UNIVERSITY OF WESTMINSTER

Making sense of

Social Prescribing

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Glossary

One of the biggest challenges in communicating our thoughts is being confident that we mean the same thing to the reader as we intended. Social prescribing necessitates working across professional boundaries. Hence we are being as transparent as possible in our use of language.

The glossary acknowledges that different terminology has been used in different areas to describe very similar or identical functions, especially regarding support brokerage, care navigation, community navigation and link workers.

Asset Based Community Development: This is a methodology for the sustainable development of communities based on their strengths and potentials. It involves assessing the resources, skills, and experience available in a community; organising the community around issues that move its members into action; and then determining and taking appropriate action. In practice, it is very much a part of the wider remit of a support broker and could involve assisting the creation of groups or social enterprises, so that the members of the community can fill local gaps in demand or fulfil their aspirations for and by themselves.

Effect-size: This is a way of quantifying the effectiveness of an intervention relative to a comparison.

Evaluation: "The systematic examination and assessment of the features of an initiative and its effects, in order to produce information that can be used by those who have an interest in its improvement or effectiveness"[1].

Evidence based medicine: "The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research" [2].

Link worker: Link workers have a variety of names, such as health advisor, health trainer, care navigator, community navigator, community connector, social prescribing coordinator and

[1] World Health Organisation (1998). Health Promotion Evaluation: Recommendations to Policy-makers. Report of the WHO European Working Group on Health Promotion Evaluation. http://apps.who.int/iris/bitstream/10665/108116/1/E60706.pdf

[2] Sackett et al (1996) Evidence Based Medicine; what it is and what it isn't. BMJ 1996;312:71

community care coordinator. In this report it refers to a non-clinically trained person who works in a social prescribing service, and receives the individual who has been referred to them. Briefly, the link worker is responsible for enabling and supporting a patient to assess their needs, co-producing solutions for them making use of appropriate local resources.

Long term conditions: A Long Term Condition is defined as a condition that cannot, at present be cured; but can be controlled by medication and other therapies. Examples of Long Term Conditions are diabetes, heart disease and chronic obstructive pulmonary disease[3].

Meta analyses: The systematic appraisal of data from randomised controlled trials to determine the overall likelihood of the effect of an intervention[4].

Personalisation: "The way in which services are tailored to meet the needs and preferences of citizens. The overall vision is that the state should empower citizens to shape their own lives and the services they receive"[5].

Practice Health Champion: Someone who gifts their time to work alongside their GP practice to support the social prescribing work by offering groups and activities and helping patients access the social support they need.

Psychosocial: This relates to the interrelation of social factors and individual thought and behaviour. The psychosocial approach looks at individuals in the context of the combined influence that psychological factors and the surrounding social environment have on their physical and mental wellness and their ability to function

Self-care: 'Self-care is all about individuals taking responsibility for their own health and well-being. This includes: staying fit and healthy, both physically and mentally; taking action to prevent illness and accidents; the better use of medicines; treatment of minor ailments and better care of Long Term Conditions[6].

Social prescribing service: Refers to the link worker(s) and the subsequent groups and services that a person accesses to support and empower them to manage their needs.

Social prescribing scheme: In this document refers to the three components that make a scheme i) referral from a healthcare professional ii) consultation with a link workers, iii) use of a local voluntary and community organisation or statutory sector e.g. social services, social care, public health funded health behaviour programmes and self-management programmes, weight management programmes, children's centres, libraries, museums, leisure centres, employability programmes.

Socioeconomic: The combination of both social and economic factors.

[3] Department of Health http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_064569

[4] Higgins et al (2011). The Cochrane Collaboration's tool for assessing risk of bias in randomised trials. BMJ;343:d5928

[5] Department of Health (2008) Transforming Social Care. Local Authority Circular (DH). Department of Health, London

[6] Department of Health (2006) Supporting people with Long Term conditions to self care- A guide to developing local strategies and good practice. Department of Health, London.

Support Brokerage: Support Brokers help people to choose, plan and lead the lives of their choice. Ideally, they are independent of statutory services. Recently in the UK, brokers have often been limited to working with disabled people in receipt of a personal budget, and helping them write a support plan. However, internationally and historically, the role has rightly extended well beyond this.

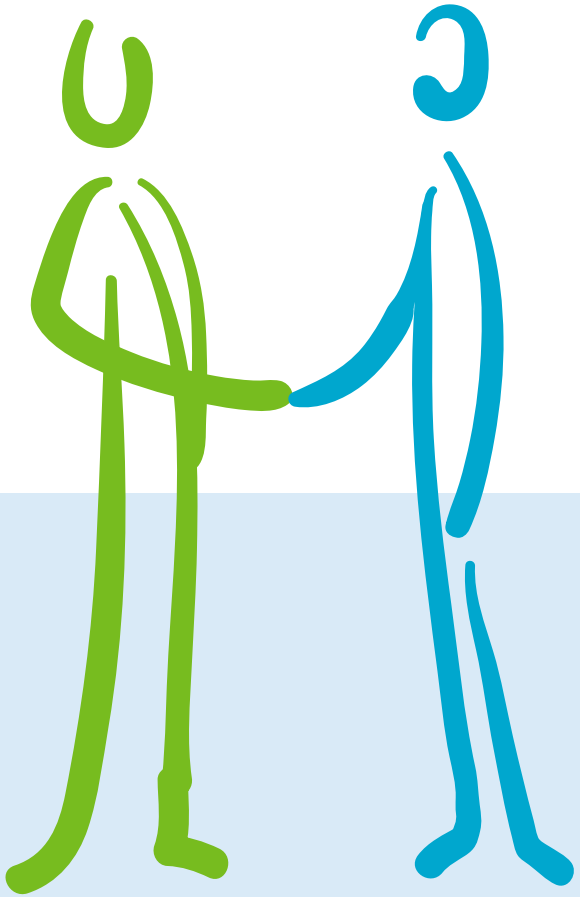
Systematic review; "A systematic review summarises the results of available carefully designed healthcare studies (controlled trials) and provides a high level of evidence on the effectiveness of healthcare interventions. Judgments may be made about the evidence and inform recommendations for healthcare".[7]

Third Sector; The part of an economy or society comprising non-governmental and non-profit-making organizations or associations, including charities, voluntary and community groups, cooperatives and social enterprises.

Wellbeing: The state of being comfortable, healthy or happy.

[7] Higgins et al (2011). The Cochrane Collaboration's tool for assessing risk of bias in randomised trials. BMJ;343:d5928

1. Introduction



Social prescribing has been in place for a good number of years now, albeit on a relatively small scale. Brandling and House (2009)[8] for example, cite the Bromley-By-Bow scheme which was developed in the 1990s. Friedli and Watson reported on a social prescribing scheme for mental health in 2004[9].

Many inspirational and hard working professionals have all come to the same conclusion – that we can do better for the person who stands before us. Since the inaugural conference of the Social Prescribing Network in January 2016, we have identified far more social prescribing related projects than we ever expected. Bringing people together with a common purpose is always an exciting and powerful venture. We have seen a steady increase in the interest in developing and commissioning social prescribing schemes. Social prescribing was highlighted in the General Practice Forward View[10] as a mechanism to support more integration of primary care with wider health and care systems to reduce demand on stretched primary care services. Social prescribing schemes also help to integrate services and make improvements in the social and economic determinants of health.

As with many ventures, it started in a beautifully organic way, with local solutions to suit local need and aspirations to develop health creating communities. Some structured sharing of knowledge and best practice is now essential to support people to develop new social prescribing ventures, and to make the best use of the resources that are available.

This guide has been coproduced by people with practical experiences of designing, commissioning, delivering, and evaluating social prescribing schemes. We want to support commissioners to understand what a good social prescribing scheme looks like. We also want new schemes to put the key ingredients into place – ones that we know will give them the best chance of success.

This guide reflects the latest information we have about social prescribing. You can access this resource in several ways. Each section is designed to be a standalone summary of a key aspect of social prescribing. There may be cross-references to other sections. If you are completely new to social prescribing, you may want to read all of this.

We hope you find this resource beneficial. If you have suggestions for new sections, please email the Social Prescribing Network socialprescribing@outlook.com

[8] Brandling J and House W (2009). Social Prescribing in general practice: adding meaning to medicine. British Journal of General Practice 59(563) 454-456.

[9] Friedli, L. and Watson, S. (2004) Social prescribing for mental health. Durham: Northern Centre for Mental Health.

[10] NHS England (2016) General Practice Forward View

2. What is social prescribing?

- What is the reason for developing social prescribing schemes?
- What is the definition of social prescribing?
- What comprises a social prescribing scheme?

In this section, we will review the definition and key components of a social prescribing scheme and list a range of resources.

The terms 'social prescribing', 'community referral' and 'non-traditional providers' have all been used to describe a way of expanding the range of non-medical options that could be available to healthcare professionals when a person has needs that are related to socioeconomic and psychosocial issues[11].

Whilst the concept of social prescribing is relatively recent, the term is now more frequently used than ever. Social prescribing is listed as one of the ten high impact actions in the General Practice Forward View[12]. The term social prescribing, however, may mean slightly different things to different people.

Social prescribing is listed as one of the ten high impact actions in the NHS England General Practice Forward View

[11] Friedli L, Jackson C, Abernethy H, Stansfield J. (2008) Social prescribing for mental health — a guide to commissioning and delivery. Care Services Improvement Partnership
South J, Higgins TJ, Woodall J, White SM. (2008) Can social prescribing provide the missing link? Primary Health Care Residential Development 9: 310–318.
Brandling J and House W (2009). Social Prescribing in general practice: adding meaning to medicine. British Journal of General Practice 59(563) 454-456.
NHS (2011). Year of Care, Thanks for the petunias: A guide to developing and commissioning non-traditional providers to support the self-management of people with long-term conditions.

[12] NHS England (2016) General Practice Forward View

What is the reason for developing social prescribing schemes?

Social prescribing shares the values that underpin the wider Personalisation movement in health and social care[13-17] that have paved the way for social prescribing as we see it today.

Many people in the UK are in situations that have a detrimental effect on their health. The Marmot Review provided comprehensive analysis on the causes and consequences of health inequalities in England[18]. Factors contributing to health inequalities can include financial, educational, poor housing, low self-esteem, isolation, relationship difficulties, and physical and mental health problems. There are also more people who are living longer and struggling to cope and adapt to living with Long Term Conditions which can't be addressed by a clinical consultation.

Almost without exception, people want to improve their situation, particularly those with complex needs. These changes can seem impossible to navigate or achieve without sustained support and the motivation needed to make a positive change. Without support, negative consequences can build up, such as depression, anxiety and social isolation.

A GP can quickly work out that the traditional options might have only a limited impact if, for example, poor housing is a factor in a persons emotions; finance and employment concerns also have an adverse impact. It has been estimated that around 20% of patients consult their GP for what is primarily a social problem[19]. In fact the Low Commission reported that 15% of GP visits were for social welfare advice[20].

As well as facilitating the use of non-clinical support for people, it also leads to NHS health care professionals developing wider relationships with their communities and the third sector, and vice-versa.

Social prescribing is an opportunity to implement a sustained structural change to how a person moves between professional sectors and into their community. To fully address the social determinants of health, social prescribing schemes view a person not as a 'condition' or disability, but quite simply as a person.

[13] Department of Health (2008) Transforming Social Care. Local Authority Circular (DH). Department of Health, London

[14] HM Government (2010) White Paper: Healthy Lives, Healthy People: our strategy for public health in England.

[15] HM Government (2012) Public services (Social Value) 2012, London

[16] NHS (2014) Five Year Forward View, London

[17] NHS England (2016) General Practice Forward View. London

[18] Marmot, M (2010). Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010

[19] Torjesen, I. (2016) Social Prescribing could help alleviate pressure on GPs. BMJ, 352:i1436

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

Social prescribing supports the individual, families, local and national government, and the private, voluntary and community sectors to work in collaboration. When done well, it allows people to self-manage their personal situation whilst experiencing physical, emotional and social challenges.

Social prescribing can offer many people a personalised and flexible offer of support back to health at a pace that is appropriate to the person.

There are many models of how social prescribing schemes have been organized (see section 3.0). These models have a range of aims and therefore enable a range of outcomes to be achieved.

