International Social Prescribing Network Conference July 2019

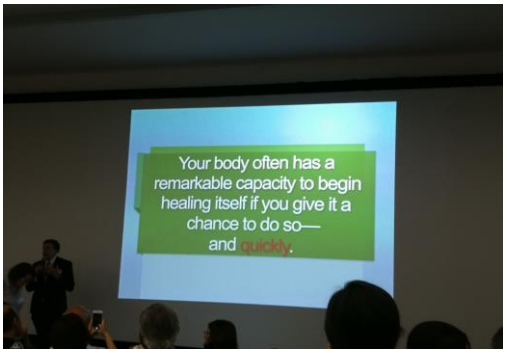
'From system to local'

Emily Foulkes ***(Director of Cymaz Music and Singing for Health Practitioner/Researcher)***

On 11th and 12th July 2019, the University of Westminster hosted the 2nd International Social Prescribing conference which attracted delegates from more than 13 countries. Attendees were a broad mix of Healthcare professionals, Social Prescribing Link Workers and Managers and organisations/practitioners involved in providing community or complementary activities. The Social Prescribing Network exists to share knowledge and best practice, to support Social Prescribing at a local and national level and to inform good quality research and evaluation. It is supporting the setting up of regional Social Prescribing Networks across England.

This report covers some of the key presentations and then reflects on key themes and headlines from across the conference rather than providing an account of each presentation.

The two day conference was kicked off with a rousing keynote speech from Dr Dean Ornish. His research and evidence based programme in the US is saving lives and money. His UnDo It programme has four key components; A plant based diet, Exercise, De-stressing through Meditation and Yoga and a Social Support system. He believes and has evidence to demonstrate the power in these four components in improving health outcomes. It is simply putting the body and mind into the optimum environment for natural healing to occur. His programme has reversed symptoms of major health conditions such as Heart Disease and type 2 Diabetes.



Dr Dean Ornish set the conference off to a positive and optimistic start. He promotes a move away from fear based models, which do not work long term. People need to feel in control, feel loved and supported to move from a fear of dying towards a joy for living. The sentiments were echoed by Dr Michael Dixon (Co-Chair of the Social Prescribing Network) when he touched on the importance of self-efficacy by 'valuing and enabling people to be agents of their own well-being'.

The NHS Long Term Plan and Social Prescribing

James Sanderson, Director of Personalised Care, NHS England gave an overview of the vision for Social Prescribing and more person centred health care from the NHS Long Term Plan. He announced the plan to recruit 4,500 Social Prescribing Link Workers over the next five years representing ½ a billion investment. His data shows that at least 40% of patients don't feel that they have adequate knowledge or understanding to be able to manage their condition. 1 in 5 GPs appointments is not a medical concern.

There is a drive towards putting healthcare choices into individuals through the Social Prescribing Movement, increased support for self-management and more devolvement of funds through personalised health budgets.

Social Prescribing Link workers will undergo a certified programme. In the 7 regions there will be co-ordinator roles aimed to bring together regional networks of Link Workers for shared learning, training, workshops and networking.

The newly formed Social Prescribing Academy has been set up as a multi-disciplinary body to support the sector and address inequalities.

Themes and Headlines from the conference

- **Culture Change**

For Social Prescribing to be the move towards integrating a social model within a medical model then it must be a whole culture shift. It cannot sit solely with the Link Worker. Altogether Better is an NHS scheme which has supported more than 150 GP practices across 24 CCGs with embedding an organisational change. It is their firm belief that for this movement to succeed then it must be adopted and fully embedded into the culture of Primary Care and GP practices (from Secretaries to Practice Managers). The approach involves looking at GP Practice data, identifying patients who are 'frequent visitors' and applying a Social Prescribing model to reducing GP visits for those who need something other than a medical intervention. Some of the case study examples presented from other countries continued to make the case for a complete 'buy in' for models to be successful. In Singapore there is a model of a Link Worker in the Hospital who then connects with a Community Link Worker, helping to bridge gaps and move patients from a programme within the healthcare environment out into a community environment. Only when this works as a well-oiled machine, with commitment on all sides, can this be an effective model.

- **Patient and Communities at the Centre**

This key message sits at the very core of every example given at the conference. Asking 'what matters to you' instead of 'what is the matter with you' is at the heart of Social Prescribing. Link Workers will have more time to spend getting to know patients. GPs are time pressured and don't have much chance to consider a more holistic approach. Points were raised from delegates about also focussing on non-attenders as well as the frequent ones. This is particularly pertinent in ethnic minority groups where people are not accessing any healthcare services. How can a culture shift in the way people access support make sure that people don't slip through the gaps? Can outreach work be part of this culture change?

