/17, Sydenham Garden received 421 referrals. In 2015/16 they received 403 referrals and in 2014/15 they received 269.[20]

13.3 Lewisham Carers operates on a neighbourhood model throughout Lewisham, providing regular "pop-up" advice and information sessions in GP practices. They provide a wide range of advice, information and advocacy, emotional support and specialist support. Lewisham Carers also seek and respond to

[19] ibid, p9
[20] Annual Evaluation of Sydenham Garden 2016 – 2017, p3

feedback and understand that the services they provide are much needed and helpful.

13.4 Lewisham Speaking Up works exclusively with adults with learning disability. They run a number of groups and activities that could be described as social prescribing and make referrals to other schemes that could be described as such. They are aware of other groups for people with learning disability, such as “Heart n Soul”, an arts-activity group. From being based in the Albany in Deptford, they are also aware of a number of schemes specifically for older people, such as “Meet me at the Albany”, which is another arts-based programme.

13.5 Lewisham Speaking Up has recently received funding from the Deptford Challenge Trust to set up a “Speak Up and Wellbeing” group for adults with learning disability who receive little or no support from statutory services. This stemmed from organising a “People’s Parliament” event on loneliness and friendships, at which 60% of people with learning disability said that they experienced loneliness. Those who said they were lonely were often those who received traditional services such as a day service or support in the community.

13.6 The Lewisham Disability Coalition (LDC) provides an advice service primarily for adults living with a long-term health problem or disability. They are part of *Community Connections* and signpost to other groups and organisations. Many people who approach LDC for advice are in fact lonely. LDC said that being part of Community Connections makes it easier to refer people on to more appropriate support.

13.7 Bromley and Lewisham Mind provides a range of community-based mental health support services, This includes the Community Support Service (CSS), Peer Support Service, MindCare (for people with dementia), and Mindful Mums (for pregnant and new mums).

13.8 Support from the CSS usually lasts for 12-20 weeks. Towards the end of their support, Mind often signposts people to other community groups and organisations in order to sustain the mental health improvements made during their short-term support. Mind will also follow up to check if there are any barriers to people engaging. Mind noted that it’s easy to pick out a community-based activity, but “whether it’s suitable, understanding, welcoming and appropriate for a particular person with a mental health problem is another matter altogether”.

13.9 In 2016/17, Mind’s Community Support Service received 540 referrals. 33% of these were from secondary care, 18% were self-referred and 17% were from GPs. GP referrals came from 25 practices in the borough. Nine of these provided 76% of all GP referrals. The issues most often mentioned in referrals include: motivation and confidence (85%), meaningful use of time (75%), developing skills (65%), money, budgeting and social activities (50%).

13.10 The committee noted the importance of following up on referrals and gathering feedback and drew attention to written evidence from a local GP

who had not received any feedback after making referrals to Community Connections, which he said makes it very difficult to understand how useful or effective a referral has been. The committee also recalled a previous visit to Downham Leisure Centre where GPs were not following up and it seemed that people were being referred but not attending. As an example of good practice, the committee cited the Abbots Hall Road Healthy Lifestyle Centre, which provides follow-up, mentoring and coaching.

Recommendation

1. *Given the importance of those involved in social prescribing, both prescribers and providers, building a better understanding of the usefulness and effectiveness of different referrals and interventions for different people and different needs, the committee recommends that following up on referrals and gathering feedback from all parties becomes a compulsory part of the Community Connections referral process. This would allow GPs and other organisations better understand each referral and better target social prescribing interventions.*

Evidence of effectiveness

14.1 There is emerging evidence that social prescribing can lead to a range of positive health and well-being outcomes, and that getting people involved in community life, keeping them active and improving social connections is good for both health and wellbeing.[21]

14.2 Studies have pointed to improvements in areas such as quality of life and emotional wellbeing, mental and general wellbeing, and levels of depression and anxiety.For example, a study into a social prescribing project in Bristol found improvements in anxiety levels and in feelings about general health and quality of life.[22]

