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**SUSTAINABLE HOUSING
& URBAN STUDIES UNIT**

Social Prescribing in Greater Manchester

Andrea Gibbons, Michelle Howarth, Anne Lythgoe
With support from Kirsty Marshall and Alison Brettle

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About the authors

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/.

Dr Michelle Howarth is a Senior Lecturer in nursing with a specialist interest in social prescribing and the use of nature based approaches to promote health and wellbeing. Michelle is a member of the BLF Social Prescribing Advisory Group and the National Nurses Specialist Social Prescribing Specialist Interest group lead.

Dr Andrea Gibbons is an Urban Planner and Geographer with the Sustainable Housing and Urban Studies Unit (SHUSU) at the University of Salford. She researches social movement, housing, health and homelessness, and is the author of *City of Segregation: 100 Years of Struggle for Just Housing in Los Angeles*.

Anne Lythgoe is the Strategy and Policy Lead at 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/

Preface

In early 2018 the Greater Manchester Devolution Voluntary, Community and Social Enterprise Reference Group (The Reference Group) decided to commission from within its membership a piece of research to map what was happening across Greater Manchester (GM) in terms of social prescribing.

Reference Group members were keen to find out more about what was going on in GM because we wanted to make the case for VCSE-led schemes, based on emerging national evidence of the value of such approaches. The GM Health and Social Care Partnership, with whom the Reference Group has an MoU (Memorandum of Understanding), also wanted to get a clearer picture of what types of schemes were in operation already across the 10 local authority areas.

As a member of the Reference Group, with prompting from Bernadette Conlon, Chief Executive of Start and a fellow Reference Group member, I agreed that Salford CVS would submit a proposal to undertake this work. My first port of call in marshalling support for the task was my Salford CVS colleague Anne Lythgoe, who agreed to undertake some of the work. We then approached Dr Michelle Howarth from the University of Salford, a leading proponent of the benefits of social 'prescribing', to help us with the research.

This report reflects the partnership work undertaken by Salford CVS and the University of Salford to map social prescribing in Greater Manchester during the spring / summer of 2018.

I would urge you to read the whole report, which provides useful information on social prescribing in Greater Manchester, in the context of a review of national evidence. There is also a summary version available. The report ends with some key recommendations for those working in localities and for Greater Manchester as a whole.

Our challenge now is to get the recommendations adopted!

To conclude, I'd like to thank the following people for their contributions and support:

Anne Lythgoe (Salford CVS), Dr Michelle Howarth and Dr Andrea Gibbons (University of Salford), Bernadette Conlon (Start inspiring minds), fellow members of the GM Devolution VCSE Reference Group, and colleagues from GM Health and Social Care Partnership.

Alison Page
Chief Executive, Salford CVS

"I welcome this excellent report from Salford CVS and the University of Salford. It's in- depth review of the extent and varieties of social prescribing across Greater Manchester add significantly to our understanding of where we are now, identifying the many strengths we can build on as well as the challenges we must overcome together. Combining this Greater Manchester work with a study of some of the best examples of social prescribing from around the country has helped reach the clear shared vision for Greater Manchester set out in the report: to support a GM holistic social prescribing approach devolved within each locality."

Giles Wilmore
Associate Lead: People & Communities
GM Health & Social Care Partnership

Contents

Tables

Figures

1. The Brief

In February 2018, the Greater Manchester Devolution VCSE Reference Group (The Reference Group) decided to commission from amongst its membership a review of social prescribing in Greater Manchester. Alison Page, Chief Executive of Salford CVS and Bernadette Conlon, Chief Executive of Start, as members of The Reference Group, agreed that Salford were well placed to do this work and so Bernadette became the 'sponsor' of the work and Alison and Salford CVS were commissioned to lead on it. Salford CVS subsequently met with the University of Salford's Dr Michelle Howarth, who agreed to work in partnership with Salford CVS to deliver against the agreed brief.

The main task of the research was to carry out a mapping exercise of the existing patterns and nature of social prescribing across Greater Manchester (GM). The particular focus was to establish what was happening across the GM Voluntary, Community and Social Enterprise (VCSE) sector in relation to social prescribing. The VCSE sector is defined as *'voluntary organisations, community groups, the community work of faith groups, and those social enterprises where there is a wider accountability to the public via a board of trustees or a membership and all profits will be reinvested in their social purpose'* and as such, includes a diverse population.

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 districts. Each locality seemed to be different in terms of the approach(es) it used, nor did there seem to be a single overall map of the VCSE *market* into which people were being (or could in future be) referred into.

It was also thought to be useful to better understand the efficiency and effectiveness of existing social prescribing models, both in terms of their outcomes for people as well as operational and process impacts. This research could thus identify models of good practice for sharing across GM, as well as highlighting learning from social prescribing which hasn't been as successful.

Working in partnership, the University of Salford and Salford CVS have undertaken a review of existing research, a survey of social prescribing activity across GM and a *deep dive* involving interviews and qualitative investigation in one locality (Salford). The research aimed to provide the following:

- An overview of the current picture across GM

- A description of documented good practice (VCSE sector and beyond both in GM and across the country)

- A description of models of social prescribing in use in GM, referral systems that are in place and service user pathways

- A description of the VCSE provision and capacity across GM to receive social prescribing

- Analysis covering what an exemplar offer might look like and what might prevent GM achieving this at the moment

- Recommendations as to the options now available for GM on how best to support social prescribing through a developing partnership with the public and VCSE sectors

Taking Charge of our Health and Social Care in Greater Manchester (Greater Manchester Health and Social Care Partnership, 2015) set out the view that it is vital to change the relationship between people and public services to better enable people to prevent and/ or manage long-term health conditions, maintain their independence longer, and improve their health and well-being. This builds on the work undertaken by NESTA and The Health Foundation for NHS England to support the NHS Five Year Forward View vision to develop a new relationship with people and communities that can both support people to live happier and healthier lives while also reducing demand on services (NESTA & The Health Foundation, 2016). This view also dovetails with the growing salutogenic as opposed to pathogenic philosophy enshrined within the social prescribing movement. This also reflects the Greater Manchester Population Health Plan, which clearly articulates its view of the VCSE sector role going forward and provides examples gleaned from the *'Taking Charge Together'* consultation. It clearly references how investing via the VCSE sector can produce social and added value and deliver wider benefits to the community.