In 2016, the Social Prescribing Network asked social prescribing stakeholders to list the outcomes achieved by social prescribing, that they are aware of. 180 people responded and Figure 1 summarises the categories of outcomes that were developed[21].

More recently a review of the evidence[22] assessing impact of social prescribing on healthcare demand and cost implications was completed. This showed average reductions following referrals to social prescribing schemes of 28% in GP services, 24% in attendance at A&E and statistically significant drops in referrals to hospital.

Physical and emotional health & wellbeing	Cost effectiveness & sustainability	Builds up local community	Behaviour Change	Capacity to build up the VCSE	Social determinants of ill-health
Improves resilience	Prevention	Increases awareness of what is available	Lifestyle	More volunteering	Better employability
Self-confidence	Reduction in frequent primary care use	Stronger links between VCSE & HCP bodies	Sustained change	Volunteer graduates running schemes	Reduced isolation
Self-esteem	Savings across the care pathway	Community resilience	Ability to self-care	Addressing unmet needs of patients	Social welfare law advice
Improves modifiable lifestyle factors	Reduced prescribing of medicines	Nuture community assets	Autonomy	Enhance social infrastructure	Reach marginalised groups
Improves mental health			Activation		Increase skills
Improves quality of life			Motivation		
			Learning new skills		

Figure 1. Outcomes described from social prescribing stakeholders (Social Prescribing Conference Report, 2016[20])

[21] Social Prescribing Network Conference Report 2016

[22] Polley M et al (2017). Review of evidence assessing impact of social prescribing on healthcare demand and cost implications. Report. https://www.westminster.ac.uk/file/107671/download

What is the definition of social prescribing?

Several different definitions of social prescribing are already in use, but as yet there is no universally agreed definition. At the first Social Prescribing Network conference in 2016, participants were surveyed in advance of the meeting and asked to define social prescribing.

A workshop during the conference aimed to gain an insight into how participants understood and explained social prescribing. Based on this information, the definition below was constructed[23].

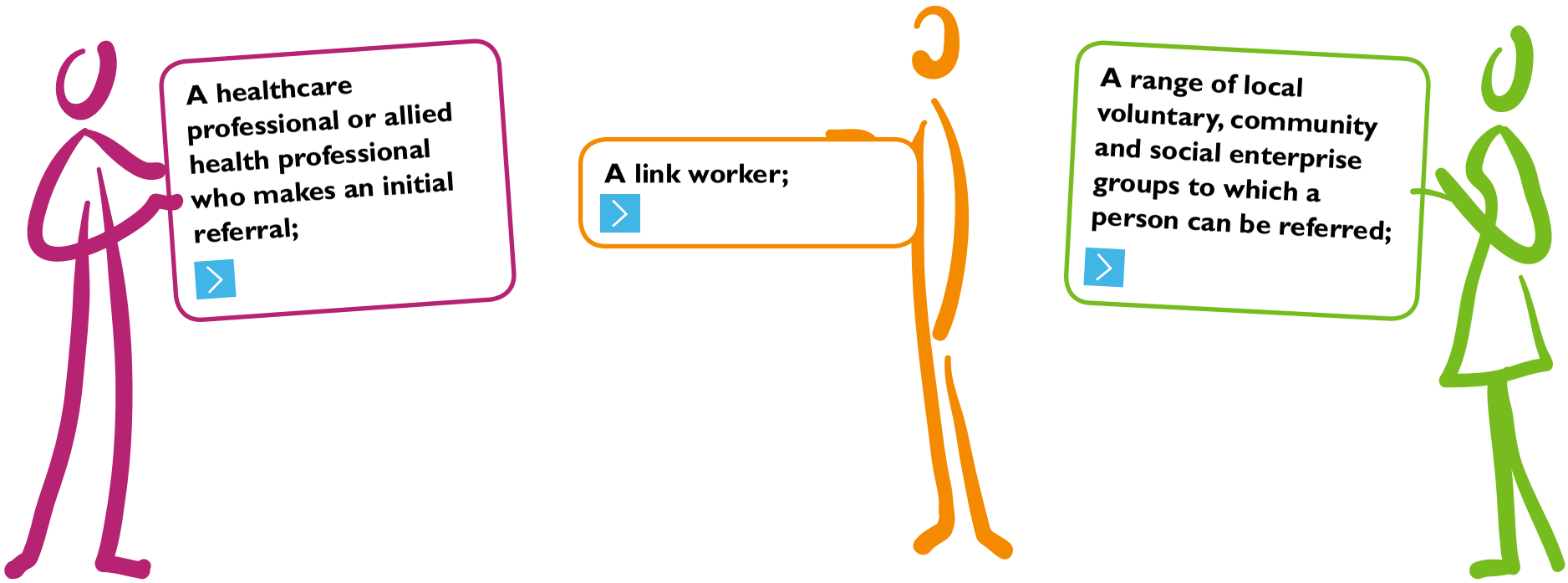
'A means of enabling GPs and other frontline healthcare professionals to refer patients to a link worker - to provide them with a face to face conversation during which they can learn about the possibilities and design their own personalised solutions, i.e. 'co-produce' their 'social prescription'- so 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, community and social enterprise sector'.

A shorter 'elevator pitch' was also produced:

[23] Social Prescribing Network Conference Report 2016

What comprises a social prescribing scheme?

Based on the original descriptions of social prescribing[24], a social prescribing scheme can have three key components – i) a referral from a healthcare professional, ii) a consultation with a link worker and iii) an agreed referral to a local voluntary, community and social enterprise organisation:



[24] Friedli, L. and Watson, S. (2004) Social prescribing for mental health. Durham: Northern Centre for Mental Health.

Friedli L, Jackson C, Abernethy H, Stansfield J. (2008) Social prescribing for mental health — a guide to commissioning and delivery. Care Services Improvement Partnership

South J, Higgins TJ, Woodall J, White SM. (2008) Can social prescribing provide the missing link? Primary Health Care Residential Development 9: 310–318.

Brandling J and House W (2009). Social Prescribing in general practice: adding meaning to medicine. British Journal of General Practice 59(563) 454-456.

A healthcare professional or allied health professional who makes an initial referral;

- Most often GPs are involved in making referrals. GP referral is underpinned by evaluation reports of social prescribing also focussing on the role of social prescribing in primary care.
- Referrals could be made by a practice nurse, or nurse specialist, or a consultant – particularly for people with cancer - or an allied health professional such as a physiotherapist.
- As more social prescribing schemes develop, it is likely that Adult Social Care professionals, who work for local authorities may become more active referrers.
- Some large third sector organisations such as Macmillan Cancer Support also have social prescribing referral schemes[25].
- Referrals from this component of the social prescribing scheme go to a link worker.
- Some schemes that are described as social prescribing directly refer patients to local voluntary, community and social enterprise groups. It is as yet unknown whether there are specific groups of people who would suit a direct referral to a community group as opposed to a link worker. Using a link worker, however, was identified as a key component of successful social prescribing schemes[26].

[25] Social Prescribing Network Conference Report 2016

[26] Macmillian Cancer Support provide a social prescribing scheme at the Bromley-by-Bow Centre

A link worker;

- Link workers may have a variety of names including health advisor, health trainer, care navigator, community connector, community navigator, social prescribing co-ordinator, and community care co-ordinator. These roles aim to understand what matters to the person and to link them with appropriate support. Some link workers may act as a signposting service, as opposed to spending consultation time with a person.

- In this report, link worker refers to a non-clinically trained person who works in a social prescribing service and receives the person who has been referred to them. It offers a service that is based on an equal relationship between the person receiving support and the link worker.

- A link worker may be situated within a GP surgery, in the local community, or a mix of these, depending on how the social prescribing scheme has been developed.

- A link worker spends time with a person working out together needs and goals. They can accompany the person on their journey through different organisations, both within and outside the NHS. The link worker can motivate and support individuals to achieve the change(s) that they want to achieve.

- Healthcare professionals cannot be expected to have an up-to-date knowledge of local community groups, but the link worker will be able to build up knowledge of what services are available in the local and wider community.

- Further information on the role of a link worker can be in section 5.0

A range of local voluntary, community and social enterprise groups to which a person can be referred;

- There are a range of groups and organisations that receive referrals as part of a social prescribing scheme. What is available is different in every locality.

- When establishing a social prescribing scheme, it is necessary to find out what is available in the local area and if the organisations and services have appropriate governance in place to receive social prescribing referrals (See section 7.0).

- A link worker would usually build up this local knowledge of services and groups. For example, people may need information, such as welfare or housing advice. Alternatively, people may wish to try a new activity, undertake or increase physical exercise and enjoy the outdoors and nature, or become involved in an arts based project.

- What is available is different in every locality and could include lunch clubs, walking groups, nature based activities, arts and museum visits, books, physical activity classes (e.g. yoga), or counselling.

- Some local areas have developed creative partnerships with organisations such as the Fire and Rescue Service, who provide support through 'safe and well' visits in people's homes, to prevent falls. Others have worked with social housing providers to organise community singing groups and gardening clubs.

- A link worker is likely to identify local gaps in meeting specific need and may encourage the creation of new groups and services as appropriate.

- Some organisations act as brokers for many small local voluntary and community groups. An example of this is Voluntary Action Rotherham. These brokerage organisations are able to fund groups to meet local needs, often via small grants.

Resources – these are just a selection of policies, papers and reports that relate to social prescribing. There are a growing number of resources, on the social prescribing network website and will be updated at regular intervals.

Academic papers:

South J, Higgins TJ, Woodall J, White SM. (2008) *Can social prescribing provide the missing link?* Primary Health Care Residential Development 9: 310–318.

Brandling J and House W (2009). *Social Prescribing in general practice: adding meaning to medicine.* British Journal of General Practice 59(563) 454-456.

Bungay, H and Clift S (2010) *Arts on Prescription: a review of practice in the UK.* Perspectives in Public Health 130(6)

Kimberlee, R. (2015) *What is social prescribing? Advances in Social Sciences Research Journal, Volume 2, No1.*

Torjesen, I. (2016) *Social Prescribing could help alleviate pressure on GPs.* BMJ, 352:i1436

Pilkington K, Loef M and Polley M (2017). *Searching for Real-World Effectiveness of Health Care Innovations: Scoping Study of Social Prescribing for Diabetes.* Journal of Medical Internet Research 19(2):e20

Policies and reports:

Friedli, L. and Watson, S. (2004) *Social prescribing for mental health.* Durham: Northern Centre for Mental Health.

Friedli L, Jackson C, Abernethy H, Stansfield J. (2008) *Social prescribing for mental health — a guide to commissioning and delivery.* Care Services Improvement Partnership

Department of Health (2008) *Transforming Social Care. Local Authority Circular (DH).* Department of Health, London

HM Government (2010) *White Paper: Healthy Lives, Healthy People: our strategy for public health in England.*

HM Government (2012) Public services (Social Value) 2012, London

Marmot, M (2010). *Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010.*

NHS (2011). *Year of Care, Thanks for the petunias: A guide to developing and commissioning non-traditional providers to support the self-management of people with long-term conditions.*

NHS (2014) *Five Year Forward View*, London

NHS England (2016) *General Practice Forward View.* London

Reports published from different sectors relating to social prescribing

AESoP (2017) Dance to Health: Evaluation of the pilot programme

Friedli, L, et al (2017). Good practice in social prescribing for mental health: the role of nature-based interventions. Natural England

Health Education England, (2016). Social prescribing at a glance: North West England

Bertotti et al (2015). Shine 2014 final report. Social Prescribing: Integrating GP and Community assets for Health. Health Foundation

Healthy London Partnerships (2017). Steps towards implementing self care: A focus on social prescribing for commissioners.

Kimberlee R (2016). Gloucestershire clinical commissioning group's social prescribing service: Evaluation report. Project Report. UWE.

Local Government Authority (2016). Just what the doctor ordered: social prescribing – a guide for local authorities.

Social Prescribing Network (2016) Inaugural National Social prescribing conference report.

Steadman K, Thomas R and Donnaloja V, (2016). Social prescribing: A pathway to work. The Work Foundation

The Low Commission (2015). The role of advice services in health outcomes: evidence review and mapping study.