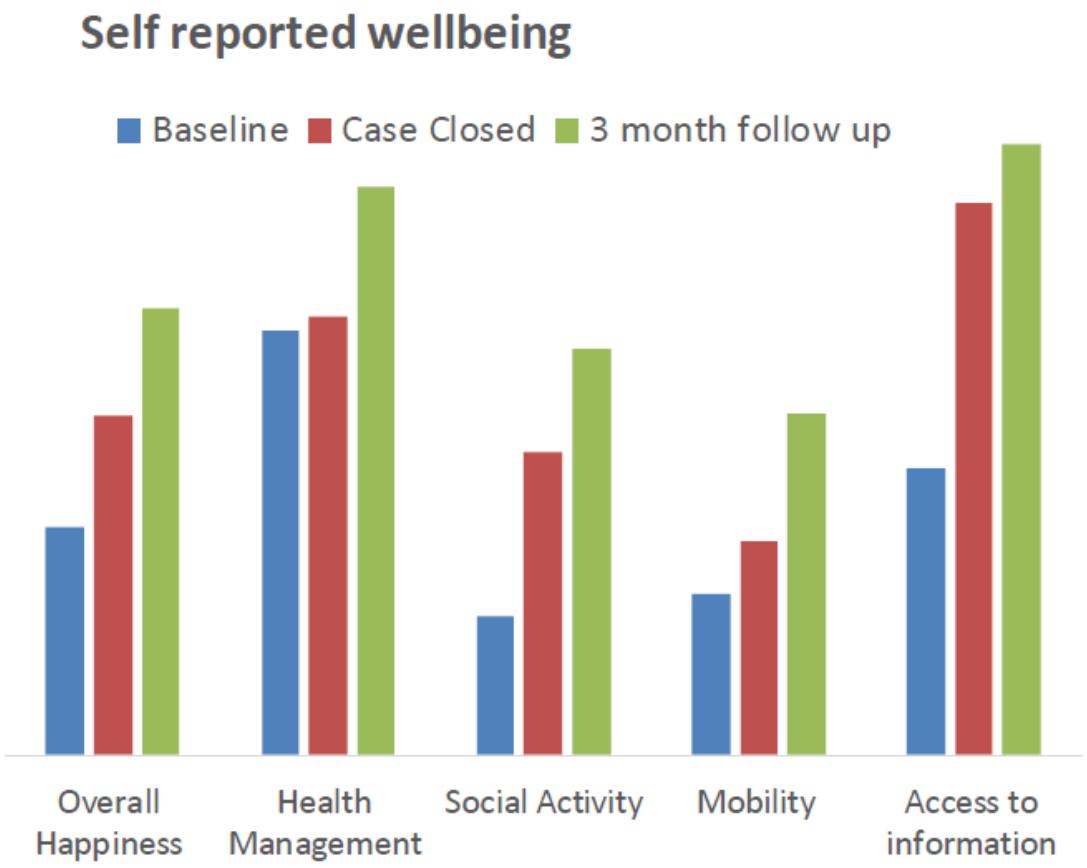
14.3 Social prescribing schemes may also lead to a reduction in the use of NHS services. A study of a scheme in Rotherham found, for more than 8 in 10 patients referred, that there were reductions in NHS use in terms of accident and emergency attendance, outpatient appointments and inpatient admissions.[23]

14.4 However, commentators have noted that systematic and robust evidence on the effectiveness of social prescribing is very limited. Quantitative evidence deploying robust methodologies to demonstrate effectiveness is particularly hard to find.[24]

14.5 In Lewisham, 68% of those supported by *Community Connections* in 2016/17 reported an increase in mental wellbeing. This is based on a five-item wellbeing checklist completed at the start and end of the intervention. A three-month follow-up found that self-reported wellbeing continued to increase after the end

[21] *ibid*, p5
[22] King's Fund, *What is social prescribing? (webpage)*, February 2017 (accessed May 2017)
[23] *ibid*
[24] Kimberlee, R. (2015), p108

of Community Connections' involvement. From the point of referral to three months after the intervention was completed, there was a 10% increase in average wellbeing score.



