Healthier Communities Select Committee		
Report Title	HCSC Recommendations on Social Prescribing: Update on progress	
Key Decision	No	Item no: 6
Wards	Borough wide	
Contributors	Executive Director for Community Services	
Class	Part 1	**Date**: January 2019

1. Purpose

1.1 Healthier Communities Select Committee conducted a review into social prescribing during 2017. The response to the recommendations was presented by the Executive Director of Community Services for Mayoral consideration in June 2018, this report provides an update on progress for those recommendations.

2. Recommendations

2.1 Healthier Communities Select Committee is:

- Asked to note the progress on activity arising from the recommendations that were made in the report in June 2018.
- 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. The 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 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 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.

3.4 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.

3.5 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".

3.6 In November 2018 the Health and Social Care Secretary announced plans to establish a National Academy for Social Prescribing to lead the practice under a renewed drive to improve the prevention of ill health. The academy is to "be the champion of, build the research base, and set out the benefits of social prescribing across the board, from arts to physical exercise, nutritional l advice and community classes".

3.7 In a conference at the King's Fund the Health and Social Care Secretary remarked that "Social Prescribing is fundamental to prevention and prevention is fundamental to the future of the NHS". A view that is widely supported.

3.8 The objectives of social prescribing also support the principles set out in more recent NHS policy documents. In January 2019 the NHS published the Long Term Plan which sets out a ten year plan to make the NHS "fit for the future, and to get the most value for patients out of every pound of taxpayers' investment ". The Plan sets out the new funded action the NHS will take to strengthen its contribution to prevention and reducing health inequalities.

3.9 Social Prescribing is prominent within the plan and features an ambition to train 1000 link workers this year and incrementally over the next few years and to see 900,000 people referred to social prescribing schemes by 2023.

3.10 At London level the consultation document released in December 2018 "Social Prescribing: Our Vision for London 2018-28 Improving lives, Improving health" sets out a vision developed by the Greater London Authority, NHS England, Healthy London Partnerships and the London Social Prescribing Network for every Londoner to have easy access to social prescribing to meet their changing needs, from cradle to grave with a focus on developing healthy and thriving communities."

3.11 The plan sets out a road map for social prescribing and how it can be scaled up across the city, so that everyone can access a wide variety of support within their own community. Finally, 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.

3.12 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.

3.13 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.

3.14 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 (Community Based Care) 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

Communities 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 the opportunity to raise the profile and benefits of social prescribing. The themes from the review will continue to be monitored 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) shows that since the formal launch in February 2017 SAIL has been embraced by local stakeholders with over 50 different organisations using the checklist, 1063 referrals have been received to date and 926 older people have received support. About 20% 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 WarmHomes 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 In 2017-2018, Community Connections Development Workers supported 39 groups through development plans and made 517 development visits to those and other groups around the borough. Meanwhile, Community Facilitators supported 804 vulnerable adults through person-centred planning and work. The team supported an additional 201 vulnerable adults through advice provided to the London Borough of Lewisham Social Care team. 72% of those supported reported an improvement in their overall wellbeing after Community Connections'

6.8 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.

6.9 A full Evaluation of the SAIL Project was conducted earlier this year using a Social Return on Investment (SROI) methodology, it also included an assessment of social value by including case studies, stories and stakeholder feedback. The evaluation demonstrates the SAIL model to be highly effective and achieving excellent outcomes for older people in Lewisham.

6.10. The most consistently highlighted benefits of the project were that it improves efficiency, making it very quick to make multiple referrals, and improves access to services. The SAIL checklist achieves this through its simplicity and by gathering multiple services onto a single form. Healthcare services can now receive referrals from the community and likewise there is capacity for an increase in referrals to Police, fire prevention and community services from Healthcare professionals. Analysis in the evaluation has shown that for every £1 invested so far, the return has been £4.91.

6.11 Additional benefits of the SAIL Connections model highlighted by Partners include:

- Identifying and supporting those who are 'hard to reach' or likely to slip through the gaps in services
- Meaning older people do not 'go around in circles' when seeking support, which can be a causal factor in relapse or deterioration in health
- A flexible and person-centred approach

7. Developing the Lewisham Social Prescribing Model

7.1 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. The provision of a broader social prescribing scheme that supports a wellbeing offer to people of working age with access to arts,

gardening and community activity has great potential. This proposed expansion of this model is now in a feasibility stage.

7.2 Four Neighbourhood Community Development Partnerships (NCDPs), one in each neighbourhood were set up in 2017. 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.

7.3 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.

7.4 In 2018 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 was made available for each partnership to deliver local solutions to the local priorities identified. This scheme will continue in 2019/20.

7.5 The development of the Health and Wellbeing on-line directory of services has a close link with the expansion 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.

8.0 Response to specific recommendations

8.1 Officers responded to the recommendations that were made by the HCSC in a report presented to Mayor and Cabinet in June 2018. An update on the progress to the specific recommendations is set out in Appendix A.

9. Financial Implications

9.1 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.

10. Legal implications

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

11. Crime and Disorder Implications

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

12. Equalities Implications

12.1 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.

13. Environmental Implications

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

14. Conclusion

Healthier Communities Select Committee conducted a review into social prescribing during 2017. This report provides and update on the response to the recommendations that resulted from the review and describes how social prescribing is being developed in Lewisham.

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