Thomson, L., Camic, Paul M. and Chatterjee, H. (2015) Social prescribing: a review of community referral schemes. Technical Report. London: University College London.

3. What do different models of social prescribing schemes look like?

- Who can refer the person?
- Who employs the link worker and where are they situated?
- Mobilising citizens

Social Prescribing shares the values that underpin the wider 'personalisation' movement in health and social care (DH, 2008)[27]. This means that schemes will be and should be different in different areas. Despite the differences, we do know that there are essential ingredients that successful social prescribing schemes have in common.

For more information on these essential ingredients, go to section 4.0. A truly successful scheme requires an acceptance of organic growth, requiring a commissioning approach that seeks to work in partnership with all stakeholders. In this section, we offer a number of examples to illustrate some of the various ways that schemes have been managed, but none is meant to be prescriptive. Ultimately, this is an exciting opportunity for commissioners to be innovative in their thinking and draw upon local grass roots expertise, in order to co-produce the best possible fit in each area.

Social prescribing has been categorized by Kimberlee (2015)[28] as ranging from basic signposting through to what he describes as 'light', 'medium' and 'holistic'. These classifications refer to the level of engagement that a link worker has with a person. For example, a holistic social prescribing scheme is where a link worker spends as much time as is necessary with a patient to assess their needs, support them, co-produce solutions and see an improvement in wellbeing.

Many established social prescribing schemes have evolved to meet increasing demand, serve a larger geographical area or extend the range of people who can be referred for support. There are an increasing number of pilot schemes. To reflect the diversity of social prescribing schemes, the rest of the section is organised into two main themes:

- Who refers the patient to the link worker?
- Who employs the link worker and where they are located?

[27] Department of Health (2008) Transforming Social Care. Local Authority Circular (DH). Department of Health, London

[28] Kimberlee, R. (2015) What is social prescribing? Advances in Social Sciences Research Journal,Volume 2, No1.

Who can refer the person?

Some social prescribing schemes refer people via practice staff such as GPs and practice nurses. Practice nurses who see people with specific conditions, such as diabetes, are well placed to identify suitable people for referral.

Example
In Cullumpton, Devon, GPs and practice nurses from three GP surgeries make referrals to a link worker, who has an office in one of those surgeries. The link worker offers appointments to support and motivate people in order to make changes to their health. They do this by accessing support available both in the local community and at the GP surgery[29].

Example
Ways to Wellness in Newcastle West provides GP practices with a dedicated link worker. The link worker contacts and meets with people who have been referred from primary care, hospitals or community healthcare professionals. The link worker will work with a person on an agreed action plan to help them better manage their Long Term Conditions[30].

Example
Wigan Community Link Worker service which is jointly commissioned by Wigan Borough CCG and Wigan Council. Professionals from primary care, the hospital and social care make referrals to a link worker[31].

[29] http://www.collegesurgery.org.uk/p6619.html?a=0 (last accessed 31 March 2017)

[30] http://waystowellness.org.uk/health-professionals/ (last accessed 31 March 2017)

[31] http://www.innovationunit.org/wp-content/uploads/2017/05/Wigan-CLW-service-evaluation.pdf (last accessed 31 March 2017)

Who employs the link worker and where are they situated?

Link workers may be located within a GP practice or within third sector organisations. The location of where the link worker is based is not always indicative of how their position is funded or who employs them.

Some link workers are predominantly located in a GP practice:

Example;
Gloucestershire Clinical Commissioning Group has commissioned social prescribing across the county of Gloucestershire. Link workers predominantly meet the people they serve in GP practices. However they also make some home visits and phone appointments[32].

Example;
Brighton and Hove Community Navigator Social Service uses well trained link worker volunteers (called community navigators) in sixteen GP practices. The link worker service is delivered by a partnership between Brighton and Hove Impetus, Age UK Brighton and Hove, and Brighton Integrated Care Service. Link workers refer people to relevant services within the community[33].

Example;
City and Hackney Clinical Commissioning Group has commissioned a social prescribing service in twenty-three GP practices. Three social prescribing co-ordinators were employed by Family Action, to meet people, assess their needs and support them to access further services[34].

Some link workers may spend time both in GP practices and the community. This approach allows flexibility for the link worker to meet in the most convenient or comfortable location for the person.

Example;
Rotherham Carers' Resilience project is commissioned by Rotherham Clinical Commissioning Group. Link workers in GP practices are employed by Crossroads Care Rotherham, who receive referrals from all GP practices in Rotherham. The link workers can determine which service is most appropriate for the carer. The service is led by Crossroads Care and delivered in partnership with Rotherham and Doncaster Alzheimers Society and Age UK Rotherham[35].

[32] http://eprints.uwe.ac.uk/30293/3/Report%25406.pdf (last accessed 31 March 2017)

[33] http://www.bh-impetus.org/wp-content/uploads/2015/06/Community-Navigators-interim-report-June-2015.pdfommunity (last accessed 31 March 2017)

[34] http://www.health.org.uk/programmes/shine-2014/projects/social-prescribing-integrating-gp-and-community-health-assets (last accessed 31 March 2017)

[35] http://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/eval-rotherham-carers-resilience-service-final-report.pdf (last accessed 31 March 2017)

Some schemes are joint ventures between third sector organisations:

Example;
Bromley-by-Bow Macmillan social prescribing service is funded by Macmillan. People living with cancer can be referred by practice GPs or nurses, and hospital, community organisations and by self-referral. They are supported by Bromley by Bow Centre social prescribing staff, to discuss their needs and non-medical ways to help them live well[36].

Two organisations are well-known for acting as co-ordinating organisations.

Voluntary Action Rotherham working alongside Rotherham CCG
Rotherham's social prescribing service uses link workers (called Voluntary and Community Sector Advisors), who are employed by Voluntary Action Rotherham. These link workers receive referrals from all GP practices in Rotherham, (according to agreed criteria with commissioners), and assess people. The link worker meets with people then refers them to the appropriate voluntary and community service. The link worker also attends integrated care management team meetings at the GP practice when appropriate[37].

[36] http://www.bbbc.org.uk/bbbc-social-prescribing (last accessed 31 March 2017)

[37] http://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham.pdf and http://www.varotherham.org.uk/social-prescribing-service/ (last accessed 31 March 2017)

Wellbeing Enterprises working alongside Halton CCG

Community Wellbeing Practices were commissioned by NHS Halton CCG. Link workers in the form of Community Wellbeing Officers are employed by Wellbeing Enterprises CIC and are based in GP practices. The Community Wellbeing Officers work with practice teams, clinicians, patients, and other stakeholders to develop action plans that are responsive to local needs and assets[38].

- These services have a voluntary, community or social enterprise sector acting as the lead agency. This organization co-ordinates the menu of social prescribing services that are available to patients.
- GPs and other health and social care professionals make referrals to this lead agency, according to agreed criteria, as the single point of contact.
- The lead agency provides a link worker who is able to identify the specific needs of the patient and refer them to the appropriate support service. NB for mental health schemes, the designate mental health worker may also meet with the link worker and patient to ensure a smooth transition.
- The lead agency can be responsive to local needs and spot purchase services from the voluntary, community and social enterprise sector if gaps in provision are identified. This creates flexibility by providing a truly personalized local offer and enhances community cohesion.
- The lead agency approach also allows the money to follow the patient, in that the community and voluntary services receive the funding required to provide the support to the patient. This is a critical factor in ensuring the sustainability of those services.
- The investment in the funded voluntary, community and social enterprise sector services reaps significant additional investment in the voluntary and community sector e.g. increased volunteering, additional funding, income generation. It supports voluntary and community sector sustainability and increased citizen involvement and independence, often enabling this sector to come up with further sustainable options.

[38] http://www.investinwellbeing.org.uk (last accessed 31 March 2017)

Mobilising citizens

Altogether Better promote a model of Collaborative Practice to engage and support enthusiastic citizens to work alongside the GP practice as Practice Health Champions. Collaborative Practice works with or without a paid link worker, with Practice Health Champions becoming part of an extended practice team, working closely with paid staff to find ways to work better together. This benefits the volunteer and also the people on the list. This is underpinned by support from Altogether Better who model a new way of working to practice staff[39].

Practice Health Champions help people to find offers, services and activities either in the GP practice (which could be provided by the champions) or in the community (often provided by the third sector) by offering a menu of options that a paid link worker might refer to.

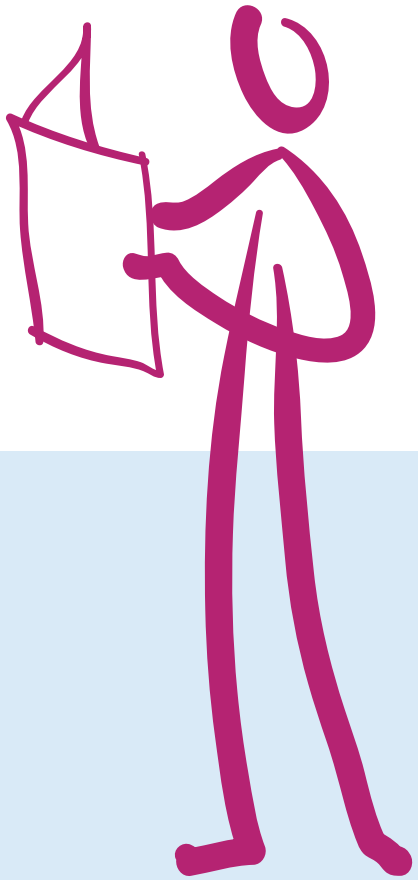
All offers and activities delivered in the GP practice by the Practice Health Champions are co-produced with the practices, with attention paid to risk, as it would be in any other area of work. People can access the benefits of the scheme:

- via the GP who might suggest that a person becomes involved
- by the practice identifying the top 2% of people who attend frequently for problems that the practice cannot solve
- by self-referral
- via champions
- via paid or volunteer navigators.

Experience suggests that social prescribing schemes can become popular very quickly. It's important to ensure that local community services are ready for the likely increase in the take-up of their services. This means ensuring that they are properly supported, resourced and able to meet increasing need. Commissioners should consider the most appropriate way to do this within the local context. For instance, this would involve developing good communication between sectors, in order to respond quickly to any need that arises. Another possibility is to have a 'social prescribing development fund' available to the third sector, which should be relatively quick and easy to access.

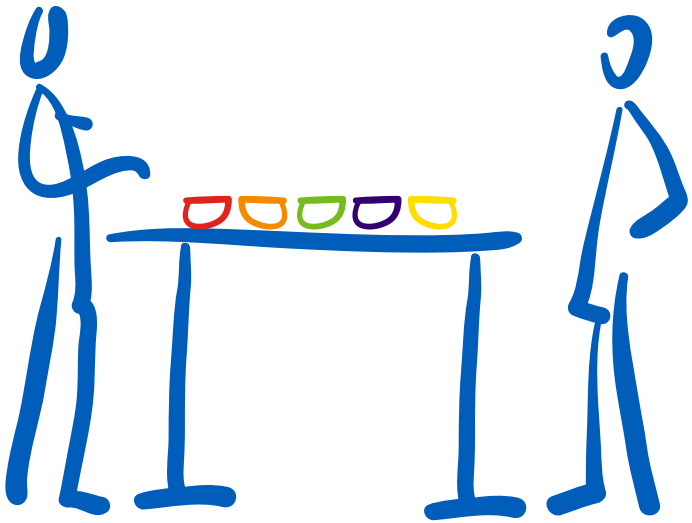
[39] Altogether Better (2016) Working together to create healthier people and communities: bringing citizens and services together in new conversations. http://www.altogetherbetter.org.uk/SharedFiles/Download.aspx?pageid=36&mid=57&fileid=126 (last accessed 31 March 2017)

4. The essential ingredients of social prescribing schemes



This section will review the different ways that social prescribing schemes have been designed and review the essential ingredients for successful schemes.

Many social prescribing schemes were designed to be responsive to the local needs of people and to use local resources, as opposed to an enforced one-size-fits-all approach. Social prescribing schemes tend to view a person not as their 'condition' or disability, but quite simply as a person. By understanding the essential ingredients that give social prescribing schemes the best chance for success, it is possible to ensure these aspects are present when commissioning or building a scheme.