> Patients, peers and communities represent a huge resource. Whether in terms of effective behaviour change at scale, high-quality volunteering, informal networks of care, impactful models of VCSE Sector practice or growing social enterprises, there is significant opportunity within Greater Manchester to support people living with long-term conditions, prevent ill health and reduce costs (Greater Manchester Health and Social Care Partnership, 2017, p.20).

In 2017, the GM VCSE sector and the Greater Manchester Health and Social Care Partnership agreed a Memorandum of Understanding (MOU). This document transforms the relationships between local VCSE organisations and health and social care devolution to the benefit of all groups involved with health, social care and wellbeing. The mapping and evidence presented in this report supports the implementation of the commitments within the MOU to collaborate towards the following shared outcomes over the next five years:

A step change in the understanding and involvement of people and communities in the transformation of health and social care

- Better services and greater support for the public

- The development of Local Care Organisations with highly bespoke local place-based characteristics

- Increased mutual learning and continuous professional development

- Increased leverage of the talent, capacity and social value of VCSE organisations above and beyond whatever is commissioned from it

- Effective development of VCSE activity.

The MOU embodies certain common values and ways of working within the sector – including a spirit of inclusion and collaboration. Many VCSE organisations from across GM have now signed up to the MOU, which was a national first driven by devolution.

Data and intelligence such as that reported here will be key in the development of a thriving and sustainable VCSE sector. Social prescribing is a key component of GM Person and Community-Centred Approaches, and the VCSE sector has a huge part to play in embedding effective social prescribing arrangements into the GM health and social care system.

This piece of work has been driven by the VCSE sector to inform the development of locality and neighbourhood activities across GM. The goal has been to promote self-care, provide community-based support, and really get to grips with the prevention agenda across GM. Ultimately, this will also have a financial and operational benefit for the clinical system, with GP visits avoided, fewer A&E admissions and reduced prescribing costs.

The VCSE sector is well placed to take the lead on early help / prevention models within communities; whilst also excelling in supporting people living with long-term conditions and in helping to improve wider wellbeing and reduce social isolation. Its strength lies in its holistic, asset-based, community-embedded and personalised approaches. Its diversity, flexibility and potential for innovation gives it the ability to meet the needs of people that the statutory sector often find more difficult to support. Their expertise represents an important complement to medical and social provision in supporting people into improved health and wellbeing and building healthier, more connected communities. This salutogenic approach has the potential to support the person-centred, asset based approach espoused by GM and reciprocated across the VCSE sector through the growing social prescribing movements across GM.

2. Context
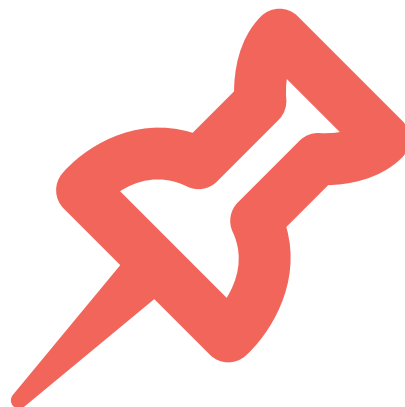
The dramatic rise in the use of various forms of social prescribing lies at the intersection of several forces: the increased understanding of wider social and environmental determinants of health as highlighted in the Marmot Report (2012); a move towards providing more holistic person-centred care to promote wellbeing rather than focusing simply around interventions to heal sickness; and an increasing understanding of the potential of non-medical solutions to help reduce the pressures on GPs and costs to the NHS (Kimberlee, 2015; Marmot & Bell, 2012; NESTA & The Health Foundation, 2016; Polley, Bertotti, Kimberlee, Pilkington, & Refsum, 2017). Within the wide range of existing academic literature, evaluations, reports and working papers that have been developed across the country, one of these strands will often be made central, although all three will be present to different degrees. It is this confluence of much broader shifts in thinking about health and priorities emerging from national government, however, that perhaps explains how similar approaches have arisen almost independently in different parts of the country, tailored to regional differences and local health priorities, and employing very different terminologies to describe a multitude of variations of what could be described as social prescribing.

Thus there exist a number of different definitions of just what social prescribing is, most simply *'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). The first Social Prescribing Network conference in 2016

worked to construct a more detailed definition that ensures the process is built in:

> 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, ie '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 (University of Westminster, 2017).

This clearly excludes certain kinds of signposting and care navigation often described as social prescribing, such as the West and Wakefield model (Jones, 2014). A broader version of this comes from the Social Prescribing in Bristol Working Group:

> Social prescribing provides a pathway to refer clients to non-clinical services, linking clients to support from within the community to promote their wellbeing, to encourage social inclusion, to promote self-care where appropriate and to build resilience within the community and for the individual (Social Prescribing in Bristol Working Group, 2012).

While the process is made relatively clear in both definitions, the service can vary tremendously from practice to practice, depending on the precise mechanisms involved as well as the broader context and mission of the practitioners. For example, social prescribing pioneer Bromley by Bow Centre is a GP

practice very deeply rooted in place, whose development of social prescribing emerged from their *'fundamental belief […] that local people have the inherent capability to transform their lives and enable the community to be renewed'* (Bromley By Bow Centre, 2015, p. 3). This had led to a very expansive understanding of their role as a GP practice both within in the community, and in supporting the psychosocial wellbeing of their patients not often found elsewhere (Brandling & House, 2009).

While this expansive understanding has not necessarily been taken up more widely, social prescribing has been adopted across the country in the period since Bromley By Bow held their first workshop to explore its potential in 2002 (Brandling & House, 2009). Sixteen years later, it is now being promoted across the NHS, with multiple projects and studies taking place across the country within very different contexts. There now exists a wealth of evidence documenting both process and outcomes, which within the past few years have themselves generated a number of systematic and scoping reviews of work already conducted around social prescribing in general, as well as focused explorations of work being done in relation to particular activities (ie arts therapies or horticultural therapy) or particular conditions (ie dementia, mental health and long-term conditions). Rather than replicate this work, this report focuses on bringing together the key findings around models and best practices from among these wider reviews drawing out the relevant findings from work being done on the key interventions that primary care and link workers would be referring individuals to.

