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Social Prescribing in Greater Manchester

Executive Summary

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About the authors



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University of Salford – The Sustainable Housing and Urban Studies Unit is a dedicated multi-disciplinary research and consultancy unit of the University of Salford. It draws together researchers from a variety of disciplines across the University. This work has also been supported by the Centre for Applied research in Health, Welfare and Policy (CARE) <https://www.salford.ac.uk/research/care/research-groups/shusu> <https://www.salford.ac.uk/research/care>.



Salford CVS – Salford CVS is the city-wide infrastructure organisation for the voluntary, community and social enterprise sector; providing specialist information, advice, development support and opportunities for influence and collaboration. For further information see <https://www.salfordcvs.co.uk/>.



Start is an arts & wellbeing charity which was established twenty five years ago and delivers a range of asset-based holistic mental health services. These services provide emotional wellbeing, recovery interventions and training opportunities through creative arts-based and horticultural activities to vulnerable individuals. For further information, see <https://www.startinspiringminds.org.uk/>.



Greater Manchester Devolution VCSE Reference Group – The Reference Group seeks to promote the role and involvement of the VCSE sector and communities in devolution. It comprises individuals from 22 voluntary, community, faith, and social enterprise organisations from across Greater Manchester. For more information, see <https://www.vsnw.org.uk/our-work/devolution/gm-vcse-devolution-referencegroup/>.

in Greater Manchester

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-Salford CVS and the University of Salford 2018

Introduction

This summary presents key findings from a mapping and research exercise undertaken by the University of Salford and Salford CVS from February to May of 2018. The research was designed to fill an important gap in our knowledge about what social prescribing activities already exist in Greater Manchester (GM), whether there exists any kind of emerging consensus around models or best practices within this GM context, and how this relates to best practices existing across the UK.

The increased use of various forms of social prescribing is being driven by two convergent forces: a move towards providing more holistic person-centred care to promote wellbeing rather than a focus on interventions to heal sickness; and an increased appetite to implement non-medical solutions to help reduce pressures on GPs and costs to the NHS. Social prescribing is hence being driven both nationally and locally as a non-medical approach that supports person and community-centred approaches to creating individual and community wellbeing. As work continues to define and consolidate social prescribing nationally by NHS England and the Social Prescribing Network among others, this work to identify and illustrate examples of good social prescribing practice at the GM level will be important in enabling implementation of social prescribing which best fits the local context.

In February 2018, the Greater Manchester Devolution Voluntary, Community and Social Enterprise (VCSE) Reference Group commissioned from amongst its membership a review of social prescribing in Greater Manchester. It was noted that Salford was well placed to lead this work, which was sponsored by Start in Salford, and led by Salford CVS. Salford CVS subsequently developed a research partnership with the University of Salford to deliver against the agreed brief.

The perception of both the Reference Group and GM Health & Social Care Partnership was that there was a range of formal and ad hoc arrangements for social prescribing across GM's ten local authority districts, and no one single overall 'map' of what is happening. The research set out to test these perceptions; and consisted of a systematic desk-based mapping of best practices in social prescribing across the UK, a survey to map existing social prescribing activity across Greater Manchester and a 'deep dive' involving a more extensive survey and interviews with key personnel in Salford.

Key Findings

National Learning and Best Practices

It is clear from our research that there exists a number of different definitions of just what social prescribing is, the simplest being 'a process whereby primary care patients are linked or referred to nonmedical sources of support in the community and voluntary sector' (Pilkington, Loef, & Polley, 2017). Key to this referral process is the role of a link worker – to provide a face to face conversation during which the patient can learn about what support might be available to them as an alternative to prescribed medication, and to allow them to work with the link worker to design their own personalised solutions.

The national evidence base shows broad agreement that social prescribing is an area that is quickly expanding; that the term remains differently defined and covers a diverse array of models, interventions and outcomes and that social prescribing leads to improved wellbeing among patients and usually benefits both the community and voluntary sector.

The variety of models and definitions reflect their organic development adapted to local assets and challenges. This was their strength, and one that work to formalise the sector should support and build on as flexibility and adaptability of provision proved central to improved outcomes.

Models ranged from providing basic signposting services to fully holistic provision. While signposting was adequate for certain patients, for the majority (particularly those patients with more complex needs who accessed services most often), the more holistic the service provision the better the outcomes.

The link worker role, working closely with individuals referred by the health sector to improve their health and lives through involvement in community programmes and activities, was key to success but often underfunded and insecure.