Source: Community Connections Annual Report 2016/17

14.6 Sydenham Garden said that in their experience a number of their projects are "some of the most effective non-clinical interventions". Based on their scores on a recognised wellbeing scale, co-workers leave Sydenham Garden with their wellbeing at normal levels. This has been confirmed through case studies, focus groups, questionnaires and carer feedback. With Sydenham Garden's Garden Project, for example, in 2016/17, 68% of co-workers recorded a positive change to their mental wellbeing.[25]

14.7 In 2016/17, 79% of those supported by Mind's Community Support Service recorded a meaningful improvement in their wellbeing. The biggest improvements were in "feeling significantly better about themselves, more cheerful and confident, and that they were dealing with their problems well". In a survey rating satisfaction with the service at point of discharge, 150 clients expressed an average 91.2% satisfaction.

14.8 Lewisham Speaking Up noted from their experience of supporting people with learning disability that the most important non-clinical interventions are those that address the social problems this group can face. This includes helping people with debt, benefits, and housing problems, and providing self-advocacy

[25] Annual Evaluation of Sydenham Garden 2016 – 2017, p5

which addresses issues with self-esteem, confidence, meeting friends and socialising. Activity-based groups such as arts, gardening and sports also work well. Lewisham Speaking Up recognised that much of the evidence on social prescribing is more anecdotal than quantitative, but stressed that in their experience people “really value these groups and activities”.

14.9 The committee heard from a number of witnesses that more consideration needs to be given to how social prescribing interventions are evaluated. More services should have clear outcome measures so that more evidence on the effectiveness of interventions can be shared. As well as data, the committee noted that patient-reported feedback is also important evidence of effectiveness, which should be capable of being captured, analysed and shared. The committee discussed with a number of witnesses whether a lack of coherent evidence on social prescribing, generally and locally, could be one of the barriers to greater take-up among GPs and the wider clinical community.

Recommendations

2. *The committee notes that there is evidence of the effectiveness of social prescribing interventions in the borough. However, given that there is still a significant lack of a coherent body of evidence, generally and locally, the committee recommends that officers look into ways of building a more comprehensive database of evidence and feedback. This should include statistical analysis of wellbeing outcomes where available, but it should also include patient-reported feedback and case studies.*
3. *In order to build a more comprehensive database of statistical data the committee also recommends that officers look into the possibility of drawing up a set of clear outcome measures for social prescribing interventions, which could be reported on and shared with health and care partners, particularly GPs and services users. The committee suggests that it may be helpful to link this information to the Lewisham health and social care directory of services so that prescribers, providers and service users can view it when searching for services.*

Gaps in provision and awareness

15.1 The Social Prescribing Review Group has so far found that the majority of social prescribing activity in Lewisham is targeted at specific groups, such as people aged over 60, or people with long-term conditions, for example. The group also found that there is clear gap in support for people under 60.

15.2 SAIL Lewisham noted that there is unmet need for a range of support, particularly home visits to provide information and advice to people who are unable to leave their home. The committee also heard that social prescribing needs to be accessible to those who are unable to leave their home to engage with support because they have social phobia.

15.3 SAIL is aware of a gap in social prescribing support for people under 60, as they continue to receive referrals from people in their 40s and 50s. SAIL said

that GPs in particular have difficulty finding support for people who are over 50, but under 60 – often people who are vulnerable.

15.4 The Lewisham Disability Coalition (LDC) said that social prescribing could play more of a role for people with learning disability in particular. There are only two organisations that people with learning disability can be referred to, and during the school holidays there are none. There is also significant gap in support for people who need help navigating the health and care system, including social prescribing.