There are a number of difficulties in undertaking a review of the social prescribing literature, even one focused on a review of reviews. Principle among these is the continued problem of social prescribing's multiple definitions, multiple models, and the multiplicity of situations in which a primary care provider might decide that a social—rather than, or in addition to—a medical intervention would be useful as well as a wide range of possible activities that could also be subject to prescription. Some social prescriptions have been captured under the terminology of *daily activities* or *health promotion*, the person making the links between service users and social activities which are described as *link worker*, *health connecter*, *health champion* etc. Kimberlee (2015) describes not just this complexity, but also the many differences in the scope of the service provided, with models ranging from the most basic of signposting, to what he terms light, medium and holistic support provision in accessing community services. Many of the referral systems developed around particular interventions have also be referred to as models interchangeably with how the link is made. Thus, as Chatterjee et al. (2017) describe, *Arts on Prescription*; *Books on Prescription* or *Bibliotherapy*; *Education on Prescription*; and *Exercise Referral/ Exercise on Prescription*; *Green Gyms* and other *Healthy Living Initiatives*; and *Time Banks* all involve their own complexity.

2.1 Social Prescribing: A growing movement across the UK

2.1.1 National Guidance and Standards

This is a pivotal time for social prescribing across the country – within two years of the founding of the Social Prescribing Network (2016) and in the midst of efforts to consolidate definitions and explore more broadly used outcome measures and models, there has been a proliferation of social prescribing models, services and interventions. These are often predicated in the variation that the population and community needs. NHSE refer to 3 distinct models which include:

1 Referral to a commissioned *'one-stop connector service'*,

2 The involvement of *'Collaborative Practices: GP surgeries as community 'hubs', invite citizens in to work collaboratively, as 'health champions', 'In-house 'community link workers/ navigators'* – employed by GP Practices and,

3 *'Active Signposting: 'Care Navigators'* in GP practices, having different conversations with patients, signposting them to community support, as well as pharmacy, physiotherapists and care providers.

The range of interventions provided as a result is also reflected in the titles proffered to describe social prescribing – for example, *community referral* or *non-medical prescribing*. The models and associated terms have some common elements which include the *referrers*, the *connecters* or *links* and the *intervention* or *service* provided. The recent NHSE interest in social prescribing and inclusion in the NHS Five Year Forward (2014) and GP Five Year Forward GP Review (2016) was as a result of the need for a radical review of health promotion and the prevention of long term conditions. The appetite for thinking differently about how communities and individuals develop resilience and the ability to self-manage has fuelled the social prescribing movement, but also highlighted the lack of a national competency framework associated with social prescribing. The NHSE has consulted with commissioners, providers, academics and evaluators to establish a common framework that could be applied across the UK. This involves explicating how social prescribing impacts on community groups, the wider health care system, and the individual and their families. These key areas represent a broad framework from which more in-depth evaluations and monitoring could be contextualised within different regions and communities. The work happening at this level, particularly with the National Social Prescribing Network, will be returned to in the recommendations section through its resonance with the research findings here in GM.

3. Methodology

This study is comprised of three sections – a survey to map existing social prescribing activity across Greater Manchester, a systematic desk-based mapping of best practices in social prescribing across the UK, and a *'deep dive'* involving a more extensive survey and interviews with key personnel in Salford.

3.1 Survey and deep dive

The survey was co-produced with Salford CVS. The sampling strategy used a stratified purposive sample, with a sampling framework developed in cooperation with Salford CVS and members of local CCGs. This enabled the research team to ensure that the sample was as representative as possible- reaching out across all ten GM districts through relevant personal. The survey was developed using Bristol Online Survey, and links were cascaded through a wide variety of CCG and VCSE sector contacts in April of 2018, with follow up efforts made to ensure that the survey was distributed to a representative sample of organisations that provide social prescribing across the ten GM districts.

Key stakeholders in Salford were identified both through the initial discussions in developing the sampling framework, and through survey responses and ongoing discussions with the project team. Interviews were conducted with key stakeholders in May, 2018.

3.2 Systematic scoping review of the literature

An initial scoping review identified a large number of existing systematic reviews of social prescribing practices within the UK undertaken within the past two years, and it was therefore determined that an additional full systematic review would be an unnecessary replication. A modified review was therefore undertaken to identify and examine existing systematic and scoping reviews in order to consolidate an understanding of the state of the field and emerging consensus around definitions, best practices and outcomes. Thus, this review follows a simplified version of the framework described by Arksey and O'Malley (2005). The research question was:

> What are the current systematic or scoping reviews of the literature around social prescribing that exist nationally, and is there any emerging consensus around definitions, typologies or best practices?

These steps are outlined in more detail in Appendix A, along with charts summarising the nine initial systematic reviews focused on social prescribing directly, and twelve additional reviews focused on particular social prescribing interventions either by activity or condition.

In speaking with practitioners, we were also able to identify five key models that are felt by those in practice to broadly represent the different models currently being promoted as best practice. It is curious that only one of these was included within the 13 projects identified through the academic literature. This report therefore looks at both sets of evaluations to draw out a wider overall picture of emerging best practices.

3.3 GM plenary and international Social Prescribing conference

There was an opportunity to present this research on two separate occasions to different groups (with some overlap between the two), initially to sound out some of the key findings, and latterly, to test out the emergent findings. The first was in a plenary on 24th May for people interested in social prescribing across GM. Thirty-nine people attended, among them those who identified as social prescribers and service providers, others as a mixture of both along with a range of other management or academic roles. The plenary ran from 9:00 to 15:00, with presentations in the morning and discussion in the afternoon. Presentations included:

- Andrea Gibbons, Researcher from the University of Salford: *Social Prescribing in GM Mapping Project: Initial results*

- Siân Brand, Consultant & Programme Manager, Co-Chair of East of England Social Prescribing Network: *Connect Well: The Social Prescribing Model of Mid Essex & the Royal Borough of Kingston*

- Giles Wilmore, Associate Lead for People & Communities within the Greater Manchester Health & Social Care Partnership: *Person and Community Centred Approaches*

The results of a very rich set of discussions within small groups that followed and built on the presentations will be integrated into the body of results.

The second presentation of results took place across the 13th and 14th of June. The first day consisted of a networking lunch scheduled before the first International Social Prescribing Conference hosted at the University of Salford. Twenty-seven people attended: eight academics, two providers and prescribers, two providers, two commissioners and seven others in a variety of other roles. Again, the rich discussion that took place in the small groups will be further explored through the discussion of results.