The Greater Manchester Model

- **Children and Young People**

Seen as a 'movement within a movement', a focus on what Social Prescribing means for children and young people is being explored by many organisations across the country. The conference presented some of these examples, from arts organisation Helium Arts delivering activities in hospital settings and bridging them into community based activities in Ireland to a YMCA service focussed on mental health and well-being for young people in Brighton & Hove. In the same way as Social Prescribing for Adults works, there is a Young Person's Link Worker, who is more

adept at working with children, young people and families. Brighton & Hove YMCA reminded us that 42% of Global Citizens are under the age of 25 and that mental health problems are likely to manifest before the age of 25. Qube in Shropshire gave examples of providing arts based programmes for young people to be referred to. Helium Arts uses the 5 ways to well-being model. They capture data using the Warwick Edinburgh Well-being scale. Sessions are weekly and run for 4-6 weeks. Participation is a co-production model and referrals are mainly made by the family.

- **Quality Assurance**

It is a shared belief that a robust Quality Assurance framework needs to underpin Social Prescribing and that it needs to reflect the diversity of provision and activities which may sit under the umbrella of Social Prescribing. There was a session at the conference which unveiled the new Framework for Allied Healthcare Professionals which was launched directly after the conference. It is recommended that the framework covers three components of Social Prescribing;

  - The overall model of SP and the referral pathways/processes
  - The Link Workers and their competency to deliver the SP service
  - The providers to which people are referred to during or at the end of the service

The framework works at different levels and the aim is to provide a framework which can be tailored and proportionate to the activity and the intensity and formality of that activity. Measures include;

- Data protection/GDPR
- Safeguarding/DBS
- Insurance
- H & S and Risk Assessments
- Financial
- Equality
- Operate within a recognised constitution/governing document/guidelines etc.
- Process/pathway
- Skills/experience
- First Aid Training (incl. Mental Health)
- User experience

For charities and voluntary sector organisations there is guidance and support offered by the NVCO including existing QA Frameworks and toolkits.

Social Prescribing needs an 'Informed Consent' agreement. The person at the centre has the ultimate responsibility for themselves and their safety. The way that activities are prescribed has implications in terms of legal responsibility. If patients are 'referred' there is some onus on the referrer, however if a patient is 'recommended' the responsibility lays with them.

A Quality Assurance framework can offer some protection and an operating system which can give credibility and professionalism to the service. It does, however, need to demonstrate flexibility and be appropriate to the activity.

- **Language and Understanding**

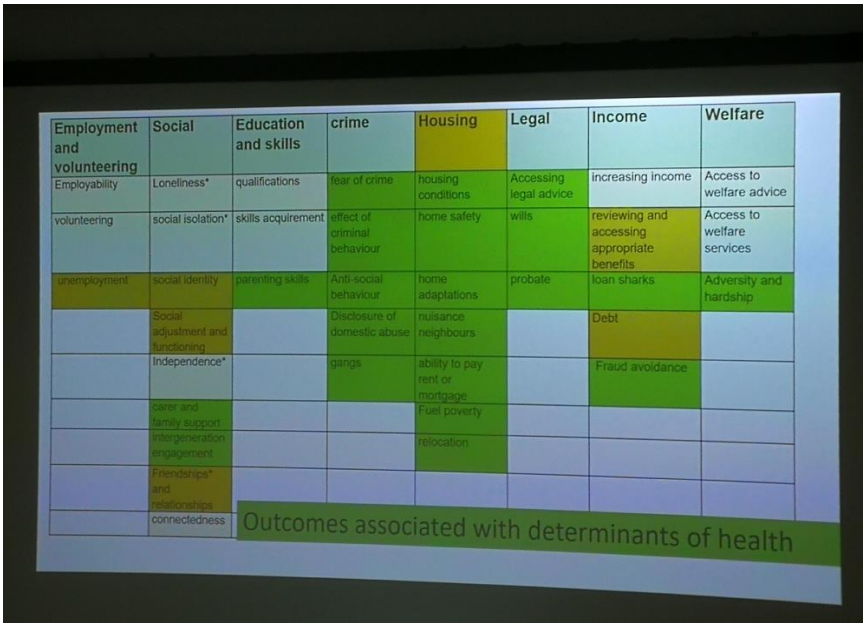
A theme which cropped up several times across the conference was the issue of language from terms used across the Health sector and language more common in the Voluntary sector and how we can move towards a more shared

understanding. There are different titles for what has now commonly become known as the Link Worker role. In some cases this is also known as the Social Prescribing Navigator or Facilitator.

There were suggestions from some of the case studies presented that we move away from using the term 'patient' and start referring to everyone as 'citizens' as a more empowering word. Another example of a shift in terms is to move away from 'volunteer' and use 'champion' or 'buddy' to describe those in the community who may volunteer their time to support Social Prescribing initiatives.