Consistency of provision and relationships between the medical, VCSE and informal community sectors were equally central, but often threatened by a lack of long-term core funding and secure contracts for experienced staff.

Across the research, services were found to be more successful the more holistic the provision, the more face-to-face contact provided for the time needed by the patient, and the stronger the relationships between the health worker, the link worker, the VCSE sector and the patient. Primary challenges to success included:

1. rapidly changing commissioning models,
2. insecure funding for the VCSE sector and/or funding for the link worker position, and
3. a lack of streamlined communication between GP and link worker (a single data system or point of access to records was recommended).

Our review found a dearth of research looking at the full impact of social prescribing on the VCSE sector, particularly in terms of increased demand on their services

GM Mapping

A total of 94 surveys were received from 78 unique organisations, and findings reflected the research and evaluations taking place at the national level as summarised above.

- A significant number of organisations identified themselves as both referring to and providing social prescription as shown in Figure 1, and we found no emerging standardised model, service or approach.
- The surveys uncovered a huge breadth in provision, which could roughly be divided into three main types:
 - Service provision to particular populations (LGBT, elderly, BME and immigrant communities)
 - Service provision to particular neighbourhoods
 - Service provision targeting particular health issues (cancer, fitness, etc)
- Social prescribing was provided within each of the boroughs, although somewhat unevenly as shown in Figure 2. This work is intended to be only a starting point for each borough to more fully map out existing provision, given how the Salford 'deep dive' brought to light many more examples than in the other boroughs through local knowledge and relationships. Social prescribing is happening within each of the boroughs, although the responses showed a somewhat uneven geographical pattern. This pattern may in part result from the limited window for which the survey was available, and the mapping was intended to be only a starting point for each Locality. It is recommended that each area more fully map out existing provision, as the Salford 'deep dive' brought to light many more examples than in the other boroughs through local knowledge and relationships.

The GM findings appear to correlate well against Kimberlee's (2015) typology of social prescribing levels, proposed as a way to bring some order to the variety without imposing an overly constrained definition of model or type. He argues for four levels:

Figure 1 - What social prescribing activities is your organisation involved in?