The GM mapping undertaken was also made available to all delegates as a poster presentation during the course of the Social Prescribing Conference of 14th June, and can be found in Appendix C, and for download at **https://www.salford.ac.uk/research/care/research-groups/shusu/sustainability**
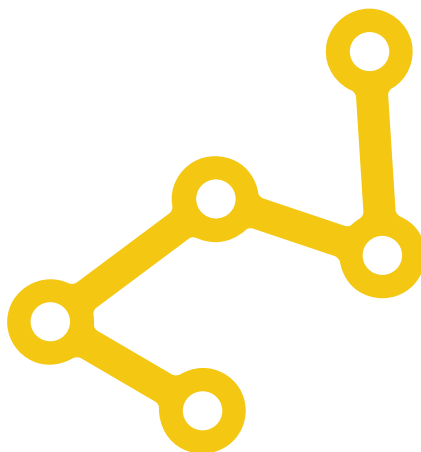
4. Existing Models

4.1 An Exploration of specific models around the UK

The multitude of studies now existing on social prescribing broadly agree: 1) that it is an area that is quickly expanding; 2) that the term remains differently defined and covers a diverse array of models, interventions and outcomes both from area to area and from project to project; and 3) that it is widely felt to be beneficial both by those being prescribed to the VCSE sector as well as by those doing the prescribing and the NHS more generally (though not everyone agrees that there is enough evidence of this). To ground this diversity in actual practice, five case studies felt by the study team to represent the spectrum of available models are presented below. The models range from basic sign-posting (West and Wakefield) to holistic support (Bromley By Bow):

■   West and Wakefield – Training of receptionists, Apple style kiosks and direct referral to physio and pharmacy

■   Health Connections Mendip, Frome – Volunteer community coordinators supported by 7 Health Connectors

■   Rotherham Social Prescribing Service – GP referrals to Voluntary and Community Sector Advisors (VCSAs) based in Voluntary Action Rotherham combined with direct funding for VCSE programmes

■   AllTogether Better, York & Humber – Health Champions

■   Bromley By Bow, East London – Social Prescribing in combination with Health Trainers within a holistic community centre/GP practice(s)

Each model is explained briefly below alongside images they have developed to help describe their process and pathways. The principal details can be found in Figure 1, comparing each against the other.

As a check, and to further develop our thinking around emerging best practices, the main features of these projects are then also compared with those models most referenced in the academic reviews as listed in Appendix A – the evaluation of Rotherham was the only overlap in these two lists of models. The others identified through the academic studies included: Age UK (Yorkshire & Humber); Newcastle Social Prescribing Project; Amalthea Project, Avon; Doncaster's Patient Support Service; Dundee Equally Well, Wellspring Healthy Living Centre (2014); WellFamily Service, Hackney (2014), CHAT, Bradford (2007) and Stockport North West Social Prescribing Development Project (2007). The evaluations which we could access are described in section 4.3 below.
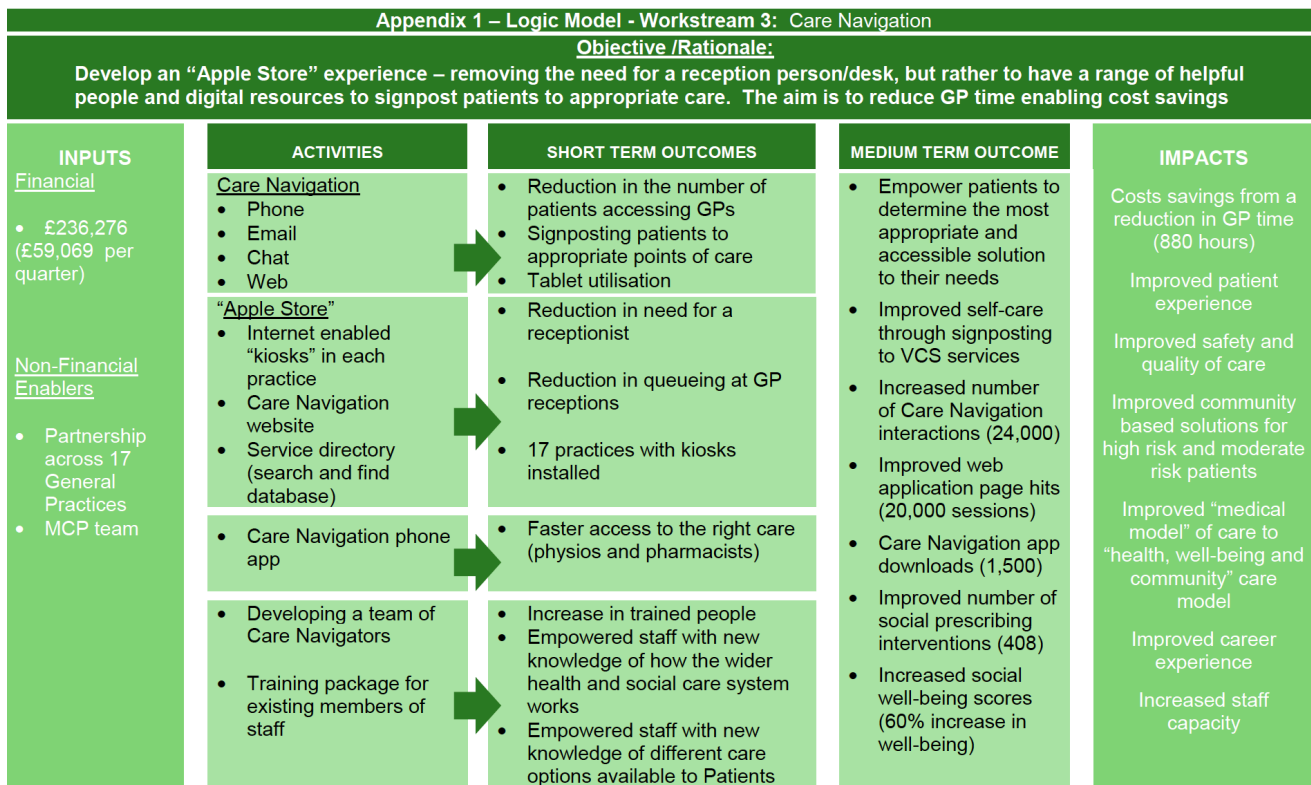
Appendix 1 – Logic Model - Workstream 3: Care Navigation				
Objective /Rationale: Develop an "Apple Store" experience – removing the need for a reception person/desk, but rather to have a range of helpful people and digital resources to signpost patients to appropriate care. The aim is to reduce GP time enabling cost savings				
INPUTS	**ACTIVITIES**	**SHORT TERM OUTCOMES**	**MEDIUM TERM OUTCOME**	**IMPACTS**
Financial • £236,276 (£59,069 per quarter) Non-Financial Enablers • Partnership across 17 General Practices • MCP team	Care Navigation • Phone • Email • Chat • Web "Apple Store" • Internet enabled "kiosks" in each practice • Care Navigation website • Service directory (search and find database) • Care Navigation phone app • Developing a team of Care Navigators • Training package for existing members of staff	• Reduction in the number of patients accessing GPs • Signposting patients to appropriate points of care • Tablet utilisation • Reduction in need for a receptionist • Reduction in queueing at GP receptions • 17 practices with kiosks installed • Faster access to the right care (physios and pharmacists) • Increase in trained people • Empowered staff with new knowledge of how the wider health and social care system works • Empowered staff with new knowledge of different care options available to Patients	• Empower patients to determine the most appropriate and accessible solution to their needs • Improved self-care through signposting to VCS services • Increased number of Care Navigation interactions (24,000) • Improved web application page hits (20,000 sessions) • Care Navigation app downloads (1,500) • Improved number of social prescribing interventions (408) • Increased social well-being scores (60% increase in well-being)	Costs savings from a reduction in GP time (880 hours) Improved patient experience Improved safety and quality of care Improved community based solutions for high risk and moderate risk patients Improved "medical model" of care to "health, well-being and community" care model Improved career experience Increased staff capacity