- **Outcomes and Measures**

Dr. Marie Polley, Co-chair Social Prescribing Network, University of Westminster has carried out an analysis of existing outcome measures in Social Prescribing programmes. The results of this work will be published in the few months following the conference and is still under review at the time of the conference. She wanted to see what is being collected and analysed and map this against an outcomes framework built on health determinants.



Dr Polley's aim is to see where the gaps in data might be and how Social Prescribing providers might be able to strengthen the evidence base to move away from the perception that voluntary sector provision is 'soft, fluffy and not robust'. To the Medical model the most robust is an RCT (Randomised Controlled Trial), to Citizens it's the 'experience' and the feeling that 'someone cares'. So how can we make sure we collect evidence that is robust and can be mapped to robust outcome measures? The outcome measures currently shown in green are virtually invisible from any data set collected and analysed by Marie.

The key and overarching message from this research is that Social Prescribing programmes are so far only measuring 50% of the possible outcome measures. 123 outcomes were identified and 40% of these were rarely or not reported on at all. 17% of outcomes were reported qualitatively only.

Marie's recommendations are;

- A shared investment fund needs all investors to be able to identify where their return on investment is
- Collaborative decision on outcomes needed by all
- More reporting on citizen outcomes needed
- More reporting of changes in social and community capital

Keep an eye out for the full published report which is likely to be announced via the Social Prescribing Network.

- **Community Assets, Partnerships & Funding**

Dr Daisy Fancourt shared her estimated level of community assets we have in the UK and highlighted the new MARCH Network which has been set up to research, explore and share good practice in making the most of community assets to promote positive mental health and well-being. There are special interest groups which people can sign up to as well as becoming part of the overall network. Funding is available for Sand Pit events and research projects.

Daisy's research at UCL has incorporated a number of large scale population studies examining data related to arts and culture and health and well-being. Epistemology studies have credibility due to the large scale of respondents, in line with RCTs (Randomised Control Trials favoured by Health Commissioners and bodies). The work carried out by Daisy and her team gives weight to what many of us already know and believe – that taking part in arts and cultural activities is good for you.

In one study it was found that whilst being part of a social group can have a marked effect on well-being, it is more significant if there is uptake of an activity. You can access Daisy's research here.

The case study examples from across the Globe were all underpinned by a commitment to partnerships and collaboration between Health, Communities and Voluntary Sector Organisations. For the models to work, this is essential and must be a value shared by all involved. Models need to make the most of the communities and also build in work with families. There were many encouraging examples of arts programmes working alongside Social Prescribing initiatives, including Qube based in Shropshire where community led arts programmes are successfully improving health and well-being outcomes.

In an effort to counter the claim made by Matt Hancock in 2018 that Social Prescribing should utilise 'free or cheap' community provision, there are organisations building strategies to advocate for the recognition of professional services being offered by the Voluntary Sector. The Culture Health and Well-being Alliance was formed in 2018 with a remit to provide sector support, build resources and toolkits and to facilitate sharing of practice. Alongside this growing Alliance is support from Arts Council England. John McMahon is the Lead for Arts and Health at Arts Council. His message regarding funding for Social Prescribing provision is that we must be forming partnerships and consortia. CCGs are unlikely to respond to several enquiries and requests for funding. His recommendation is to be a single and united voice.

We have to see the Social Prescribing movement as an opportunity to work more intelligently together, to form partnerships and to be creative in fundraising models. Suggestions included; making the most of community assets, getting buy in from across a local area with financial and in kind contributions from a range of interested partners; making use of facilities and venues, particularly healthcare settings which may have space that can be utilised in

evenings and at weekends; making applications to a range of funders and work in partnership where possible on this.

There is a case to be made to CCGs with an idea to identify a small percentage of their budget to allocate to Social Prescribing provision. This is being piloted in some areas. In London the Community Foundation is managing a fund for Lambeth to support Social Prescribing programmes. Here's another example of a CCG actively engaging in the Voluntary Sector and there are probably many others.

The key point here is that currently there is no Government guidance on a percentage of budgets for CCGs to invest in the Community and Voluntary Sector and therefore the approach is patchy and inconsistent across the country.

Giles Wilmore, Associate Lead, Peoples & Communities, Greater Manchester Health & Social Care Partnership closed the conference by drawing out the strengths, weaknesses, opportunities and threats for Social Prescribing. He recognised that whilst it's useful to represent the cost saving implications of Social Prescribing, this may not automatically mean that those saved funds can support the provision. We need to be realistic in the view the any cost savings are most likely to be diverted to the next priority on the list, especially when so many CCGs and Healthcare Trusts are working with deficits in funding. We need to go beyond this argument. However, there is tremendous opportunity and with such a surge of support, the Social Prescribing movement can be viewed as a Trojan Horse breaking into the medical model with a revolutionary way of thinking. But most importantly thinking which has decades, if not thousands of years, of evidence, support and belief.