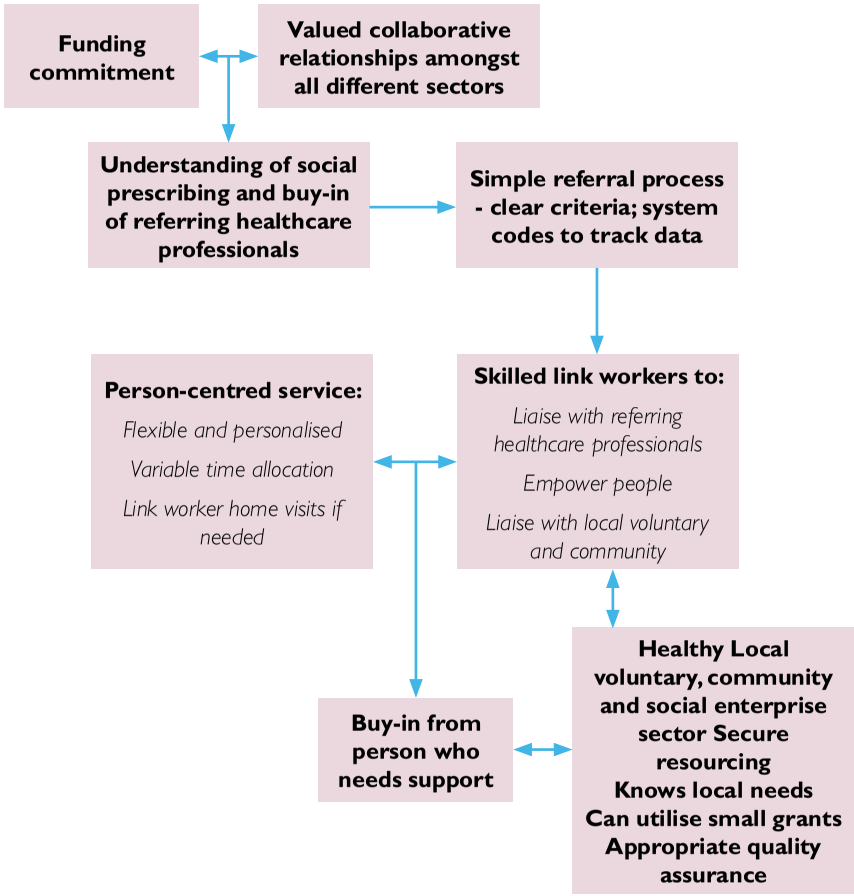


Figure 2. Essential ingredients of social prescribing schemes.

Funding commitment

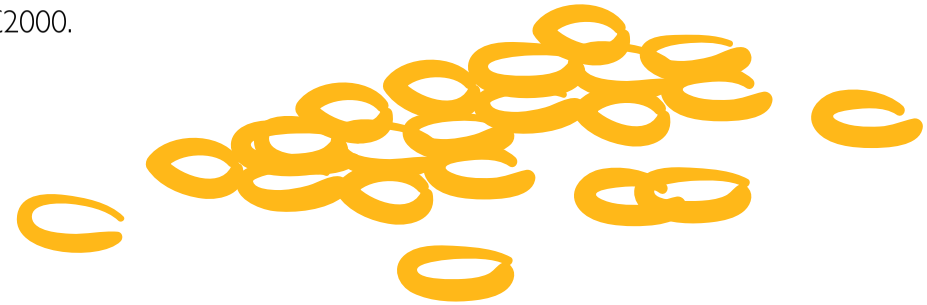
- Previously established social prescribing schemes have been funded in a variety of ways. Some have been via Clinical Commissioning Group and/or local authority funding. Some schemes were funded with public health money, others used grants and trusts, a few use social impact bonds.

- Social prescribing facilitates relationships being established, especially between the link worker and the local community. The relationship and trust between a person and a link worker can empower a person to take action to change their circumstances. These relationships take time to develop therefore continuity of funding is very important to ensure relationships can continue.

- The link worker may be employed by a third sector organisation – it is important to ensure funding to support and maintain their position.

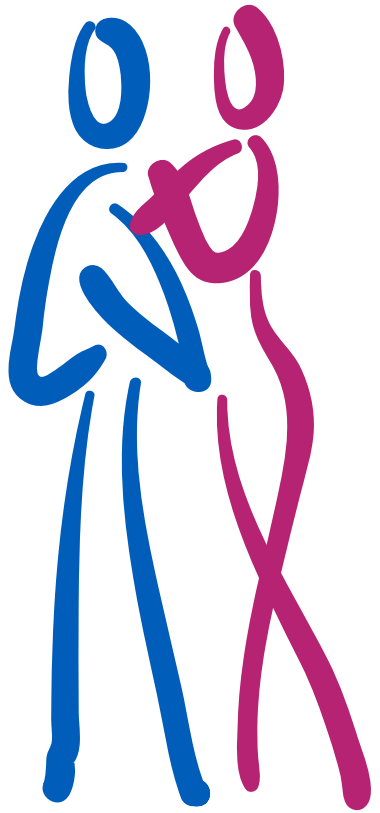
- By increasing the number of people that are using local community and voluntary, community and social enterprise organisations, it is particularly important that money follows the patient and that the organisations receiving referrals can sustain their income and service provision.

- Not all groups need large sums of money to support them. Some local community groups may only need small grants of £2000.



Collaborative working between sectors

- Social prescribing is about aligning the services that are available to a person in different sectors and identifying the need for new services.
- It's important to involve as many voluntary, community and social enterprise organisations in designing the scheme as possible. The earlier on in the process these partners meet to discuss their plans the better
- Aim for steering group meetings quarterly, for example, made up of a Clinical Commissioning Group representative, a GP, a public health representative, local authority representative, link worker, practice manager, and representatives from the local voluntary and community sector.
- Ensuring a local champion in each stakeholder group is vital.

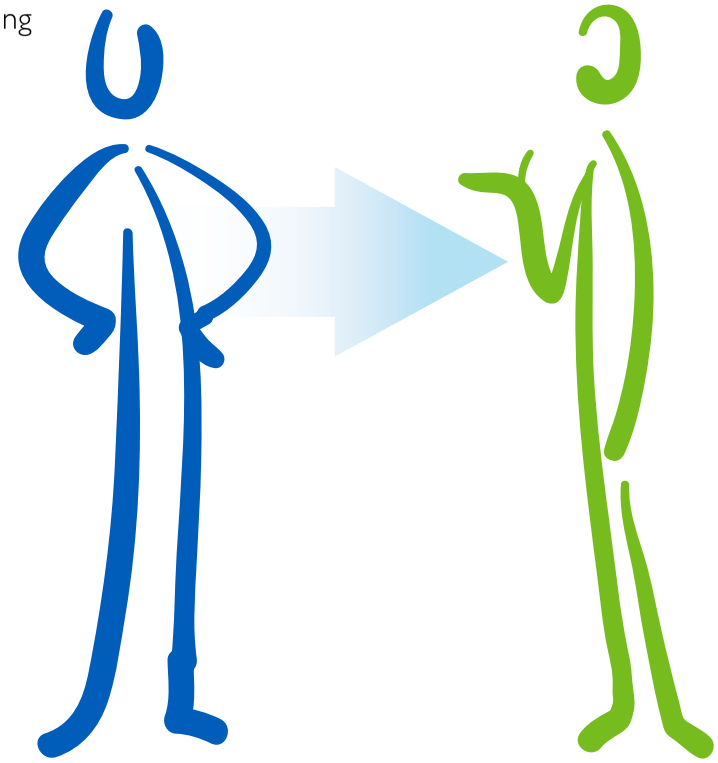


Buy-in of referring healthcare professionals

- Referrals of patients to link workers are important, however, not all healthcare professionals have the time to get up-to-date with recent developments in social prescribing. For many, this is still a new concept that raises a lot of questions. Making time to educate healthcare professionals on aspects of social prescribing is therefore very important.

- This helps to manage demand and regulate the flow of referrals to community groups.

- Referral criteria need to be designed to fit the target people for the social prescribing scheme – different schemes have different targets based on local need – the referral criteria need working out with all partners in the scheme to ensure transparency.



Communication between sectors

Communication and feedback loops between all stakeholders in the scheme allow for transparency.

- Commissioners need to be clear about outcomes for the service they are commissioning, ensuring local communities and other stakeholders are engaged in this discussion. For instance, schemes can be victims of their own success if open to a wide range of referrals in a stretched third sector. On the other hand, a social prescribing scheme may fail to get off the ground very quickly if the target person group is too narrow.
- It is important for the healthcare referrer to know if and when the person receives the support they need. Adding codes on to the data management system is important for basic tracking of referrals. It is anticipated that social prescribing codes will be added to the national GP coding system in future.
- It is a challenge to link electronic patient records to records from group activities and services that the person undertakes in the local voluntary, community and social enterprise sector. It is important to review what exists within your area, and if necessary plan to implement a joined up system – there are companies that have now developed software to track people from primary care to the local voluntary, community and social enterprise sector, without compromising data protection.
- The link worker becomes the communication hub, communicating with healthcare referrers as necessary and crucially, building up local knowledge of the groups and services in the community, what's new, what has closed down (usually due to lack of funding), what's good and what's not as good as expected.
- Clear information, advice and referral pathways between voluntary, community and social enterprise groups can allow value to be released without the need for additional investment.

Using skilled link workers within the social prescribing scheme

- As previously mentioned the qualities and skills of a link work are very important in supporting a person to make a change in their circumstances. More detail about link workers can be found in section 5.0.

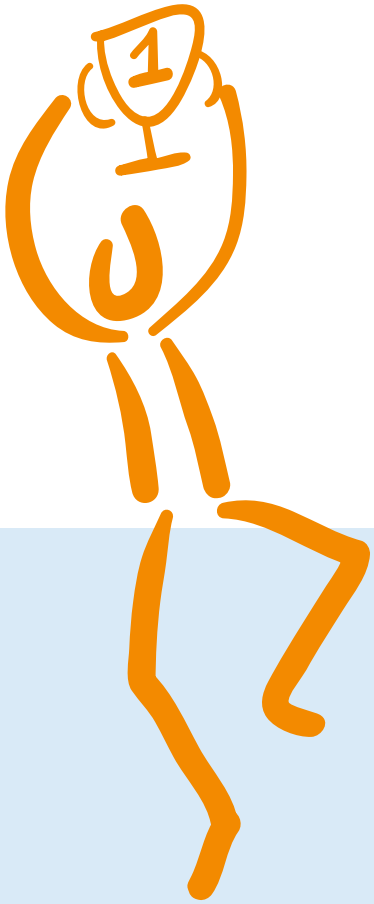
Person-centred service

- Many social prescribing schemes value the link workers carrying out home visits. This is particularly important when aiming to reach people who are unlikely to come back to the GP practice or to visit the link worker. These people may be socially isolated and lack the confidence to meet a new person, or they may have difficulty getting about for a variety of reasons.

- People may need a number of visits with a link worker before they are confident to act on their own. The link worker may also want to accompany a person to a group for the first time, to support them make this first step – this is particularly important where people have confidence issues, and visiting an unfamiliar group will be a barrier to progress. Much has been written about the level of engagement of link workers with people who use the service. (Kimberlee, 2015)[40]

[40] Kimberlee, R. (2015) What is social prescribing? Advances in Social Sciences Research Journal, Volume 2, No1.

5. What makes a good link worker?



Since the advent of 'personalisation', there has been a series of job titles that describe very similar roles. This is reflected in different social prescribing schemes who have named the role of a link worker in many different ways.

Titles for people who have a linking role (that we refer to as link workers) continue to grow, and include: health advisor, health coordinator, health facilitator, health trainer, community connector, community navigator, social prescribing coordinator, support broker, health broker, community broker; wellbeing coordinator, voluntary, community and social enterprise sector advisor.

Whatever the job title, the link worker has arguably the most important role in a social prescribing scheme, as this section will explain. Link workers are person-centred, passionate about what they do. They are people who really care and go the extra mile. We hope readers will give appropriate value to the role and have realistic expectations of what is do-able. The risk of undervaluing this role is that the link-worker ends up with an unmanageable caseload and becomes 'burnt out'.