Figure 1 - West and Wakefield Logic Model (Esmond, Fay, Haining, & Thackray, 2017)

4.1.1 West and Wakefield

West and Wakefield is one of the few models developed in a top down approach, and the most basic of the models explored in the report. From its inception in 2016, the goal has been *'To create a multidisciplinary workforce to improve care for patients and relieve pressure on GPs'* (C. Jones, 2016). This is primarily achieved through training receptionists or other existing staff, termed *care navigators*, to refer patients directly to physio and pharmacy services or signpost them to other community or statutory services. It has also included Apple style kiosks for online signposting in GP offices.

Despite the visual complexity of the above logic model, there is little complex in a model that empowers receptionists to direct patients away from GPs to physio, pharmacy (often newly provided in GP offices, and with extended hours) or offsite community groups. Its day-to-day outcome metrics focus primarily on hours of time saved through GP dashboards, and the results of the initial evaluation seem fairly ambiguous. A survey of 720 patients revealed that only 7% of those surveyed reported accepting signposting as an alternative to the GP, and concerns were raised by both receptionists and patients about lack of privacy and lack of sufficient knowledge for an appropriate signpost in lieu of medical support. The referrals to physio and pharmacy seemed most successful, the number actually following up on a referral to the third sector unclear (Esmond et al., 2017).

4.1.2 Health Connections Mendip, Frome

There has been little robust evaluation undertaken of the Health Connections Mendip programme centred in Frome and running since 2015. Other publicity, however, including George Monbiot's (2018) article in the Guardian, has given it some prominence. It developed out of GP offices funded both by the GPs and the local CCG, recruiting volunteer Community Coordinators to support people to access resources and funding seven Health Connectors to provide one-to-one support for more complex cases. In addition, its goals have been to map existing community resources and compile a resource directory available online, and to form new groups where there appear to be gaps.

The programme now extends across all 12 GP practices in the area, has trained 53 volunteer coordinators and runs weekly talking cafes in 5 different villages. They have used both the Patient Activation Measure (PAM) and the Warwick-Edinburgh Mental Well-being scale (WEMWBS) to measure outcomes for those participating, but both have been found difficult to complete. They have emphasised support for the broader development of community networks and flexibility in adjusting service provision to the needs and preferences of local communities as key to their success (Health Connections Mendip, 2016).

Mapping what is already out there

We start with the assets in the community – its opportunities and strengths. We map local support and let people know about this support in a variety of ways.

Building social capital

Where there are gaps in service provision we work with people in the local community to find solutions. We draw on their knowledge, abilities and resources to develop a new service where appropriate, checking that this would complement rather than duplicate existing services. This leads to increased local confidence and a sense of empowerment for those involved.

Peer support

Groups and services take many forms. We support people to set up peer support groups. We recognise that local people and communities have assets, skills, knowledge and experience that enables them to offer valuable help to their peers. We can help people do this by guiding them through the group set up process and we are there for as long as they need us.

Communicating with the community

There is so much support out there. We recognise that people access support and information in different ways. We have a website, local radio slot, face to face information from Community Connectors, information points in the community and an information phone line. Our model enables people to find information in the way that suits them best.

Figure 2 - Brochure (Health Connections Mendip, 2016)

4.1.3 AllTogether Better

AllTogether Better is another model that emerged from GP practices in 2008 through a Big Lottery grant, whereby community *health champions* are identified and trained to provide peer support, referrals to existing programmes and the development of new programmes where there are gaps. They in turn feed back to the GP practice, which is thus able to adapt and improve their offer to their patients. The process as outlined consists of: 1) Recruiting and supporting project leads; 2) Finding and supporting practices; 3) Finding and supporting champions; 4) The practice and champions working together supported by the project lead; 5) Champions developing offers and making them happen; 6) The practice evolving to do things differently. They describe their vision as:

[T]o build the region's capacity to empower communities to improve their own health and well-being and reduce health inequalities. Our model of empowerment is three pronged: building capacity (awareness, knowledge and awareness); building confidence (self-esteem and social capital); and collectively supporting a systematic change of culture in ¬policy and practices (Davies, 2009).

Their view of champions acting as catalysts for broader, more holistic change can be seen in Figure 3.

Group education and support

As well as working one-to-one we run Health Connections groups such as Talking Cafes, Self Management Programme, On Track goal setting groups, introduction to exercise sessions and a Health and Wellbeing Information programme.