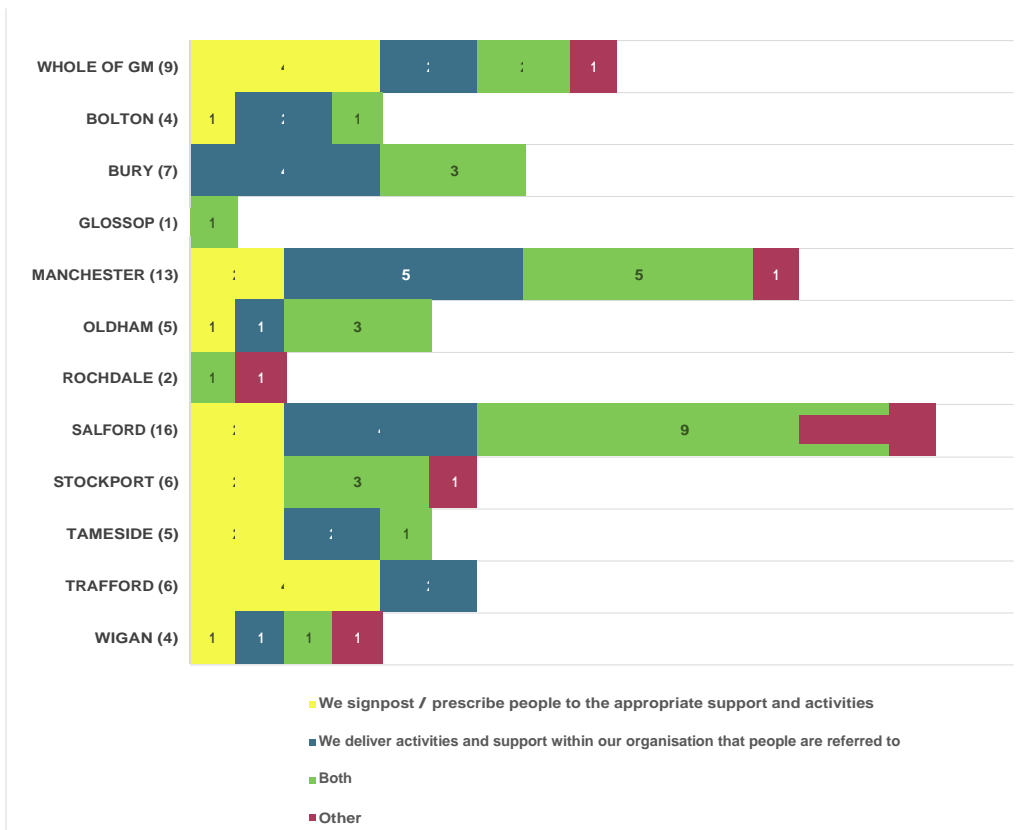
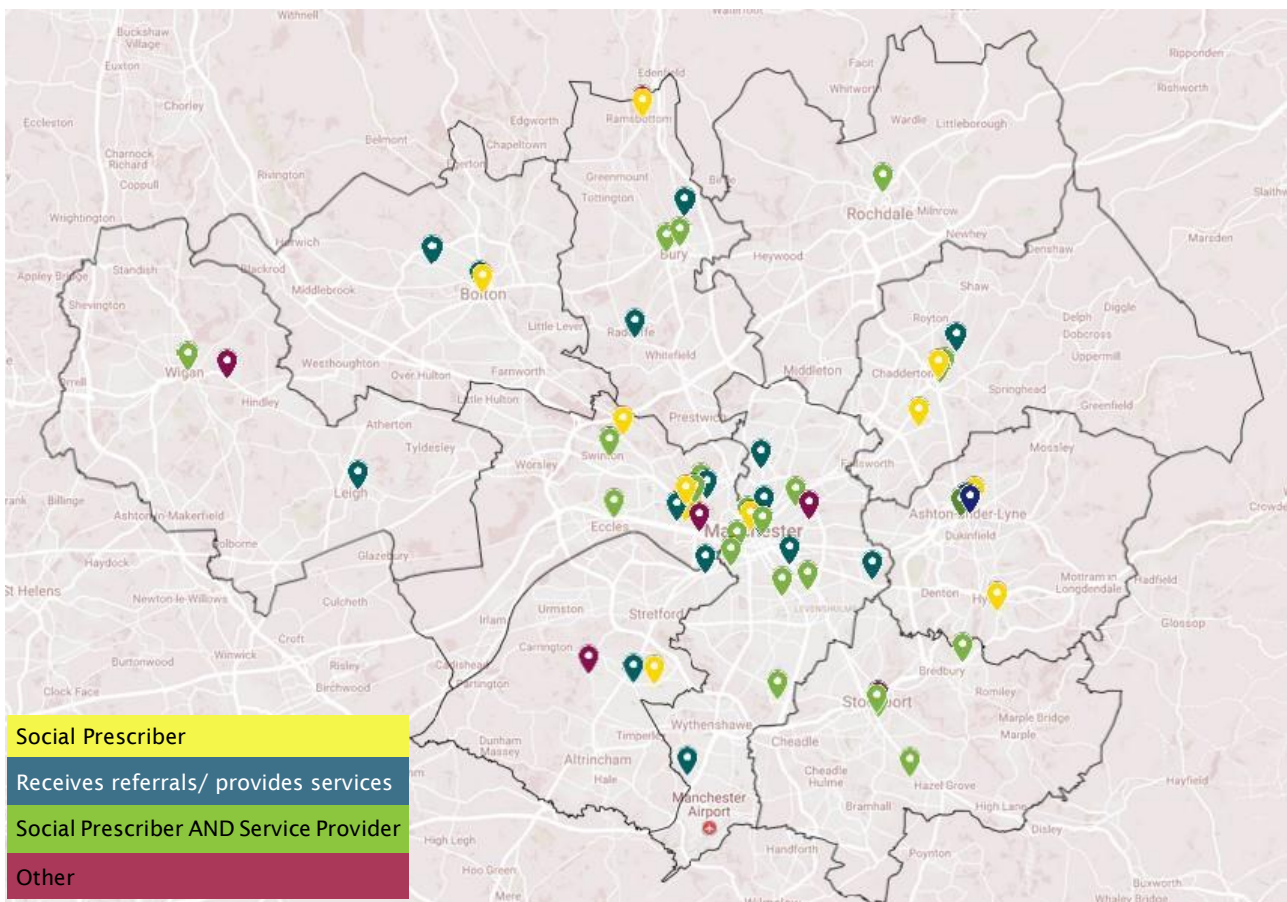


Figure 2 - Social prescribing activity in Greater Manchester



- Signposting: Most basic referral, often without relationships with organisation referrals made to, minimal contact with patient and little to no follow up
- Social Prescribing Lite: Community or Primary care-programmes referring people to a specific programme to achieve specific objectives
- Social Prescribing Medium: Health facilitator in practice with good relationships both with patients and VCSE sector, more support but still very directed to specific behaviours or objectives
- Holistic: involving direct primary care referral, comprehensive network of local provision, strong partnership working, consideration of all aspects of support – including budgeting, nutrition, addiction, loneliness, access to employment, etc.