The link worker needs to have a broad range of skills and be able to work independently and pro-actively with people. Primarily, link workers support people, some of whom may be experiencing acute crisis. To this end, clinical supervision for a link worker to allow them to debrief on their cases is important for their wellbeing as well as for 'safeguarding'.

In practice, commissioners may wish to consider whether it's better to work in areas of specialisms (such as older people) or in geographical communities, perhaps based around GP surgeries.

Creating connections between link workers in different sectors could be very productive to share learning and local intelligence to increase the efficacy and cost effectiveness for all parties.

Below we describe some typical activities of a link worker under three broad remits:

- engaging with referring professionals
- engaging with people
- engaging with the local voluntary, community and social enterprise sector.

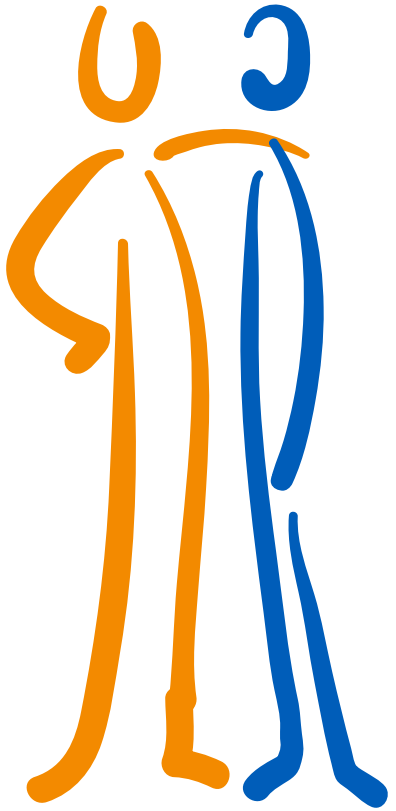
The link worker needs to have a broad range of skills and be able to work independently and pro-actively with people.

Engaging with referring professionals

- Link workers need to establish and maintain relationships with the referring professionals. A period of time should be dedicated to this before the social prescribing scheme goes live.
- When working with primary care health professionals, a link worker may attend weekly meetings at GP surgeries or other referring bodies. Attending such meetings can greatly help to establish appropriate practical aspects of the schemes. These aspects include:
  - the criteria for practice teams to refer people to the link worker
  - the criteria for link workers, when a person needs to be referred back to a GP
  - the criteria for link workers when a person needs to be referred to adult social care.
- Increasingly adult social care and other voluntary, community and social enterprise organisations act as referring agents to the link worker and may also be cross-referring to each other. The link worker needs to maintain relationships with all agencies. In a scheme with a broad remit, a link worker may refer people to anything between 30 to 120 different groups and services.

Engaging with people

- The type of people that meet with a link worker will vary depending on where the service is located and who the target population is. They may vary from:
  - o those who need support to manage long-term conditions
  - o those who may be vulnerable, socially disadvantaged or at high risk of mental health crisis
  - o those who have a mixture of needs at different levels
  - o those who may be lonely or socially isolated
- Link workers need to be able to engage, empathise, listen, empower and motivate individuals. Solutions must be co-produced and tailored to a person's individual needs in line with what is available within a neighbourhood. Motivational interviewing skills are important as is the ability to manage people with acute anxiety and crisis.



Engaging with the local voluntary, community and social enterprise sector

- When the social prescribing scheme is being set up, link workers should undertake a community mapping exercise. They need to know which local voluntary, community and social enterprise groups already exist, what amenities are available, what they offer, and establish relationships with those groups. Time should be dedicated to this before the social prescribing scheme goes live.

- It is important to be realistic about the size of the voluntary sector available to refer people to. If the third sector is not on board, more time needs to be spent on developing relationships between link workers and between third sector organisations for cross-referral.

- In some schemes, link workers can only make referrals to specific pre-agreed organisations or programmes. The link worker should have an intimate knowledge of these programmes. Setting such limits may reduce the level of person-centeredness that the social prescribing scheme can achieve.

- Some link workers have a more complex role that involves some design of the social prescribing scheme, monitoring and supervision, and requires an enhanced knowledge of governance and safety.

- As the social prescribing scheme develops, it is inevitable that the link worker will identify gaps in local services or activities. Filling these gaps would require new groups to be set up. In some cases, a link worker may support new groups to get started, including looking for suitable grants and funding and discussing governance related matters. In this situation, the link worker may encourage people to set something up in their community.

Other skills, competencies and qualities of link workers:

- The ability to maintain an active caseload and keep accurate records.
- Good organisational, written and IT skills, such as word processing and maintaining databases.
- The ability to collect primary data for monitoring purposes
- Good knowledge of information governance and ability to maintain confidentiality at all times, within any statutory guidance on safeguarding.
- The ability to speak fluent English. Depending on the local area, the ability to speak other languages can be advantageous.
- The ability to effectively communicate with a wide range of stakeholders, including good social interaction and listening skills.
- The ability to work both as part of a team and independently.
- To have motivational interviewing training
- To have basic life support skills
- To have training on how to recognise and deal with safeguarding issues, including being able to refer back to NHS services for further support.
- To be sensitive to the needs of individuals and communities that are perceived as hard-to-reach
- To be non-judgmental and to take a positive approach to all people.
- To be honest and to have integrity.

Role of a link worker

There is a wide variation in how link workers have been used in different social prescribing schemes. This may reflect the amount of time a link worker has been allocated to work with a person within any given scheme.

Some schemes allocate four- six meetings with a link worker, whilst others are open-ended and contact lasts until the patient's wellbeing has improved. The level of engagement that a link worker has with a patient has been categorised by Kimberlee (2015)[41] as social prescribing 'light', 'medium' and 'holistic'.

The consultation:
A holistic social prescribing scheme is where a link worker spends as much time as is necessary with a patient to assess their needs, support them, co-produce solutions and to see an improvement in wellbeing.

In practice, the level of engagement with people will depend on their individual support needs when they are referred to the scheme. Commissioners may wish to consider the best way to deal with this variation in order to make the scheme as effective as possible and not impose arbitrary cut-off points.

Some people may already have a good level of 'activation'[42/43], which reflects their readiness to make a change. In this instance, the person may only need to see the link worker once or twice, and can be easily referred to a local organisation for further support.

In some settings, the link worker might be an approved social worker, or health professional (DoH, 2006)[44], or have specific skills e.g. motivational interviewing and 'work' coaching. The link worker can work on a one-to-one basis directly with the person, where other organisations cannot help, and be able to identify people who are at risk of mental health crisis. Employing link workers with professional qualifications may help where there people have significant needs, (for example, Asperger's Syndrome).

[41] Kimberlee, R. (2015) What is social prescribing? Advances in Social Sciences Research Journal, Volume 2, No1.

[42] Hibbard J, Stockard J, Mahoney ER and Tusler M (2004) Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers Health Service Research 39(4 Pt 1): 1005–1026.

[43] Blakemore A, Hann M, Howells K, Panagioti M, Sidaway M, Reeves D, and Bower P (2016). Patient activation in older people with long-term conditions and multimorbidity: correlates and change in a cohort study in the United Kingdom BMC Health Serv Res16: 582

[44] DoH, 2006 'Our health, our care, our say: a new direction for community services'

In a holistic social prescribing scheme, a link worker engages with each person in longer consultations, lasting between thirty to sixty minutes. Together they identify the barriers to an enhanced quality of life.

Link workers often co-produce a programme specific to each person to address their social problems. This entails engaging with the third sector or specialist projects set up specifically to address a pattern of need.

The link worker works at the person's own pace, supporting them to drive much of the journey themselves. This leads to a time in the future where the person has the confidence and the life skills to move on without support.

For people with anxiety or depression, or who have low confidence or self-esteem, it can feel like an insurmountable challenge to go to a group where they do not know anyone. In the most person-centred schemes, the link worker may accompany a person to a new group to help them overcome this barrier to support.

An improvement in quality of life (whether financial, housing, relationships, employment, debt management, new skills, community engagement, reduced isolation or other) contributes to the alleviation of low-level depressive symptoms, anxiety, social phobia, low confidence and low self-esteem.

The link worker should refer the person back to the referring doctor if they think they are at imminent risk, e.g. of a mental health crisis.

The link worker works at the person's own pace, supporting them to drive much of the journey themselves.

6. What makes for a good referral?

Referrals mainly take place at two points in a social prescribing scheme:

1. from a health professional to a link worker
2. from a link worker to a local third sector or statutory organisation.

- Depending on how the social prescribing scheme has been set up, other referrals to a link worker may come from other providers such as housing, secondary care, or cross referrals from other voluntary organisations.
- Sometimes a link worker may also make a referral back to a health professional, if they identify someone who needs crisis support

The referral process is not to be confused with signposting. Signposting is when a person is provided with information about another service and has to initiate contact themselves. A referral is a request from one part of a system to another part of the system, on behalf of the person.

For people who are experiencing challenging life situations such as low confidence or self-esteem, anxiety, depression or social isolation, signposting will not be a suitable approach to enabling change. This is evidenced by the increasing number of people who present to primary care with mental or physical health problems associated with their social circumstances. A growing number of people need and seek more support than general practice can offer. One way to provide that support is through the contact with a link worker who can give people more space to talk about their issues and provide motivational guidance and access to community organisations

On the other hand, people who are already confident, 'activated' (Hibbard et al 2004[45]; Blakemore et al, 2016[46]) and ready for change may benefit from supported signposting.

[45] Hibbard J, Stockard J, Mahoney ER and Tusler M (2004) Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers Health Service Research 39(4 Pt 1): 1005–1026.

[46] Blakemore A, Hann M, Howells K, Panagioti M, Sidaway M, Reeves D, and Bower P (2016). Patient activation in older people with long-term conditions and multimorbidity: correlates and change in a cohort study in the United Kingdom BMC Health Serv Res16: 582.

Referral to the link worker

Many GPs use electronic referrals. However, it is important to understand the local situation before deciding which systems are best. It may be that an electronic referral system is not yet in place. An integrated IT approach will allow better tracking of outcomes over time and across the social prescribing journey, and it is likely to become more common over time.

The following are critical elements of a good referral.

- Clear consent from the person who is being referred.
- Why the person is being referred and what they need support with. In reality, the person and the link worker may end up working on other issues as well, because they have longer contact time than the original health professional and other issues tend to emerge.
- The person's views on what they need and want.
- Any communication requirements the person may have.
- Risk issues. Where complex cases are involved, health professional referrers need to ensure the link worker has relevant information to keep everyone safe.
- Clarity on how and when the referring health professional expects feedback.
- Clarity on any relevant issues that the link worker now has lead responsibility for.

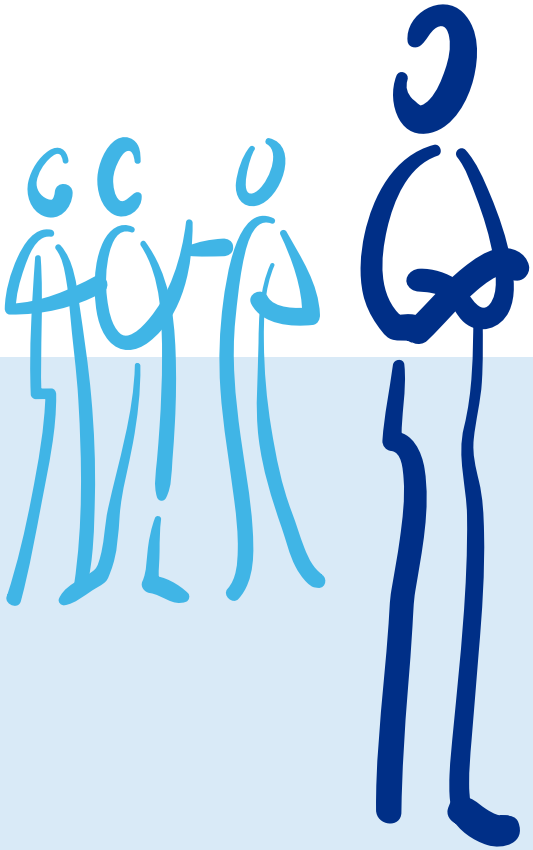
Referral to a local voluntary, community and social enterprise organisation by a link worker

- Clear consent of the person to the referral.
- A co-produced view of what the person may need support with.
- Any communication requirements the person may have.
- Clarity about handover. It is important that the link worker, the person and the community groups are clear on the following:
    - o At what point the person's involvement with the link worker and the social prescribing scheme is replaced by their membership of local groups and networks, for example; who is contacting the person after the referral? Is it the link worker's responsibility or the community group's responsibility?
    - o If there is any follow up expected from the social prescribing scheme?
    - o Whether the person can return to see the link worker, within a certain time frame, and if so, how.
    - o The expectations on the local group being referred to. For example, if the person stops attending the group, does the group have a responsibility to report this? Non-attendance may be an indication that a person's vulnerability has escalated.
    - o If the group has collected any outcomes, do these need to be shared with other stakeholders in the scheme, if so, how?