Community Connectors

Community Connectors are members of the community who know what's out there and signpost friends, family, colleagues and neighbours to support in their own community. Community Connectors are very effective at integrating with their local communities – providing a bridge between local people and other services and building community knowledge.

Health Connectors

Our Health Connectors work one-to-one with patients in Mendip General Practices and in patients' homes. Health Connectors inform, empower and connect people with services in their community. The Health Connector and the patient work together, in partnership, to help build the knowledge, skills or confidence that the patient might want in order to help improve thier health and wellbeing or manage thier long term health condition.

Social prescribing

Social prescribing links patients in Mendip GP practices with non-medical sources of support within the community. It connects people to the assets on their doorsteps. Our service directory is embedded in the EMIS patient record enabling health professionals to have signposting at their fingertips.

In this model, the greatest transformation in wellbeing seems to be experienced by the health champion (whose ongoing meaningful engagement also means outcomes are easier to document), but they support improved health outcomes for patients, improved practices among GPs, and better networked communities. They have used, and found useful, the New Economics Foundation's (NEF) Five Ways to Wellbeing as a tool to measure outcomes (Davies, 2009).

The community health champion approach

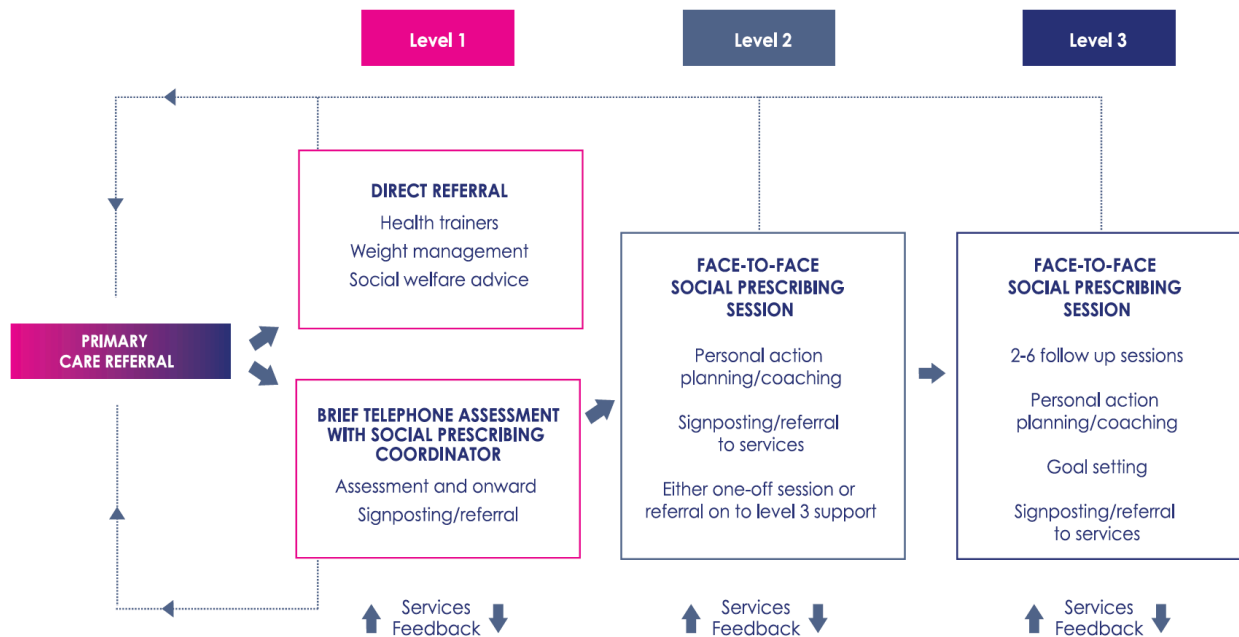Figure 3 - All Together Better's Health Champion Approach (Davies, 2009)

The Referral Pathway

Figure 4 - Bromley By Bow's Social Prescribing Referral Model (Bromley By Bow Centre, n.d.)

4.1.4 Bromley By Bow, East London

Bromley By Bow is one of the first, and most unique, of the social prescribing models, including a GP practice and community centre that has been working to develop an asset-based community health model over the past 30 years. The service provided by their social prescribing coordinator is only one of an array of support services in addition to Health Trainers and community programming. The model above is designed to provide individuals referred the level of support they need to engage with community programmes and services provided within the Bromley By Bow Centre itself and other local groups.

The website shows the array of issues the Centre offers support in accessing: health and wellbeing; work or training; help and advice; learning new skills; enjoying the Centre's spaces; activities, sports and groups; starting a new business; making new friends; adult social care (*"Bromley By Bow Centre Website,"* n.d.). They trialled the use of SWEMWBS in documenting patient outcomes but found it too unwieldy. Their findings on best practice emphasise adequate time given to communication and building relationships with patients and partners. They advise where possible having link workers actually accompany patients to services and provide additional, holistic provision of services, along with more, longer-term funding to the VCSE sector to provide the services that are being referred into.

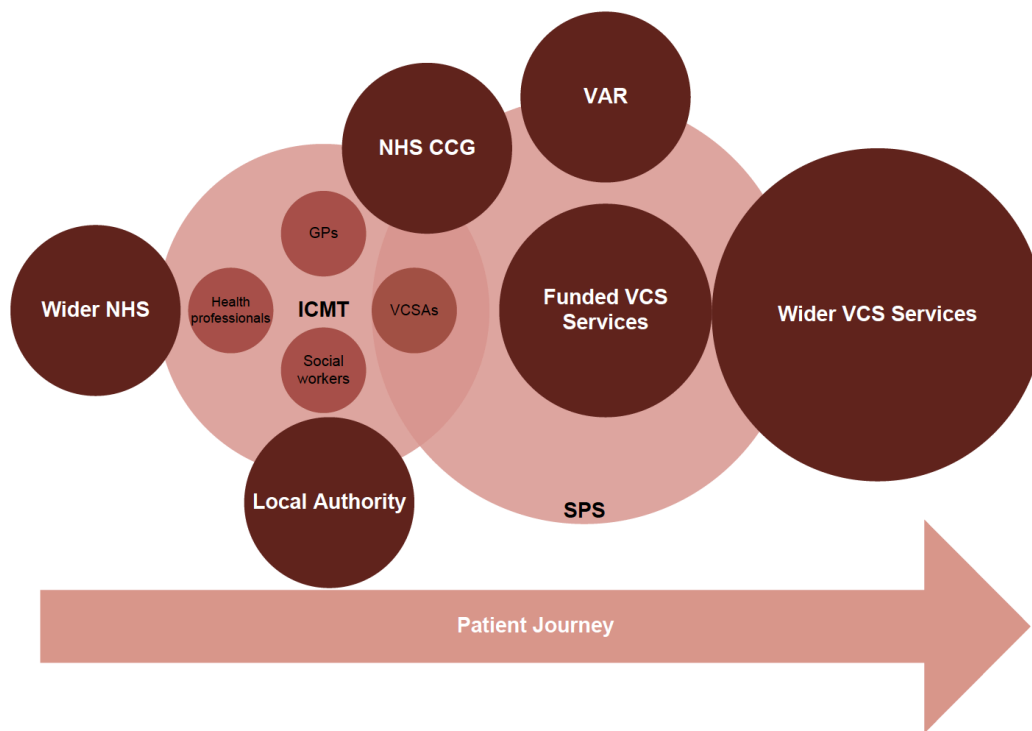**Figure 2.1: The Rotherham Social Prescribing Model**

