MAYOR AND CABINET		
Report Title	Response to HCSC Review on Social Prescribing	
Key Decision		Item no:
Wards	Borough wide	
Contributors	Executive Director for Community Services	
Class	Open	**Date**: 6 June 2018

1. Purpose

1.1 Healthier Communities Select Committee conducted a review into social prescribing during 2017. The Executive Director of Community Services has been asked to prepare a response to the recommendations for Mayoral consideration to be reported back to the Healthier Communities Select Committee.

2. Recommendations

2.1 The Mayor and Cabinet is asked to:

- agree the response (paragraphs 9 to 17) which will be sent to Healthier Communities Select Committee in answer to their recommendations.
- note the next steps for the development of social prescribing in Lewisham to be taken forward by Health and Care Partners.

3. Policy Context

3.1 Members of the Healthier Communities Select Committee considered a scoping note for the in depth review of social prescribing in June 2017. This scoping note set out the policy context, summarised below:

3.2 The challenge of caring for an elderly population, with increasingly complex health needs, has generated considerable interest in the benefits of social prescribing. It has been estimated that 20% of GP visits are attributable to social rather than medical problems (2010 Marmot review, 'Fair Society, Healthy Lives').

3.3 The objectives of social prescribing also support the principles set out in various NHS policy documents, including the NHS Five Year forward view 2014. This document outlines the NHS's commitment to empower people and engage communities to take more control of their own health. The south east London Sustainability and Transformational Partnership (STP) , in common with all London's STPs, includes a commitment to self-care and social prescribing.

3.4 A growing body of evidence has demonstrated the value of person-centred and community-centred approaches, alongside greater local understanding of NHS England's self-care efficiency aspiration. This underpins why coordinated action on self-care and social prescribing is important. The evidence indicates that involving people in community life is positive for individual health and wellbeing outcomes, stimulates creativity and innovation and is good for the wider community.

3.5 More recently, the *General practice forward view* (2016) emphasised the role of voluntary sector organisations, through social prescribing specifically – in efforts to reduce pressure on GP services. In addition, social prescribing contributes to a range of broader Government objectives, for example in relation to employment, volunteering and learning.

3.6 In 2017 the Mayor of London produced a draft Health Inequalities Strategy 'Better Health'. A key ambition of the strategy is to support the most disadvantaged Londoners to benefit from social prescribing to improve health and wellbeing and to see "that social prescribing becomes a routine part of community support across London".

3.7 Social prescribing Schemes, like SAIL and Community Connections support Lewisham's Sustainable Community Strategy priority of: Healthy, active and enjoyable, where people can actively participate in maintaining and improving their health and wellbeing and Safer; where people feel safe and live free from crime, antisocial behaviour and abuse.

3.8 Social prescribing schemes contribute to Lewisham's corporate priorities of caring for adults and older people, working with health services to support older people and adults in need of care; and inspiring efficiency, effectiveness and equity: ensuring efficiency and equity in the delivery of excellent services to meet the needs of the community. Social prescribing also contributes to promoting wellbeing and the priority of active, healthy citizens, providing leisure, sporting, learning and creative activities for everyone.

3.9 Lewisham Health and Care Partners are committed to supporting people to maintain and improve their physical and mental wellbeing, to live independently and to have access to high quality care when needed. Transforming the care that people receive in the community, so that more people can be cared for out of hospital, is critical to achieving this. Social prescribing schemes play a key role in preventing the need for health and care and help connect people to services and activities to promote wellbeing. The aim is for community based care to be:

- **Proactive and Preventative** – By creating an environment which promotes health and wellbeing, making it easy for people to find the information and advice they need on the support, activities, opportunities available to maintain their own health and wellbeing and to manage their health and care more effectively.
- **Accessible** – By improving delivery and timely access when needed to planned and urgent health and care services in the right setting in the community, which meet the needs of our diverse population and address inequalities. This includes raising awareness of the range of health and care services available and increasing children's access to community health services and early intervention support.
- **Co-ordinated** – So that people receive personalised health and care services which are coordinated around them, delivered closer to home, and which integrate physical and mental health and care services, helping them to live independently for as long as possible.