A significant barrier to achieving the points on this page, is the lack of funding for the community organisations to support people after they have been referred by link workers. It is critical for community organisations to coordinate their work with link workers. This minimises the risk of people losing motivation and returning to general practice.

A successful social prescribing scheme will ensure that there is clarity and transparency between the organisations involved and the local voluntary, community and social enterprise groups. This is best achieved by having multidisciplinary stakeholder meetings several times a year. Arranging these meetings should be part of the initial design of any social prescribing scheme.

7. Managing risk, safeguarding and governance



It is important to ensure that any social prescribing scheme has appropriate governance. This requires a review of what policies and procedures are in place for each component of the scheme, for example, policies that are specific to:

- the referring healthcare professional
- the link worker
- the local voluntary, community or social enterprise group that provides the 'social prescription'.

Good quality service provision also requires that every stakeholder be clear on who has duty of care for the person as they move between professional and organisational boundaries.

It would be wrong for governance and paperwork to stifle the gifts of time and support that people are willing to give on a voluntary basis in their communities. It would also be wrong to put too many hurdles in the way of people or organisations who want to set up a social prescribing scheme and take on a link worker. It is, however, important to remember that different stakeholders can have differing expectations of the levels of governance required in a social prescribing scheme. This reflects the fact that different sectors are subject to different regulations. All partners should be involved in the design process as early as possible.

This section provides points to consider and resources for further reading to foster a sensible and safe environment. The information is provided from different perspectives to try and address some of the questions and concerns that exist.

Healthcare professionals

A common question raised by GPs is:

> 'I am a GP – do I retain legal responsibility for the patient once they have moved to using the local voluntary, community and social enterprise services and groups, as I was the person who referred them?'

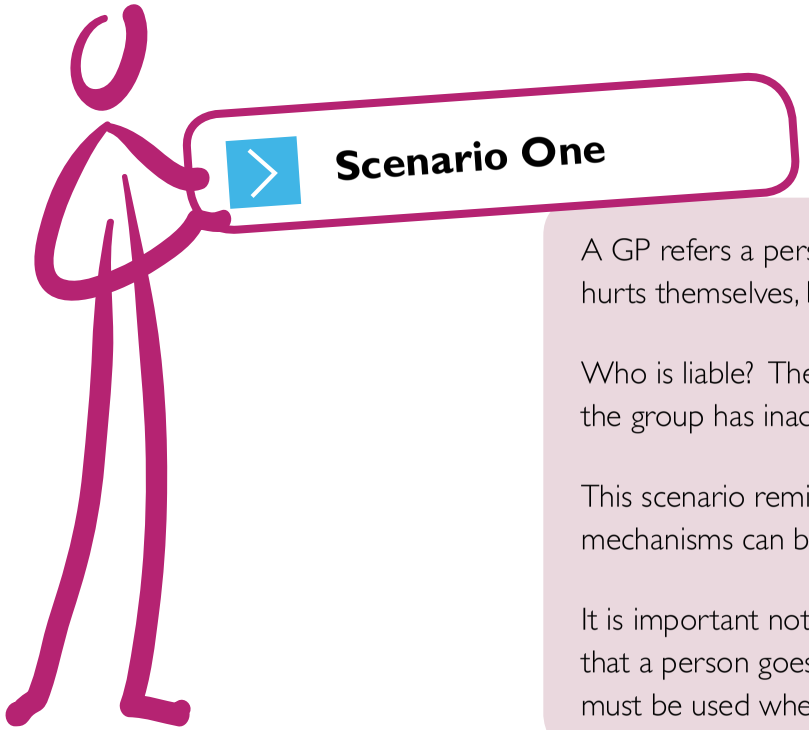
Of course, everyone is entitled to join any group in the community or access any form of help they wish. This document is focussed on social prescribing schemes that have link workers in place. Where there is self-referral, the GP does not retain legal responsibility. This question, however, raises several points.

- A person may be more likely to trust a service to which their doctor has referred him or her.
- In general, as a referrer, the GP needs to know that the link worker and/or organisation providing the social prescription have their own appropriate governance, professional standards and/or liability insurance in place.
- If more referrals are going outside the NHS, professionals may be expected to reflect on who has overall responsibility for other people's actions. One approach is to have meetings between all potential partners involved in the social prescribing scheme. All of these questions should be discussed and clarified at an early stage by all potential partners and if necessary legal advice should be sought.
- Responsibility to ensure that appropriate governance is in place is with the commissioners, if the social prescribing scheme is a commissioned service. Commissioners, as ever, need to ensure that quality standards exist in their contracts with providers and should hold contracted providers to these standards. However, whilst commissioners will set out some of what governance is expected, managing risk and ensuring good governance is ultimately the responsibility of the provider.

Let us take some hypothetical scenarios for consideration.

Scenario One

Scenario Two



Scenario One

A GP refers a person directly to a local gardening group to help with isolation and confidence. The person hurts themselves, but the group has inadequate mechanisms for complaint or inadequate liability insurance.

Who is liable? The GP who made the referral or the group? This scenario may be further complicated if the group has inadequate polices for accepting this type of referral.

This scenario reminds us that safety is never fully guaranteed under any circumstances. However, mechanisms can be put in place for vetting groups and monitoring activities through using a link worker.

It is important not to be overly cautious and create problems where there are none. If a GP recommends that a person goes walking, but then trips over the kerb, there is no question of liability and common sense must be used when it comes to due diligence.

A GP refers a person via the link worker for support with impending homelessness. The link worker refers the person to a housing advice agency. Ultimately the issues cannot be resolved and the person loses their home.

Who is liable? The GP who made the initial referral, the link worker or the housing advice agency?

Ultimately, it is for the service provider (housing advice agency) to ensure that staff and volunteers have adequate training and support, and if everything reasonable was done to prevent the homelessness, then it would be difficult to suggest a breach of organisational liability.

Scenario Two

Link workers

Link workers must have relevant training and appropriate disclosure and barring (DBS) checks in place for working with vulnerable people. The training required may vary according to the breadth of role that the link worker undertakes. We have written a specific section on the role of the link worker that covers this in more detail (section 5).

The social prescribing scheme should have a lone worker policy and sensible precautions must be taken where link workers visit people in their own homes. Link workers should also be trained to recognise and seek appropriate help for those who are at risk of self-harm.

Social prescribing supports an asset based approach. The link worker gets to know a person's needs and interests through an initial assessment. By utilising their knowledge of services they can provide options that the person may find helpful. By jointly agreeing an action plan with the person the link workers remove barriers to tackling the wider social determinants of health. The key step is that the person always has choice and therefore consents to being involved in a community organisation. Link workers do not make a decision on behalf of the person, but empower the person to choose well.

Where people are using small local groups with no formal structure (for example, a book group) the link worker might introduce the person to the group in advance. The link worker should be available to hear any concerns that a person may have once he or she has accessed a group.

Where private services are needed by the person, link workers can help them access trading standards assured schemes such as Buy with Confidence[36]. In general, the link worker should help the client to identify what will make them feel comfortable with a particular type of provider.

Scenario for consideration:

An 85 year old woman with a hearing impairment and memory problems needed a gardener to replace one she had had for many years, but needed more support than simply using Buy with Confidence[47]. The link worker helped her interview three from their pre-existing list. This both helped the woman think about her choice and made the prospective gardener aware that the woman was not totally isolated, but had access to support.

[47] https://www.buywithconfidence.gov.uk/

Local voluntary, community and social enterprise sector

Appropriate governance should be in place when a link worker refers someone to a community group or organisation. Transparency on these issues is paramount for all stakeholders across the social prescribing scheme. The personal responsible for ensuring this is the case may differ depending on how the scheme is funded or commissioned.

What constitutes necessary and appropriate governance depends on who is providing the social prescription and also how the local voluntary, community or social enterprise group is viewed in the eyes of the law.

There are two basic distinctions between groups from a legal perspective – unincorporated organisations and incorporated organisations[48].

Unincorporated organisations

These organisations are not subject to any statutory framework (unless they are registered as a charity). Examples include self-help groups and charitable trusts. This format is most suitable for small groups, who do not employ staff, provide formal services or have responsibility for buildings. Legally, these groups are run by 'a collection of individuals' that each have 'unlimited liability' if anything goes wrong and there is a legal dispute.

- Voluntary groups can access support from the National Council for Voluntary Organisations, (NCVO) or National Association for Voluntary and Community Action (NAVCA) to ensure basic policies and procedures are in place.
- Local infrastructure agencies, such as Councils for Voluntary Service can support local groups to understand their liabilities, encourage good practice, create basic policies and access funding to promote good governance for example, the creation of a health and safety policy, equal opportunities policy and a safeguarding policy.
- In their pre-planning and design, it is important that organisations reassure themselves that they are happy to undertake social prescribing activity and take referrals from others. With a moderate amount of planning and reflection, this is not onerous.
- Grants and service level agreements are the easiest ways to fund small projects and pilots, focusing on the elements of the activities to be supported.

[48] http://www.communityimpactbucks.org.uk/data/files/Self_Help_Guides/Vol_Action_Leics/your-guide-to-vcs-legal-structures-january-10-print.pdf (Last accessed 24 March 2017)

Incorporated organisations

These organisations are subject to statutory frameworks, such as company law. Examples include company limited by guarantee, community interest companies, charitable incorporated organisations. Where there is a legal dispute, people would sue the company, rather than the collection of individuals who run it. This therefore, 'limits the liabilities' of trustees and directors.

- Where more formal services are 'prescribed', such as the link worker service, debt advice or counselling, local commissioners may wish to create a legally binding contract, such as the Standard NHS or Shortened Standard Contract. This sets out clear expectations of both parties and gives commissioners confidence about quality and performance standards.

Minimum standards for people

A person should be able to expect minimum standards of governance in any organisation to which they are referred. This is dependent upon the type of social prescribing organisation and the nature of the work being carried out.

Examples of minimum standards for all social prescribing organisations of any type are set out here.

- A clear plan in place to take into account a patient's safety, governance, safeguarding, complaints, and monitoring, which can be justified according to the level of social prescribing and activities being offered.
- Information governance procedures to encompass consent, data sharing, confidentiality and data management. The organisation commits to protecting volunteers and groups from harm, as well as those person who are referred by them or to them.
- Clear lines of accountability are in place between organisations making referrals to the link worker and between link workers and voluntary, community and social enterprise organisations.
- The roles of link workers (and their managers) should be paid staff members, receiving appropriate supervision for their complex and often challenging roles. This gives people using the service continuity and confidence that minimum standards are maintained.
- Organisations employing link workers and those providing community support should organise regular reviews to check outcomes and satisfaction for the people they are supporting. This should be appropriate to the activity, involving volunteers, staff and where possible, people who use the service in its design.
- A commitment to supporting volunteers, which includes out of pocket expenses, as a result of giving their time freely and regular, informal supervision.

The following links all provide information on a range of quality standards, quality indicators and regulatory requirements of different groups and organisations, which may be part of a social prescribing scheme.

- The National Council for Voluntary Organisations (NCVO) website outlines a range of 'off the shelf' quality standards and frameworks. The site contains many useful resources on risk management, health and safety, whistleblowing, IT, quality and Improvement, and data protection guidance.

- The National Association for Voluntary and Community Action (NAVCA). NAVCA provides members with networking opportunities, specialist advice, policy information and training to support the set up and running of charities and community groups.