Figure 5 - Rotherham Social Prescribing Model

4.1.5 Rotherham Social Prescribing Service

The Rotherham model perhaps stands in greatest contrast to the others and of most use to work spearheaded by another VCSE organisation given that it is managed by Voluntary Action Rotherham (VAR). They have been funded by the CCG since 2008 both to provide Voluntary and Community Sector Advisors (VCSAs) based in VAR itself (though they typically carry out a home visit as the first appointment) who receive the initial referral from GPs and then refer on to services, as well as to further distribute a pot of funding to other VCSE organisations to support those services referred to, whether it is existing work or the commissioning of new projects where needed. This model has been more extensively evaluated than most others by Chris Dayson et al. (Dayson & Bashir, 2014; Dayson, Bashir, Bennett, & Sanderson, 2016).

They have used a bespoke well-being measurement tool to look at patient outcomes, and a NEF Cost benefit analysis to look at the cost savings to the NHS. They too emphasise the importance of relationships and clarity about the level of services provided, the importance of patients feeling in control of their care, and the importance of full funding of the VCSE sector.

4.2 The five models compared

The chart in Table 1 gives a quick snapshot of the five models as they compare in terms of goals, structure, scale and funding, patterns of participation, outcome measures, challenges and enablers.

Table 1 – The five models compared

Goals	[T]o build the region's capacity to empower communities to improve their own health and well-being and reduce health inequalities. Our model of empowerment is three pronged: building capacity (awareness, knowledge and awareness); building confidence (self-esteem and social capital); and collectively supporting a systematic change of culture in –policy and practices.		Health Connections Mendip provides peer support, social prescribing, one-to-one and group support to enable people living in Mendip to improve their personal and community resilience. The service is available to people who would like support with health and wellbeing issues in addition or instead of the support they have traditionally received from their GP Practice and other healthcare services.	The Rotherham Social Prescribing Service helps adults over the age of 18 with long term health conditions and mental health issues to improve their health and wellbeing by helping them to access community activities and services.	To create a multidisciplinary workforce to improve care for patients and relieve pressure on GPs
Basic Model	Support GP practices to find and support health champions, together they work to connect other patients to opportunities in the community and develop an offer where there are gaps. Through this the practice evolves to do things differently.		Have established 4 interlocking areas for action: Mapping existing community resources/compilation of resource directory Recruitment of volunteer Community Creators supporting people to resources Formation of groups to fill gaps in resources Health Connectors (staff of 7) providing 1-to-1 support relationship	GPs refer directly to Voluntary and Community Sector Advisors (VCSAs) based in Voluntary Action Rotherham, who typically carry out a home visit to talk through the patients' needs so they can refer them on to appropriate services/activities. The VA Rotherham also has a fund to commission projects from the VCS.	They have developed a care navigation programme and have rolled out training provision at scale with Conexus Health Partners. They have also trialled pharmacists in General Practice, longer hours, Physio First, an Information Hub and Response Centre, School programming, health champions, and community anchors with micro commissioning.
Time	2008 -present (2008-2012 pilot, now ongoing)	Bromley by Bow established 1984, 1st started exploring 'SP' through 1990s, 1st conference on it 2002	2015-present	2012-present (2012-2014 pilot, now ongoing)	2016-2017

One full time SP coordinator shared between 6 practices, after initial session provides another 2-6 sessions if needed with patients to help them connect with the community services they need. However a range of other health workers (particularly health trainers) and developing in-house provision support this position. Monthly feedback provided to referrers.

	Altogether Better: York & Humber	Bromley-By-Bow Centre, East London	Health Connections Mendip: Frome	Rotherham	West & Wakefield
Scale & Funding	2008-2012 phase 1: over 1,100 Health Champions, outreach to 1,000 citizens, 7 project areas across 3 regions working in 30 different General Practices. 2013 phase 2: £2.7 million from the Big Lottery Fund to continue in the same areas, two projects (one hospital based, the other for young people) added to developing Practice Health Champions	2016: £30,000 funded by Tower Hamlets CCG, 2017 wider roll out of SP across TH 2016: 534 referrals across the 6 practices in 2016, vary considerably between practices. One third triaged to health trainers, the rest supported through signposting and up to 6 sessions with the SP worker.	Funded by CCG and local GPs: 7 part-time (5 full time equivalent) Health Connectors working with all 12 GP practices in area, 53 volunteer coordinators trained, weekly talking cafes in 5 villages	2008-2012 Pilot: 24 voluntary and community organisations (VCOs) – grants with a total value of just over £600,000. 31 separate social prescribing services. 1,607 patients referred: 1,118 were referred on to funded VCS services, 200 to non-funded VCS, over 300 referrals to statutory services 2012-015: up to 27 VCS organisations commissioned at any one time, in 2015, 17 VCOs delivered 20 different services.	£236,00 devoted to care navigation but expected £4.22M to be invested in programme as a whole through 2020.
Patterns of Participation	Champions: Fairly evenly spread across all age groups from teens to elderly, and some preteen. Majority (75%) women Majority (78% white, but range of from 51% to 98% white in different areas showed programme reflected local diversity	Fairly evenly spread across age groups, women 30-39 the highest 62% female Mostly Bangladeshi, racial breakdown roughly matches that of area	Fairly evenly spread across all age groups Majority (66%) women	2012-2015 Majority older (86% over 60) Majority (62%) women Majority white (93%)	Not given
Outcome Measurements	New Economics Foundation's (NEF) Five Ways to Wellbeing, statistical analysis of champion survey data to explore their influences on wellbeing	Qualitative feedback embedded in SP process through anonymous questionnaires after SP sessions, and through focus groups. Feedback also collected from GPs and community service providers. Trialled use of SWEMWBS but found it was not a useful tool in sessions.	Have used patient feedback forms and two standardised measures: Patient Activation Measure (PAM) and the Warwick-Edinburgh Mental Well-being scale (WEMWBS). These were difficult to complete and few were collected.	For individuals: Bespoke well-being measurement tool consisting of eight measures associated with different aspects of self-management (Feeling positive; Lifestyle; Looking after yourself; Managing symptoms; Work, volunteering and other activities; Money; Where you live; Family and friends). NEF cost benefit analysis for savings to NHS and on social impact.	Looked at GP dashboards, and broad NHS data on admissions, lengths of stay and A&E visits. Surveyed 720 patients.