4 What is social prescribing?

4.1 The scoping paper previously considered by Healthier Communities Select Committee provided a definition of social prescribing that came from the Annual Social Prescribing Network Conference held in London on 20 January 2016:

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

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

4.4 Social prescribing schemes can include a variety of activities which might be delivered by the community and voluntary sector; examples include arts projects, sporting activity, gardening, cookery, crafts, peer support and other social groups.

5 The extent of social prescribing in Lewisham

5.1 Lewisham has a rich and vibrant voluntary and community sector and this is reflected in local social prescribing activity. The scoping note previously submitted to the Healthier Select Committee in 2017 provided detail about social prescribing interventions in Lewisham. Further examples of social prescribing were presented to the Healthier Communities Select Committee during the evidence sessions held on the 20th July and the 7th September 2017.

5.2 In summary, this includes activity that might be considered 'formal' or systematic social prescribing schemes. These tend to have a formalised mechanism for making referrals and a link worker or coordinator who will follow up on the referral. Examples include Community Connections, SAIL Connections and some of the interventions commissioned by Public Health such as exercise on referral, Weightwatchers / Slimming World and the "Be Inspired" programme delivered by Greenwich Co-operative Development Agency (GCDA).

5.3 There are many other examples of 'Informal' social prescribing activities delivered by voluntary and community sector organisations, these tend not to be linked into a formal referral system or have a designated link worker or co-ordinator.

5.4 London Voluntary Services Council (now known as the Charity Hub for London) have mapped social prescribing initiatives in London and have highlighted the work of Sydenham Gardens and the Prince's Trust. In addition, a range of activities are delivered by community organisations that health and care partners can refer into. Additional examples are:

5.5 Natures Gym who provided 2685 volunteer hours to support conservation activities in Lewisham parks. Trinity Laban's 'Retired not Tired' programme provides opportunities for over 60s to take part in creative activity, interact socially and develop new skills. Meet Me at the Albany is a programme of activities for isolated older people produced by Entelechy Arts and the Albany.

6 Developing Social Prescribing in Lewisham

6.1 Health and Care Partners participated in the HCSC review and welcome this opportunity to raise the profile and benefits of social prescribing. Many of the themes

from the review were previously highlighted by the joint stakeholder group established by Health and Care Partners in 2017.

6.2 The stakeholder group focussed on identifying gaps in social prescribing, understanding how schemes worked locally and evaluating the infrastructure and capacity of the local voluntary and community sector to deliver, with particular focus on the formal mechanisms for referral. This showed a flourishing sector in Lewisham with formal schemes targeted at specific groups, for example over 60s, people with long term conditions etc. In taking the work forward the group established that an approach that includes both physical and mental health, with broader health and wellbeing objectives would be of benefit.

6.3 The SAIL Connections Impact Report (The first twelve months, 2017) has also provided evidence that will support further development. Since the formal launch in February 2017 SAIL has been embraced by local stakeholders with over 50 different organisations using the checklist, over 1000 referrals have been received to date. Over a quarter of referrals are from GP practices. A significant number of referrals have also been received from the voluntary sector, hospital and the police. Each SAIL checklist generates on average 1.4 onward referrals including to the Community Fall Service, Mindcare, Dieticians and the Warm Homes Project.

6.4 The average age of service users is 78 but this extends to 98 years old. The service has also received 61 referrals for people under 60 years of age and who are considered suitable for preventative services listed on the checklist.

6.5 SAIL will continue to promote the service to widen access. For example, they have focussed outreach with housing providers in the most deprived areas of the borough. They have also targeted health and care professionals in order to ensure access to those with limited community access, socially isolated and to people experiencing a range of physical and mental health conditions.

6.6 23% of checklists include a referral to a Community Connections Facilitator to combat social isolation and the SAIL team work closely with Community Connections by referring people to community based groups and activities including social activities, lunch clubs, befriending, exercise classes and community learning.

6.7 The enthusiastic response and steady increases in referrals tells us that SAIL has local value and can assist health professionals refer to a range of non- clinical interventions to support patients' wellbeing. A further evaluation which will focus on the Social Return on Investment (SROI) is now underway and will be published in May 2018.