15.5 Among people with learning disability, there is a demand for more support with developing a social life, which can be very difficult for some people with learning disability and autism. Lewisham Speaking Up noted that disabled people experience higher levels of loneliness, which is detrimental to overall health. More support and interventions around making friends and developing relationships, including sexual ones, would help people with learning disability live happier and healthier lives.

15.6 There is an appetite for more social prescribing activity among the adults with mental ill-health that Sydenham Garden work with, and among the professionals that refer to them – Sydenham Garden receive a third more referrals than they can place. Ecotherapies, creative and social activities, peer support and physical activity are all social prescriptions that would benefit people with mental ill-health.

15.7 Mind noted that there is a lack of social prescribing options for younger people (14-25) in particular. Mind's own services are predominantly used by the 35-55 age group (as this tends to be the age at which people are more vulnerable to relationship, debt or social exclusion problems), but Mind noted that 75% of mental health problems begin before the age of 14 and that one in six young people have a mental health problem. The Chair of the Lewisham Local Medical Committee (LMC) also noted that a significant number of younger people are not accessing mental health support services.

15.8 GPs in Lewisham would like to see more social prescribing for social issues in particular. 35-40% of GP consultations relate to social issues, such as debt, family and general wellbeing problems. One of the main barriers to the greater use of social prescribing among GPs is a lack of knowledge and awareness of the services available. Some GP practices are used to and confident making social prescribing referrals, but many are unaware of what's available or how to access it.

15.9 The committee heard that social prescribing needs to be continuously promoted to GPs and that social prescribing referral pathways need to be quick and easy. GPs need to be confident that if they make a referral something will happen and people will not just return to them. The SAIL referral is a good step forward in increasing awareness of social prescribing among GPs – but there need to be more integrated pathways with a quick tick-box referral process like SAIL.

15.10 The committee heard that the link work between the prescriber and the prescription is vital. In Sydenham Garden's experience, separate organisations set up to signpost or link people do not work, as they serve their own interests and add an extra step to the patient's journey. Sydenham Garden has found funding their own link worker to be most effective. They also support the idea of having a link worker based in practices.

15.11 The committee expressed concern at the apparent difficulty finding activities and support for support for younger people with learning disability mental health needs – particularly around the ages 14-25. The committee stressed that without activities during the daytime younger people can become socially excluded and start to feel demotivated. The committee noted that there are a number of services specifically for older people which younger people are excluded from and expressed concern that the whole community was not being considered.

Recommendations

4. *Given the evidence the committee has received on the loneliness rates among people with learning disability and the rates of mental ill health among young adults, and the long-term health impacts of these, the committee recommends that Lewisham health and care partners pay particular attention to addressing the gaps in support for young adults with learning disability, men's groups and those experiencing mental ill health.*

5. *There is evidence that existing services in the borough need more support with capacity building, and the committee recommends that Lewisham health and care partners continue to help with this, but the committee also recommends that officers also explore appropriate opportunities to work with national and neighbouring borough services.*

6. *Given that lack of awareness and knowledge of social prescribing among GPs appears to be acting as a barrier to its wider use, the committee recommends that Lewisham health and care partners focus on raising awareness of social prescribing, including evidence of effectiveness, among GPs and the wider clinical community as a priority.*

7. *One measure that should be further explored is locating more social prescribing representatives in key GP practices. Without high levels of awareness among the GP community, people will miss opportunities to access activities and support which could help them. And without high levels of awareness and use by GPs, officers will be unable to accurately assess local gaps and the effectiveness of particular interventions.*

8. *The committee also notes the concern that organisations which signpost people can end up adding an extra step to the patient's journey and recommends that Lewisham health and care partners ensure that any social prescribing mechanism developed is as quick and easy-to-use as possible, for both prescribers and service users.*

Monitoring and ongoing scrutiny

16.1 The recommendations from this review will be referred for consideration by the Mayor and Cabinet at their meeting on 28 February 2018 and their response reported back to the Committee within two months of the meeting, or at the earliest opportunity following the 2018 local elections. The Committee will also receive a progress update six months after this in order to monitor the implementation of the review's recommendations.