The only caveat to this is that there appears to be some blurring of the line between Social Prescribing Lite and Medium, which is difficult to ascertain without first-hand knowledge of the programme. Many of those responding to the survey were trying to provide as holistic a service as possible within the constraints of resources, commissioning, geography, time, etc.

The activities being referred to under social prescribing are as diverse as the communities where they are situated in both the models examined and in the provision across GM. The reasons for a person being given a social prescription, however, seem fairly consistent, with social isolation being the most common across GM and a lack of wellbeing only slightly less so.

Conclusions

This initial mapping showed that there is already a wealth of activity and a great deal of collaborative working happening across GM, and that there are likely to be many more organisations and partnerships still remaining to be added through further, locality-based research. It is clear that greater clarity is required in what was being provided where, both for ease of referral and to ensure there was no duplication of service. However, it is also clear that the existing pattern of social prescribing is transitory – with much churn in activities, and arrangements dependent on word of mouth or personal contacts rather than a single, integrated ‘system’.

Furthermore, whilst initial enthusiasm and effort ensures growth of social prescribing schemes, maintaining ongoing connections between referrers and link workers or services is proving more difficult – a number of people raised the issue that referrals to programmes often tends to fall away after the initial period. Up to date ‘directories’, continued

Figure 2 on the following page shows the full extent of responses to our survey, with yellow self-defining as ‘social prescribers’, blue showing ‘receives referrals and providing services’, green doing both ‘prescribing’ and ‘providing’ and purple showing other respondents not specifically self-identifying with any single model.

Deep Dive Salford

Twelve Salford-based organisations responded to a more extensive survey, along with four others that worked in Salford as part of their work across GM.

- Individuals were being prescribed into three different ‘levels’ of care and support: commissioned services; wider VCSE activities; informal voluntary activity
- These referrals were not necessarily linear, and people were often referred from the VCSE sector back into commissioned services or to other VCSE or voluntary activities.
- Several organisations themselves provided services across two or more of these ‘levels’

It should be noted that this mapping only targeted GPs, commissioners and VCSE organisations, and there will be a number of other stakeholder groups whose views were not covered. In particular, the views of service-users and patients has not been captured through this exercise – representing a major gap in our local knowledge.

data sharing and consistent systems of referral are required to ensure sustainability.

It is also not clear whether social prescribing is consistently recognised as a referral option across primary and clinical care, which would reduce the potential effectiveness of local arrangements which have been put in place.

Enablers and Challenges:

Our research shows that the main enablers of an effective social prescribing system include:

- Holistic, joined up services – although some people only need basic signposting and referral, for all others the more holistic the service, the better the outcomes and satisfaction tend to be. Our research showed:
 - The clear need for face-to-face contact for successful outcomes.

- The importance of meeting with people where they feel most comfortable, whether in the home or community.
 - Where there is an absence of time limits, stronger relationships are made and people are allowed to make change at their own pace, thereby increasing the chances of success.
 - Good relationships - Relationships are central at all levels of service (CCGs & funders, GPs, link workers and/or champions, VCSE sector, community members) and regular communication/feedback facilitated these relationships as well as continuous adaptation and improvement
 - High levels of flexibility - provision needs to be highly flexible and free from top down constraint – it needs to be able to adapt both referral processes (some people still prefer phone and online) and services provided, in terms of programme content as well as location
 - Long term resources and secure staff - Link workers are central, and should have adequate funding, training and career pathways and bespoke Continuing Professional Development (CPD) activity
 - Up to date resource mapping
- The challenges identified through the surveys and discussions strongly align with those identified through the literature review. They can be grouped into three main categories summarised below:
- Funding and capacity - Funding is too short term and uncertain, with key staff often on short term contracts and the work of building collaborative relationships and community knowledge constantly at risk of being lost. While the referral process was key to success, equally key was a vibrant VCSE sector to receive these referrals. Both needed adequate funding for social prescribing to work.
 - Building an evidence base - There are clear differences in what the NHS and the VCSE sectors expect in terms of both the content and the form of programme evaluations. A strong evaluation methodology needs to be further developed. There is a desire for a very simple shared set of outcome measures around wellbeing, but not as yet a clear consensus around what those might look like.
 - Maintaining relationships - As with evidence requirements, there is a large difference between GP/NHS approaches and discourse and that of both community members and VCSE organisations. This needs to be better mediated to improve collaborative working. Given such differences, the literature identifies a need for a 'Leap of Faith' from GPs and the importance of maintaining ongoing engagement, which was echoed in local findings.
- All of these should be facilitated by a strong local VCSE infrastructure, facilitated by CVS / local infrastructure support organisations as well as support and collaboration from GM Health and Social Care Partnership.