7 NHS Healthy London Partnerships (HLP) Social Prescribing Dashboard

7.1 Healthy London Partnership (HLP) is supporting London Strategic Planning Groups (SPGs) to develop their Sustainability and Transformation Plans and to that end is recommending specifically the increased use of social prescribing. HLP has been working with i5health to apply the Commissioning opportunity Module. The Interactive dashboard developed by i5health in 2017 draws on a range of data to provide population health and financial modelling for social prescribing, at an individual CCG and STP level, year on year until March 2021. The resource allows the Health and Voluntary sectors to identify and anticipate demand, predict future trends, precision-target conditions and client groups, and assess 'what if' scenarios.

7.2 The data using the Commissioning Opportunity Module (COP) presented by the NHS Healthy London Partnership on South East London shows that 6,584 patients at GP

practices in Lewisham would benefit from self-management for chronic conditions which Social Prescribing can facilitate. The data also shows to which individual practices the patients belong. This model demonstrates that self-management for these patients could potentially result in a reduction in activity (GP visits, A&E admissions etc.).

7.3 Although this data is based on 'ideal' participation scenarios, it provides an indication of the potential for Lewisham, with its existing social prescribing infrastructure, to reproduce the excellent results achieved by Rotherham. Evaluation of the Rotherham Social Prescribing Pilot | Centre for Regional Economic and Social Research | Research | Sheffield Hallam University

8. Developing the Lewisham Social Prescribing Model

8.1 SAIL Connections

8.1.1 SAIL Lewisham is currently only available to those aged 60 plus and is unable to offer the longer-term support required to address the complex underlying issues affecting people with serious health issues. A proposal is currently being developed and resources secured to extend the SAIL model, by lowering the age threshold, offering tailored, specialist support to people aged 45+ (in advance of NHS 50+ Health Checks) - including those experiencing or at risk of cancers, hypertension, and complex and multiple long-term conditions.

8.2 Neighbourhood Community Development Partnerships – supporting social prescribing

8.2.1 Four Neighbourhood Community Development Partnerships (NCDPs), one in each neighbourhood, have been established. The NCDPs, delivered by Community Connections, bring together voluntary and community sector organisations and groups in that area to support community development and connect to statutory health and care providers.

8.2.2 Community Connections workers are encouraging local community groups to engage with each partnership, organising the partnership meetings, and playing a key role in aligning the work programmes of the different community development workers in each neighbourhood to maximise the use of resources and avoid duplication. The NCDPs clearly have the potential to enhance the role of the voluntary and community sector in relation to social prescribing.

8.2.3 In 2017 Neighbourhood Community Development Partnerships each produced a neighbourhood community development plan which was informed by the Community Connections gaps analysis and identified key priorities. This plan informs the future work of the local NCDP partnership and local health and care partners. A small grant fund of £25k has been made available for each partnership to deliver local solutions to the local priorities identified.

8.2.4 The development of the on-line directory of services has a close link with the development of any future social prescribing model. A project to deliver improvements in the content as well as the search functions and navigability of the directory will support the approach to self-care and support self-navigation.

9. Response to specific recommendations

9.1 *Following up on referrals and gathering feedback becomes a compulsory part of the Community Connections referral process*

9.1.1 There have been significant improvements in understanding how services work, how they are measured and recognising the difference they make. However, it is widely accepted at a national and local level that we can build upon this body of evidence to support the case for social prescribing and identify the most effective interventions.

9.1.2 Community Connections already have in place routine procedures for Facilitators to provide feedback when GPs have referred to the scheme. This includes attending Multi-Disciplinary Team meetings when appropriate and working closely with funders and other stakeholders to ensure that the services are targeted and of high quality. The Community Connections Team had identified that communication with some practices could be improved and they are taking steps to streamline the process.

9.1.3 Community Connections conduct periodic service user feedback and the SAIL Connections service has recently conducted user feedback as part of its evaluation process. Case studies are routinely provided and the service continues to improve ways to obtain feedback from all stakeholders.

9.1.4 To help promote the benefits of social prescribing and to share the rich variety of activities that are available we will introduce new and better ways to share this information with all stakeholders. For example, to provide feedback at a neighbourhood level, through the Neighbourhood Community Development Partnership meetings and to provide regular updates and newsletters.