Appendix

lewisham s.a.i.l. connections
safe and independent living
supporting lewisham residents over 60

working NHS together

Tel 020 7358 4077 | Fax 020 7378 9217
Email sailconnections@ageuklands.org.uk
Stones End Centre | 11 Scovell Road
London | SE1 1QQ

Name:	DOB:	Gender:
Address:		Postcode:
Rented (Council) ☐ Rented (Private) ☐ Housing Association ☐ Owned ☐		Ethnicity:
Telephone:	GP Surgery:	

Please tick the services you would like and return checklist to: sailconnections@ageuklands.org.uk

HEALTH AND WELLBEING

Would you like a pendant alarm to keep you safe and secure? Linkline Telecare Service	☐
Would you like to talk to someone about Telecare equipment e.g. sensors that could help you stay independent in your home for longer? Linkline Telecare Service	☐
Have you had a fall or a near miss in the last year that has **NOT** been investigated or treated? Lewisham Falls Services	☐
Do you have dementia, or do you care for someone with dementia and would like to speak to someone about support available? MindCare	☐
Are you blind, partially sighted, or do you have a specific visual impairment? BlindAid	☐
Have you lost weight recently without meaning to or are you eating less than usual and have **NOT** been referred to a dietician? Lewisham Primary Care Dietetics Service	☐
Do you smoke? If so would you like to stop? Stop Smoking Service	☐
Has your drinking or drug use increased slowly over the years, would you like to talk to someone? Do you use alcohol or drugs to unwind/relax? - would you like to talk to someone? Lewisham Drug and Alcohol Teams	☐
Do you care for someone, or does someone care for you on an unpaid basis due to frailty, disability, addiction, physical or mental illness? Would you like to talk to someone about support available for carers? Carers Lewisham	☐
Would you like to talk to someone about social activities including: volunteering, befriending, social groups, exercise classes, lunch clubs, help with using the internet? Community Connections	☐

LIVING CONDITIONS

Is your home cold? Would you like in-home advice about keeping warm, saving energy and funding available for heating and insulation? Warm Homes Healthy People Project	☐
Do you have any difficulties using the bath/toilet/kitchen facilities? Do you have difficulties getting in and out of your home, or using stairs? If yes, please specify your area of difficulty. Lewisham Council Occupational Therapy	☐
Do you have an odd job around the home that you need help with? Lewisham Handyperson	☐
Are you worried about the condition/repair/maintenance of your home? Advice Lewisham	☐

SAFETY, SECURITY AND INCOME

Would you like advice from your Local Police Team regarding crime prevention, home security, or a recent incident of crime or anti-social behaviour in your area? Police	☐
Have you ever been concerned about services or goods you have bought from someone who knocked at your door? Crime Enforcement and Regulation Service	☐
Have you sent money to anyone who contacted you by phone or mail saying you had won money or a gift unexpectedly, and that money or gift never materialised? Crime Enforcement and Regulation Service	☐
Do you have a working smoke alarm? Would you like a free Home Fire Safety Visit? London Fire Brigade	☐
Would you need help leaving your home in the event of an emergency? London Fire Brigade	☐
Are you having trouble paying your bills or would you like someone to help check that you are receiving all the income that you are entitled to? Advice Lewisham	☐

Visited by:	From:
Date:	Telephone/Email:

IMPORTANT: This must be read to the client: "In signing this form you are consenting to this information being shared with partner organisations in accordance with the Data Protection Act 1998".
Please tick here if completing by phone to demonstrate you have discussed this with the client. ☐

Signed (client/representative):

Version 1 created September 2016