Recommendations

Towards a Vision; A Holistic Approach

Enabling growth and development of social prescribing across GM will require a paradigm shift in the operationalisation of current systems. Evidence from the desk based mapping, plenaries and survey, highlights the diverse and complex context of current social prescribing across GM and Salford, and located exemplars of good, innovative practice. Whilst there is evidence that social prescribing is currently functioning across GM (and has been doing so for some time), there is also evidence to suggest that these activities require alignment within the wider GM (and emerging national) context. It is therefore incumbent on GM and the localities to facilitate a system that ensures best practice and existing good work are both recognised and included. Realising this vision means adopting a 'Holistic approach' as opposed to forcing existing services to comply with a model. Once embedded within the system, the 'holistic approach' will support the

ongoing engagement with and development of the social prescribing ecosystem.

The vision therefore is to support a GM holistic social prescribing approach devolved within each locality, which builds from the assets and activities which are already in existence.

Ultimately, the key recommendations to enable both GM and the localities to operationalise reflect both the regional and locality perspective as they relate to the evidence base, and are supported by specific, related recommendations responding to the associated challenges at the local and regional level (Figure 3)

Recommendations at a locality level:

Support and develop capacity to:

- 1 Create mechanisms to ensure the sustainability of the ecosystem being prescribed to
- 2 Create funding streams that support cooperative and collective working to avoid duplication and builds on organisational strengths
- 3 Support long-term, embedded link workers able to help patients navigate multiple organisations, activities and systems to improve their health
- 4 Develop peer support networks
- 5 Facilitate ongoing training, and potentially develop a certification programme with the possibility of career progression

Shift investment to support a holistic approach to Social Prescribing:

- 1 Fund the VCSE locality infrastructure that supports the wider VCSE sector and facilitates communication and joint working, including funding and support for VCSE neighbourhood anchor organisations
- 2 Rework GP incentives and internal markets to support this model
- 3 Ensure investment of co-designed service provision from the VCSE sector is not prescriptive and maximises their strengths, ie promotes flexibility and responsiveness to the community
- 4 Ensure sufficient investment in VCSE managed grants programmes – often more effective than commissioning services via procurement routes
- 5 Ensure the mechanisms are in place for ongoing effective communication between health and VCSE sectors, ensuring these are sufficiently resourced
- 6 Simplify referral processes, and develop shared information systems to reduce need for ongoing replications of 'diagnosis' (but also recognising that 'diagnosis' will not always be final and that it often takes time for underlying issues to be recognised and for a patient to be ready to act on them)