9.1.5 In addition to referrals from GPs Community Connections receive referrals from a variety of sources, including, voluntary and community organisations, family members and neighbours. For this reason, it is not always appropriate to provide direct feedback. Facilitators also make onward referrals to community, social and sports activities and it is not always feasible to capture information as part of this feedback or in order to collect outcome data.

9.1.6 The flexible approach to feedback is designed to both reduce bureaucracy around the process and ensure there are no data protection issues attached to social prescribing at this stage of its development.

9.1.7 Officers welcome the committee's focus on continual improvement. Building on the processes and activity already in place they will explore how best to improve the feedback process within the social prescribing model including ensuring that there is a way for GPs to highlight patients who return to them with similar issues having already been referred to the service.

9.2 Officers look into ways of building a more comprehensive database of evidence and feedback. This should include statistical analysis of wellbeing outcomes where available, patient reported feedback and case studies.

9.2.1 The stakeholder review group supports the recommendation that officers look into building a comprehensive database of evidence to support the development of social prescribing. As outlined above in paragraph 5 there are various activities that might be termed social prescribing some are part of a formal scheme and funded for this purpose whilst other interventions and community activities have developed more organically.

9.2.2 Most formal schemes already collect data from participants, feedback from stakeholders and provide information for referrers and regular case studies. In addition, some also conduct an assessment of the individual's wellbeing before and after the intervention in order to determine the success or the outcome.

9.2.3 In developing this work the stakeholder review group is mindful that "It's a difficult, but crucial, balancing act to ensure an evaluation approach can be both sustainable and provide useful information for organisations to learn and improve, whilst also being accountable to stakeholders and funders" (Balancing Act: A guide to proportionate evaluation Harrison-Evans et al May 2016).

9.2.4 This work will be taken forward by the stakeholder group and will begin by collecting the information on existing data sets, use of wellbeing measures, feedback tools and sharing best practice to work towards a more comprehensive dataset.

9.3 Officers look into the possibility of drawing up a clear set of outcome measures which could be reported on and shared with health and care partners, particularly GPs and service users. Links with the Lewisham Health and Care directory.

9.3.1 Lewisham Health and Care Partners have developed a set of outcome indicators that reflect the ambition for health and care in Lewisham. These include indicators for prevention and early action; social prescribing contributes to these outcomes.

9.3.2 Some schemes already collect outcome measures and there is good evidence of the effectiveness of a number of social prescribing activities. For example, in 2016/17 68% of those supported by Community Connections and 79% of those supported by Bromley and Lewisham's Mind's Community Support Service report an improvement in wellbeing.

9.3.3 In developing outcome and evaluation measures consideration will be given to what constitutes a proportionate and meaningful way to evaluate a programme or intervention, whilst learning from best practice. Consideration will be given to building confidence in the measures and improving quality. For some organisations there are likely to be resourcing and capacity implications if new monitoring requirements are introduced. This will need to be assessed, piloting this in one area or service may be the best way to approach this.

9.3.4 The Population Health and Care Information Management System will bring health and care information and data together, including that relating to social prescribing where appropriate, to inform progress against outcomes.

9.3.5 Lewisham SAIL Connections is currently being evaluated using Social Return on Investment methodology. This will provide an insight into how social prescribing works specifically, this work will inform the development of outcome measures.

9.4 Recommendation that H&C Partners pay attention to addressing the gaps in support for young adults with learning disability, men's groups and those experiencing mental ill health.

9.4.1 Community Connections work with local community based organisations to assist in their development and capacity building. This is key to the overall success of the work to ensure that there are strong and sustainable organisations, networks and activities in place so that individual older people and vulnerable adults can access the support and activities they are looking for.

9.4.2 Community Connections collect information on the social groups and activities vulnerable adults participate in as well as their health and other needs to support them maintain and improve their wellbeing. This information helps build the gaps

analysis and informs the community development work. They are also able to link particular groups with identified need for example the previously identified gap around groups for men and people experiencing mental ill health.

9.4.3 The 2017/18 gaps analysis identified that 33% of people referred to community connections needed practical support, for example, food poverty, 75% had mobility issues and 60% had multiple health needs. Some people had more than one need identified.

9.4.4 Data collected by Community Connections is used to ensure that the service reaches the most vulnerable adults including BME communities, older adults and people with a disability. It has also identified gaps and specific needs and highlights the challenges consistently experienced by vulnerable adults in our community.