- A short and helpful document which describes the differences between unconsituted and constituted organisations.

- Companies Act 2006. This outlines what all registered companies must do to be a legitimate company registered with Companies House

- Direct Gov Charity Commission This outlines what all charities must do to be a legitimate charity registered with the Charities Commission

- Care Quality Commission This outlines the Health and Social Care Act regulations and the 'fundamental standards', below which care must never fall.

- NHS England's Commissioning pages. These give guidance and commissioning support information

- Successful Commissioning Toolkit from the National Audit office. This helps public bodies commission effectively from third sector organisations

- Buy with Confidence This is a trading standards approved database of tradespeople providing a range of services.

8. Evaluation of social prescribing schemes

In any social prescribing scheme there will be different stakeholders who have different ideas about what constitutes success. They will therefore start the process with different expectations of what data, evidence and evaluation are.

Each stakeholder is also highly likely to have a different perspective on what data they value and therefore should be collected. It is critical that a shared understanding of the aim of any evaluation of a social prescribing scheme is agreed by holding multi-stakeholder meetings at the start of a programme.

A shared understanding becomes increasingly important as the aims of social prescribing schemes align more closely to a social model of health e.g. where health is understood to be influenced by societal, environmental, economic, political, interpersonal and individual factors. The aim and associated outcomes of the social prescribing scheme may therefore range from what difference it makes to the person using the service, to the impact on the community where the social prescribing services are delivered and the impact on the NHS and Adult Social Care Services. This section will unpick these issues and provide points to think about when wanting to evaluate a social prescribing scheme.

It is critical that a shared understanding of the aim of any evaluation of a social prescribing scheme is agreed by holding multi-stakeholder meetings at the start of a programme.

Evaluation and evidence mean different things to different people

'Evaluation' is used to understand whether an intervention has achieved its desired aims. Existing guidance documents exist which view evaluation from a social science perspective[48] and from a medical perspective[49]. Each perspective has its own expectations and assumptions.

The evaluation process normally includes:

- understanding how many people went through an intervention (known as 'process evaluation');
- collecting qualitative data from case studies, focus groups and interviews to understand how or why an intervention is impacting on people and the community. This is used to measure what is known as 'acceptability', 'satisfaction' and 'experience';
- collecting outcomes data to understand what effect the intervention had. These outcomes may relate to an individual associated with the intervention, the community, or to a wider impact of the intervention. For any evaluation the outcomes data is collected to address the aim of the evaluation, hence, the outcomes collected are dependent on the scope of the social prescribing scheme.

'Evidence' in a medical setting is related to the concept of evidence-based medicine. This is an approach to making the best clinical decisions based on the most rigorous clinical research data and experience. The 'gold standard' is often referred to, which relates to data that has come from randomised controlled trials. This is seen to be the least biased method of showing cause and effect. Systematic reviews and meta-analyses then go on to systematically appraise data from randomised controlled trials to determine the overall likelihood of the effect of an intervention.

It is therefore possible to understand how different expectations, values and perceived aims of all stakeholders of a social prescribing scheme may occur.

[48] http://www.ae-sop.org/wp-content/uploads/2014/08/Aesop-PHE- Arts-in-health-evaluation-framework.pdf (last accessed 31 March 2017)

[49] Please can this '2' become the appropriate superscript number and here is the reference https://www.mrc.ac.uk/documents/pdf/complex-interventions- guidance/ (last accessed 31 March 2017)

Discrete evaluation vs monitoring of core outcomes

Data collection and evaluation can mean many things to many people. There are some helpful distinctions that can be made to try and work out how to approach an evaluation.

Discrete Evaluations

- It is common for organisations to do their own in-house evaluations with limited resources, often to provide data requested by commissioners. This may include opinions from stakeholders, patient satisfaction, self-written case studies, quotes, individual patient outcomes i.e. better housing, improved finances, reduced depression, patient testimonials.
- Discrete evaluations by external evaluators collect data for a set period of time, often by an external organisation, such as an academic institute. These evaluations often use a range of research methods (known as 'mixed methods'). These may include questionnaires, interviews, and focus groups to collect data from a sample number of people that are using the social prescribing scheme. The evaluators have the expertise, the time and resources to collect and analyse the data.
- The evaluators gain ethical approval from their institutions (and NHS if necessary) to collect the data, recruit participants, administer any questionnaires, undertake any interviews and focus groups, collect data back in, follow up with participants who have not responded to questionnaires, analyse the data and report back to the people who funded the evaluation.
- Often these evaluations collect data when a patient starts the social prescribing scheme and then when a person has used the scheme for a period of time, which is referred to as a 'pre-post evaluation'.
- Ideally the data capture aspect of an evaluation should be acceptable to staff, discrete and unobtrusive. This will require working with staff to identify how processes can best be implemented and to pilot potential administration procedures and measurement tools for acceptability.
- Time-wise, some scoping out is needed to identify which outcomes to measure, to gain ethical approval, and to develop relationships with key stakeholders in the scheme. This may last between six weeks to three months and happens prior to patients taking part in the evaluation. Commonly, it then takes about three months to analyse the data and construct a report.

Monitoring core outcomes

This style of evaluation is when the organisation(s) integrate measurement into the social prescribing scheme itself, such as by using an outcome measure. This means that every person provides data, which is collected and entered into an internal database. Ideally, the data is also analysed internally and used to measure how the social prescribing scheme is working. Data can be routinely analysed at set points in time, typically every six months.

Determining what to measure as core outcomes requires an in-depth understanding of what impact the social prescribing scheme has, how this is achieved and what the overall model of the scheme is. There is otherwise a risk that the core outcomes do not properly represent the total impact of the social prescribing scheme. It is also important to plan for routine monitoring from the beginning of planning a social prescribing scheme.

Preparing for an evaluation

If there is an intention to evaluate a social prescribing scheme, it is important to plan for this as early on in the process as possible. This allows processes to be put in place that will facilitate easier data collection later on.

Budgeting for an evaluation is essential. The greater the budget, the more in-depth the evaluation can be. It is unrealistic to allocate a small budget and expect a meaningful, useful evaluation. There are a variety of ways in which evaluations are funded. Some are funded via Clinical Commissioning Groups, some are funded by applying for specific research funds, for example, from the Health Foundation. It is recognised that each individual service provider will struggle to fund their own evaluation, however the implementation of any new social prescribing scheme is likely to be subject to some scrutiny at some point.

Here are indicative examples of realistic budgets and what can be achieved:

£5000-£10,000 – This is likely to be a single case study or some overall processing of existing data on who has used the social prescribing scheme and why, or basic analysis of outcomes data and a small literature review.

£30,000-£60,000 – This is a sizable amount of money that will allow an evaluator to visit the site several times, meet stakeholders, advise on setting up data collection procedures, ensure good ethical practices are in place, and then analyse data that has been collected. If the data collection period is longer than three months, the organisations involved in running the social prescribing scheme will need to be involved in data collection as well, to stay within budget.

£60,000 - £140,000 – For this budget, an external evaluator would be expected to come in and do the majority of the work. In addition to the activities listed under the previous funding bullet point, the evaluators would be collecting the vast majority of data themselves. This would definitely accommodate a mixed-methods approach, where qualitative and quantitative data could be collected, analysed, and reported to provide an in-depth understanding of the impact the social prescribing scheme has, and how and why this is so.

A good evaluation of a social prescribing scheme is an investment in the future. Data that is collected in a robust way can be used for different reasons.

- To provide an overall evaluation document for commissioners and funders of the service.
- To provide learning on how to improve existing social prescribing schemes.
- To set bench-mark levels of expectations of what can be achieved within the social prescribing scheme. This is useful if there is an intention to roll out another scheme in a new location.
- To identify aspects of the social prescribing scheme that can be quantified, but which may not have been previously considered.
- To identify any unexpected impacts.
- To provide 'effect sizes' that can be quantified using specific outcome measurement tools. These effect sizes with accompanying statistical data are essential for designing comparative studies.
- To identify core outcome data that is collected with every person using the service, and is integrated into the data management system. This data would be indicative of the whole social prescribing model and used for auditing purposes.

What is being evaluated?

When a social prescribing scheme is being evaluated, it is common for different stakeholders to want different data and outcomes. This difference in views can set up unrealistic expectations of what can be achieved with a small budget. Evaluation can be viewed on different levels.

- If there is no existing evaluation data, it is important to establish that the scheme is having the desired effect for the people it is designed to help. This requires data to be collected on the person's experience, acceptability and in the case of social prescribing, health and wellbeing outcomes. To date, much qualitative data has been collected, on people's stories, to gain a deeper understanding of why and how a person is benefitting from social prescribing. You may want to know what concerns the person has in order to understand why the person is using the service. The person's view of why they need to use the service may be different to that of the referrer.

- Perspectives and experiences of other stakeholders of the service may be evaluated. For example, what were the experiences of and impacts on the people making referrals, such as GPs? Did they find the service acceptable? Would they make any changes? Were the referral criteria working as anticipated?

- System level evaluation seeks to understand the wider impact on the health service, such as demand on GP services, admissions to A&E, and unplanned admissions to hospitals.

- System level evaluation can also measure the wider impact for the local community. This may be measuring how many people started volunteering or working, how many new groups have been established and any changes to crime levels, use of emergency services or housing services.

- Economic evaluation seeks to monetarise the outcomes achieved, asking 'how much money is saved by the programme?' However, there is no agreed approach to economic evaluation for social prescribing schemes as yet.

References

Arts for health and wellbeing: an evaluation framework. Developed by AESOP and Public Health England. It is an example of how to approach evaluation of a specific sector where there are a range of arts-based interventions. This guide sets out the principles of evaluation in this sector, methods used, how to collect and report the findings from the perspective of the project/intervention being evaluated and the evaluation[50].

Developing and Evaluating Complex Health Interventions Produced for the Medical Research Council. It describes how to collect data using specific staged research methods, to build a robust foundation for developing controlled trials[51].

[50] http://www.ae-sop.org/wp-content/uploads/2014/08/Aesop-PHE-Arts-in-health-evaluation-framework.pdf (last accessed 31 March 2017)

[51] https://www.mrc.ac.uk/documents/pdf/complex-interventions-guidance/ (last accessed 31 March 2017)

Evaluation checklist

This evaluation checklist covers much of the information in the 'Evaluation of Social Prescribing Schemes' section, and aims to help you decide how to approach an evaluation.

1. Is there a shared understanding between all stakeholders as to the aim of the evaluation? What do stakeholders value? It is essential to include service users at this stage of the process.

☐ **Yes** – go to step 2

☐ **No** – convene a steering group comprising representation from all stakeholders, including people who use the service and external organisations to provide specific advice. Agree the aim of the evaluation then go to step 2.

2. Is evaluation being carried out using internal staff?

☐ **No** – go to step 3

☐ **Yes** – consider the list of points below. Only proceed to collecting data when all of these points have been addressed.

- **Have you calculated the time and resource implication of doing the evaluation internally?**
  ☐ Yes ☐ No

- **Have you identified all the data that you would need to collect?**
  ☐ Yes ☐ No

- **Is all the data you need to access readily available without contravening the Data Protection Act 1998**
  ☐ Yes ☐ No

- **If you are collecting data that is not routinely on the data records:**

  o what data is this?
  .....
  .....
  .....

  o what method(s) will you use to collect it?
  .....
  .....
  .....

- **Do you need to use any outcome measurement tools?**
  ☐ Yes ☐ No

  o What is your rationale for choosing that tool?
  .....
  .....

  o How will the data you collect contribute to answering the aim of the evaluation?
  .....
  .....

  o Is the tool validated?
  ☐ Yes ☐ No

  o Does the tool allow you to determine what a meaningful score change is?
  ☐ Yes ☐ No

  o Does the tool have any license costs?
  ☐ Yes ☐ No

  o Do you have to register to use the tool?
  ☐ Yes ☐ No

  o Have you checked the instructions to determine how you use the tools? For instance, changing wording is not usually allowed. Some data can only be analysed when a minimum number of questions have been completed.
  .....
  .....
  .....

- How long will it take the slowest person to complete the questions on the tool?

  .....

  .....