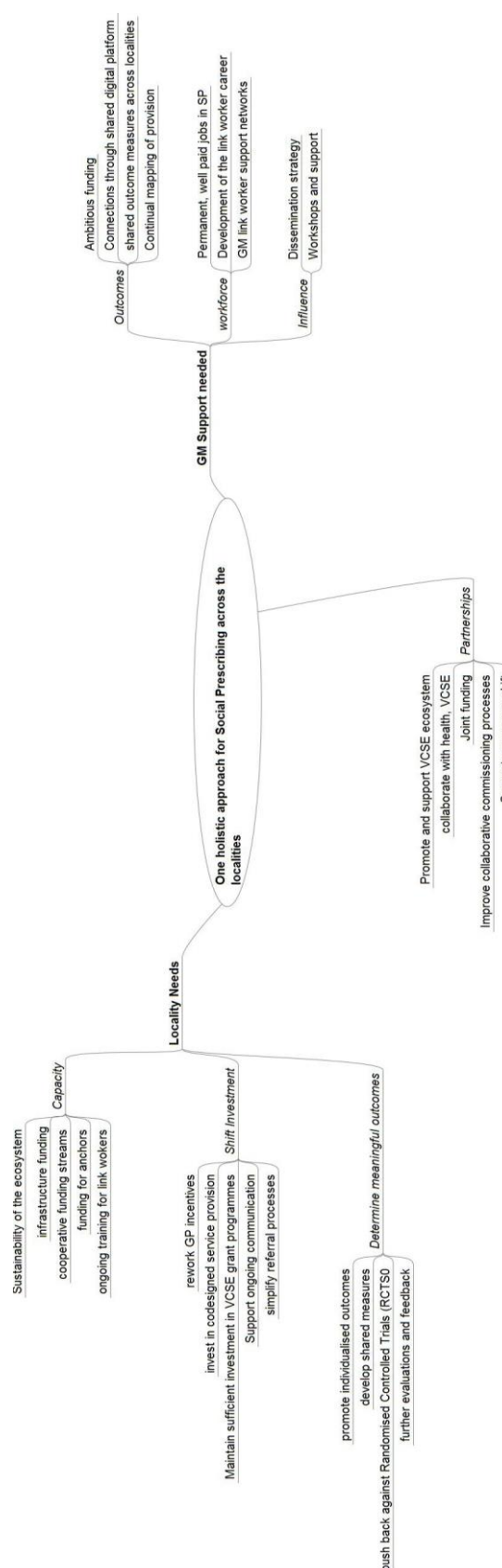


Figure 3 - Visual representation of recommendations at GM and locality level

Determine meaningful outcomes and build an evidence base

- 1 Promote individualised outcome measures specific to individual journeys within a programme alongside a set of simple shared outcome measures across the sector
- 2 Develop shared measures of broad-based reductions in demand over time on the NHS, but push back against demands for Randomised Control Trials (RCTs) and proof of causality for any one intervention
- 3 Educate funders and commissioners on the importance of qualitative over quantitative methodologies to understand causality and patient journeys to improved wellness
- 4 Undertake further research to better understand the non-linear and multiple interventions that support patient journeys, to improve support beyond linear models
- 5 Build collaborative work and information sharing between and among health and VCSE services to support and make central the individual's journey towards wellness

GM recommendations:

These build on the broader recommendations above, giving specific steps that can be taken at the regional and local level to move towards successful outcomes for individuals and communities, the NHS, and the VCSE sector. We believe that GM, particularly given the strengths of the GMHSC Partnership, has the potential to take a leadership role in creating a holistic approach that can be devolved to the localities and ensure that existing practices and new ideas are supported. Enabling the localities to grow the social prescribing ecosystem through a holistic approach will help the social prescribing agenda move forward within the national movement towards person-centred care that begins to tackle social determinants of health. These are recommendations which should be considered at GM level that will help support the localities:

Outcomes:

- 1 Funding ambitious, long-term programmes that match the period of years often needed by individuals to achieve their goals, and better measure the full impact of the intervention
- 2 Build the connections required to create an effective GM social prescribing system, including a single IT based solution for data capture and reporting to enable improved information-sharing wrapped around people rather than organisations.
- 3 Support the development of shared outcome measures across GM for key indicators.
- 4 Continue to map out and engage with existing organisations across GM, looking at the networks between them, and the gaps in provision, both geographical and in terms of provision.

Workforce development

- 1 Ensure that funding is in place for permanent, well paid jobs

in social prescribing, particularly for link workers that ensures their continuity and security

- 2 Further develop the link worker role, providing GM standards around role descriptions and improved remuneration, and identify and support career development paths.
- 3 Develop support networks for GM link workers and care navigators through shared training and appropriate assessment tools.

Partnerships:

- 1 Promote and support the VCSE activity which forms the social prescribing ecosystem in which such person-centred practice can flourish.
- 2 Increase and improve local partnership working, prioritising the development of relationships between the health, VCSE and informal community sectors.
- 3 Look to where joint funding from all those who benefit can be secured to help social prescribing projects realise their full potential.
- 4 Work to improve commissioning processes and support GP navigation of internal market systems to support social prescribing within the NHS.
- 5 Support a resource shift as well as a culture shift towards more flexible and person-centred practices within the statutory sector

3.0.1 Influencing GM:

- 1 Develop an agreed dissemination strategy that enables learning organisations
- 2 Support and fund workshops and events to share models, practice and developments

... and finally

The recommendations emerging from surveys, interviews and GM plenary resonate strongly with the six principles of the National Social Prescribing Network. Moving forward, these principles can serve to align GM work with developing best practices across the country.

These principles are:

- 1 Long term funding commitments
- 2 Collaborative working
- 3 Buy-in of referrers
- 4 Effective and sustained communication
- 5 Skilled link workers
- 6 Person-centred service



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