9.4.5 The data also highlights the need for support for people with long term conditions and multiple diagnoses. This reinforces SAIL data relating to the under 60 population with multiple long term conditions and the need for additional support for this group.

9.4.6 Lewisham will continue to strengthen and develop connections both within and across its local care networks and build stronger links within and across the voluntary and community sector, through the Neighbourhood Community Development Partnerships. This activity will seek to address gaps in social prescribing coverage as well as gaps in activities for prescribers to refer to and those identified above.

9.5 That health and care partners continue to help with capacity building and explore opportunities to work with national and neighbouring borough services.

9.5.1 Officers welcome this recommendation and will continue to work with all capacity building agencies including those that operate at a regional and national level.

9.6 That Lewisham health and care partners focus on raising the profile of social prescribing, including evidence of effectiveness, among GPs and the wider clinical community as a priority.

9.6.1 Lewisham Health and Care Partners are committed to social prescribing and will continue to raise its profile. The vision is for a sustainable and accessible health and care system in which people are better supported to maintain and improve their physical and mental wellbeing, to live independently and access high quality care when needed. SAIL and other forms of social prescribing are excellent examples of how this works in practice.

9.6.2 General Practioners report that approximately 19% of their consultations are related to social factors rather than medical issues. It is estimated that this costs £400 million each year (Caper K, Plunkett J. A very general practice: How much time do GPs spend on issues other than health 2015).

9.6.3 At a national level it is recognised that we need to improve our understanding of the social prescribing tendencies of GPs in order to maximise the potential of social prescribing, this includes recognising some of the barriers, be lack of time or resources and putting measures in place to support the model.

9.6.4 This recommendation will be taken forward by conducting further analysis to determine patterns of referrals from GPs, clinical community and other referrers.

Using the referral data for each GP practice this can be mapped against weighted list sizes and will provide a robust picture of referrals. This information can then be used to inform communications and engagement activity to help raise awareness and increase the use of the service focusing on referrers or practices that require a more targeted approach.

9.7 Explore more social prescribing representatives in key GPs practices.

9.7.1 Community Connections workers are linked to each of the four Neighbourhood areas and the Facilitators currently attend multi-disciplinary meetings in GP practices and will continue to do so. Training for GP receptionists in navigation and increasing the awareness about social prescribing in the surgery more generally has been positive.

9.7.2 However, we recognise that not all practices have the space for additional staff to be based there and working at a neighbourhood level by utilising the hub and spoke model can be more effective. Community Connections are a key part of neighbourhood working. As well as focussing within the GP practice the intention is to support a more preventative approach and focus on opportunities for interactions and referrals upstream from primary care and others in the wider community.

9.8. Recommendation that any social prescribing mechanism developed is as quick and easy to use as possible, for both prescribers and service users.

9.8.1 Lewisham SAIL Connections was developed with the aim of eliminating as many extra steps as possible. For all parties the benefits of keeping it simple are clear. Lewisham and Southwark Age UK together with the SAIL Steering Group will continue to monitor the views of stakeholders about the ease of use and efficiency. Any new scheme will build on the success of this model.

10. Financial Implications

10.1 Although there are no specific financial implications arising from this report, any proposed activity or commitments arising from activity to support the development of social prescribing will need to be agreed by the delivery organisations concerned and be subject to confirmation of resources.

11. Legal implications

11.1 There are no specific legal implications arising from this report.

12. Crime and Disorder Implications

12.1. There are no specific crime and disorder implications arising from this report.

13. Equalities Implications

13.1 Although there are no specific equalities implications arising from this report, the development of social prescribing will continue to focus on improving health and care outcomes and reducing inequalities across the borough.

14. Environmental Implications

14.1 There are no specific environmental implications arising from this report.

15. Conclusion

15.1 Healthier Communities Select Committee conducted a review into social prescribing during 2017. This report sets out the response to the recommendations that resulted from the review and describes how social prescribing will be taken forward in Lewisham. If agreed this response will be forwarded to Healthier Communities Select Committee.

If there are any queries on the content of this report please contact Fiona.kirkman@lewisham.gov.uk or on 020 83149626