- Have people using the service and other stakeholders been informed of why additional data is being collected? Have they provided informed consent? Are they given the chance to opt out?

  .....

  .....

- **Who is going to collect the data?**

  .....

- Is this expected to be an additional part of someone's job?

  ☐ Yes ☐ No

- Has the person been trained to collect data appropriately? Outcomes measures that are validated all have to adhere to certain requirements. Specific IT skills may be necessary.

  ☐ Yes ☐ No

- At what point is data going to be collected in relation to the existing social prescribing scheme?

  .....

  .....

- How long will it take to routinely collect all the data you want?

  .....

- Have you tested out the feasibility of collecting this data on a small sample of people using the service first?

  .....

- **How long are you going to collect the data for?**

  .....

  .....

- Are you collecting the data when a person first enters the social prescribing scheme and at a set follow up point? If so, when and why then?

  .....

- How many people are a good number to collect data from? What is your rationale for this choice?

  .....

  .....

- How many weeks or months will it take to achieve the target data collection?

  .....

- **Data analysis.**
  - o Who will analyse the data?
    .....
  - o Does he or she have the necessary expertise or do they need some training?
    .....
  - o Is this an additional part of his or her job?
    .....
  - o How long will it take to analyse the data?
    .....
- **Who is going to feed back the data analysis to the stakeholders?**
  .....
  .....
- **What format(s) will this feedback be in?**
  .....
  .....
- **If the data is to be used for purposes other than internally, participants need to be aware of this and therefore need to provide informed consent.**
  .....
  .....
  .....
- **What is the next step once the data has been reported? Will it be used to inform developments of the social prescribing scheme?**
  .....
  .....
  .....

3. Using external organisations to carry out evaluation

This can add a level of independence to the data that is gained. It also frees up the internal staff from trying to carry out this process when time and expertise may not always be available.

Consider the following points.

Budgeting for an external evaluation.

There is a wide variation in what is seen as a realistic budget for an evaluation by different organisations. Evaluation budgets are often more of an afterthought, once the social prescribing scheme has been designed and is up and running. To give an example of variation:

- £5000-£10,000 – This is likely to be a cursory evaluation, perhaps one case study, or some overall processing of existing data on who has used the social prescribing scheme and why, or basic analysis of outcomes data and a small literature review.
- £30,000-£60,000 – This is a sizable amount of money that will allow an evaluator to visit the site, meet stakeholders, advise on setting up data collection procedures, ensure good ethical practices are in place, and then analyse data that has been collected. If the data collection will extend for longer than three months, the organisations involved in running the social prescribing scheme will need to be involved in data collection as well (due to budget constraints).
- £60,000 - £140,000 – For this budget, an external evaluator would be expected to come in and do the majority of the work. On top of information listed above, the evaluators would be expected to be responsible for collecting the vast majority of data. This would definitely accommodate a mixed-methods approach, where qualitative and quantitative data could be collected, analysed, and reported to provide an in-depth understanding of the social prescribing scheme.
- The majority of budget is spent on staff costs, so if there are multiple schemes to evaluate or the data collection is over a long period of time, expect the cost to increase.

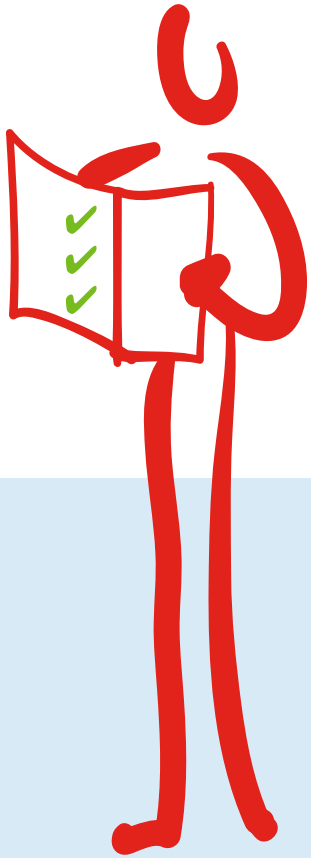
Preparing the tender and selecting the external evaluator

- Once the steering group has decided on the aims of an evaluation, this needs to be communicated to interested external organisations.

- Irrespective of which organisation is tendering an evaluation contract, there is usually internal paperwork to complete and a tender process to go through. Depending on the value of the contract, preparing this paperwork can take up to a month.

- When an external organisation has been selected, there are usually contract agreements to complete which can also take one to two weeks

9. A checklist of considerations for setting up a social prescribing scheme



This guide has provided information on the different social prescribing schemes that exist (See section 3.0). Further details on specific sections have been discussed elsewhere including essential ingredients (section 4.0), governance (section 7.0) and evaluation (section 8.0).

Common to all social prescribing schemes are three components, - referral from primary care and increasingly adult social care, a link worker who meets with people to discuss their situation and needs and a referral into the local voluntary, community and social enterprise sector.

This section highlights points to consider when setting up a social prescribing scheme, to give the scheme the best chance of success

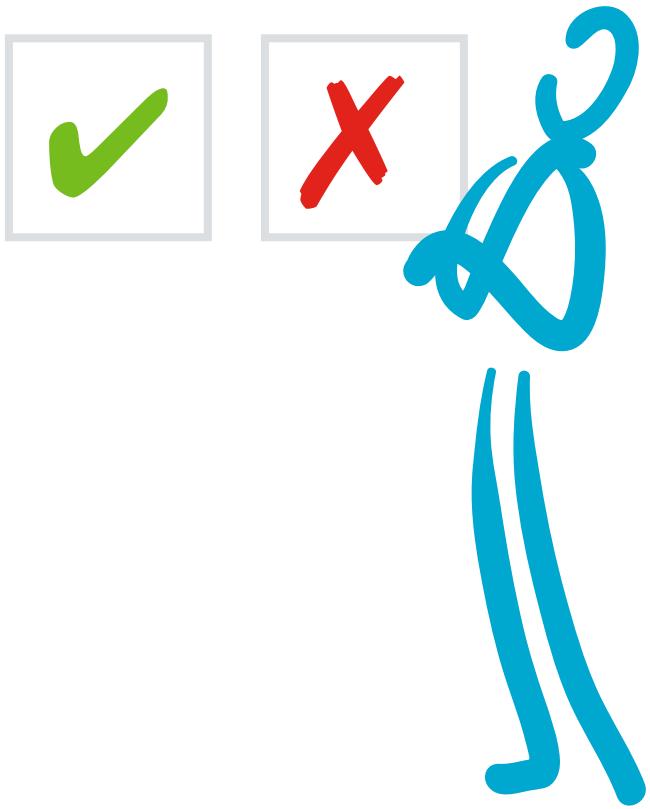
Are you clear about the aim of the social prescribing project?

- Targeting of specific conditions or populations - how are you identifying the people that the social prescribing scheme is aimed at? For example, this may be condition(s) specific or it may target those who attend primary care with mental or physical health problems associated with their social situation.

- Eligibility – of the target population identified, who is eligible for referral to social prescribing scheme?

- Who can refer people to the link worker?

- Are there simple and clear referral criteria in place, agreed by all stakeholders?



Effective partnerships

Have you set up a steering group involving all stakeholders in the social prescribing scheme? The earlier the different stakeholders can come together and work in partnership, the better chance of success for the social prescribing scheme.

- Are GP Champions part of the commissioning process?
- Are citizens and members of community groups able to take part in the commissioning process?
- Are social care partners, Public Health, Local Authorities, Housing Associations, The Fire and Rescue Service, The Police and Crime Commissioner aware and engaged with your plans as well as the voluntary, community and social enterprise sector?

When a steering group or working group is in place:

- Have you tested the broad outline of your model with these stakeholders and ensured a good 'fit' with existing provision and plans in the area?
- Are there existing partnerships with interested agencies willing to take referrals in your area?
- Will new partnerships with agencies need to be developed to set up the social prescribing scheme?
- Have you factored in time to develop new partnerships and identified who will develop these partnerships?
- Have you agreed with all stakeholders who will be responsible for the clarity of pathways, handovers, ongoing monitoring and 'closing' of cases?

Strategic fit

There are many initiatives to improve how services in different sectors can be more effectively integrated. How are you ensuring this social prescribing scheme links into the local integration agenda? For example, how is the social prescribing scheme linked to the following:

- Sustainability Transformation Plans
- Health and Wellbeing Strategies
- Joint Strategic Needs Assessments
- Prevention Strategies
- Carers' Strategies (with an eye on the new 'National Carers' Strategy' being published during 2017)

Furthermore,

- How will the social prescribing scheme work with multi-specialty teams in local areas?
- Will the social prescribing scheme work in partnership with social care and if so how?
- How will the commissioning or development of the social prescribing scheme link into any Asset Based Community Development locally.

Appropriate and reliable resourcing

All social prescribing schemes are different which is why they offer a truly local and personalised support offer. Ensuring that the appropriate amount of resource is in place to sustain a successful social prescribing scheme is critical. This is particularly important when budget cuts to all sectors mean that many small third sector organisations do not have enough resource to continue offering services.

Here are some considerations to support resourcing for the social prescribing scheme:

- If you are piloting a scheme, how will you know when it is reaching capacity and what will the solution be if a pilot exceeds capacity?
- Do you have a long-term vision for funding the social prescribing scheme?
- When can extensions of successful pilots be negotiated? Social capital takes a long time to build and a very short time to destroy
- Can you commission additional provision of services, if more needs are identified than were initially anticipated at the mapping stage?
- If your social prescribing scheme has a broad aim, to address issues around prevention, wellbeing, social care, and housing, is it possible to lever resources from other partners looking for solutions as part of a multi-agency vision?
- Is there/should there be an explicit exit strategy if funding is no longer available so that some element of community led SP would survive?
- What is a reasonable level of volunteer activity within the scheme? How do you know this is not overly ambitious, given issues around recruiting, training, supporting and finding the right level of responsibility for volunteers? How will quality volunteer management be delivered?
- Are you intending to evaluate the social prescribing scheme? Have you got realistic expectations around this? (See Section 8.0)

Infrastructure and capacity of the local voluntary, community and social enterprise sector

A social prescribing scheme will only work in a sustainable manner if the local voluntary, community and social enterprise sector is in place to receive increased referrals. This raises many issues that require upfront discussion with the steering group.

- What is the real world state of the local voluntary, community and social enterprise sector? What assessment have you done of existing voluntary, community and social enterprise groups?
- Could a new social prescribing service put additional pressures on existing services that may not be manageable? How can you support the sector - and the social prescribing scheme to deal with this?
- If cuts are being made, sensitive handling of new initiatives will be required to gain local buy-in rather than risking hostility from voluntary, community and social enterprise organisations.
- Can you reassure existing voluntary and community sector providers that the social prescribing scheme will ensure work flows to, rather than away from them?
- Do all stakeholders understand that link workers will refer to local voluntary, community and social enterprise groups?
- Are you expecting local voluntary, community and social enterprise groups to do significantly more work without additional funding? How will you reassure them that this will not occur?
- If there is a single point of access to the voluntary, community and social enterprise sector, such as a Council for Voluntary Service? How will the social prescribing scheme be integrated with it?
- If there is no single point of access to the third sector, how will you minimise duplication of effort and resource? Are there existing networks of service providers that can work with the social prescribing scheme?
- You may want data from local voluntary, community and social enterprise groups to be collected to inform further commissioning of social prescribing schemes. What agreement has been reached on this, to avoid setting unrealistic goals in these organisations?

Non-financial contributions from commissioners

Whilst setting up any new service will take time and energy, it is important to allow more time than usual when developing effective relationships in social prescribing schemes. Every one of the many stakeholders have valuable experience and knowledge to contribute to constructing a social prescribing scheme that will best suit the needs of people in your area.

How might you be able to support social prescribing schemes?

- Can you analyse need, practice by practice, to support identifying the target population for a social prescribing scheme?
- Can you suggest strategies to reach out to key groups of vulnerable people?
- Can you assist stakeholders in social prescribing projects to access key people in partner agencies?
- Can you access communications support to help promotion of the social prescribing scheme?
- Can you access data on outcomes in primary care?
- Can you support the gathering of appropriate data on the outcomes of people who have had social prescriptions?

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