	Altogether Better: York & Humber	Bromley-By-Bow Centre, East London	Health Connections Mendip: Frome	Rotherham	West & Wakefield
Challenges	Institutional invisibility: 'in almost every case, this work was invisible to the NHS'. Securing ongoing funding Language, and understanding the different 'life worlds' of patients as opposed to the institutional 'life worlds' of clinics and service providers	Best practice one SPC per practice. This model however is much higher in cost and often not applicable for lower funded schemes covering many practices. Operating effectively with existing staffing levels is a challenge; one SPC across six practices. Threats to community service funding are a constant threat to the effectiveness of the social prescribing intervention. Language barriers continue to present a problem at times with the varied ethnic mix of the patient population. Finding relevant interpretation resource at the right time is sometimes still a challenge for sensitive and nuanced conversations.	Some patients found PAM difficult to fill out (too long, they were upset or in crisis etc)	Involved a leap of faith to working differently - there had to be another dimension to meeting patient needs	Significant variation in whether and how care navigation is implemented in individual practices. Receptionists felt some reluctance (feelings of 'going above one's station' and making quasi clinical judgement of patients' health needs) Increased workload, no increased pay. Some patients resisted being asked questions by the receptionist. Most patients didn't understand they were being supported in a process of care navigation – only 18% said they remembered being signposted, and only 7% said they actually accepted the alternative appointment. [1]

1 (Esmond, Fay, Haining, & Thackray, 2017)

	Altogether Better: York & Humber	Bromley-By-Bow Centre, East London	Health Connections Mendip: Frome	Rotherham	West & Wakefield
Enablers	Clear methods for selecting, excluding and supporting champions. The value of diversity in the champion group. The need to avoid delays and obstructions when drawing on the passion of champions. The critical importance of the day-to-day working relationship between the champions and their practice, service or issue. Understanding the deep challenges faced by an NHS that is so stretched and has so little room to man oeuvre that its capacity to innovate, and even to notice when promising things develop, is so limited.	it takes time and ongoing communication to keep HCPs aware of the benefits of social prescribing. Keeping clinicians up to date with referrals and services help reinforce importance of SP. Good communication at referral stage between HCP and patient is key, need to help patients (who are often distressed) understand a little more about the process they are being referred to. Face-to-face support with boundaried sessions is proving effective for those attending SP at this level. Signposting is generally accepted to be less effective in helping people engage and attend services. A link worker to work alongside the SPC is recommended to: provide admin support, accompany some patients to services, conduct outreach, set up and run groups. SP requires committed operators and referrers AND committed funders. Longer term, sustainable funding is the only way to develop, run and evaluate a SP scheme properly.	Ability to be flexible in service provision – initiate home visits, move Talking Café location or initiate additional Talking cafes, adjust length of trainings, increase phone provision for signposting	Social Prescribing has a greater effect for people who are able to engage fully, and who continue to engage with the VCSE beyond their initial social prescription. Be clear about the outcomes/ target population & clarity on the model - is it SPS 'lite' or intensive/ signposting or prescription. Keep the model and referral mechanisms simple - single gateway. Keep it local - knowledge and expertise out there from local VCS. The perils and benefits of scaling up. Role of link workers/advisors - linked to practices/ localities part of MDT team - build the relationships and combine expertise. Importance of patient/ user to be in charge/ have responsibility for their care – keep simple. Resource the sector to deliver the solutions. Evidence base - what target needs are and what works. 3 R's: Relationships, Research, Resources .	Staff cite the wide range of options as a key part of the success, with Pharmacy First and Physio First making a big impact, together with direct signposting to social prescribing options. Use of the local Physio First scheme, for example, increased by 43% after the introduction of reception care navigators. Receptionists themselves also find additional job satisfaction in this expanded role. Training with regular updates essential. Information on services needs to be comprehensive, simple and up to date. Time is needed for both staff and patients to get used to new way of working.

4.3 Sense checking the research

The challenges and best practices emerging from the seven academic evaluations of models that have developed over the period between 1996 and the present are very similar to those emerging from the analysis above. A summary similar to the chart comparing the five models can be found in Appendix A, though not all evaluations contained the information needed to complete the chart fully. Most evaluations were unable to be supplemented or triangulated through use of a variety of sources, as many of the services evaluated had received limited, short-term funding and no longer existed. As social prescribing is now being rolled out nationwide by NHS England, this highlights the need for ongoing, long-term funding to ensure programmes do not need to be reinvented with great expense of time, energy and money.

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 were:

- changing commissioning models,

- funding for the VCSE sector and funding for the link worker position, and

- streamlined communication between GP and link worker (a single data system or point of access to records was recommended by one project).

Kimberlee et al's (2014) evaluation of the Wellspring Healthy Living Centre is particularly useful in thinking about how to best measure outcomes both for patients and for social value, while the work on Newcastle is highly relevant given the model involved siting link workers in anchor VCSE institutions. They are summarised in Table 2 below.

Table 2 - Academic Studies: Newcastle Social Prescribing Project and Wellspring Healthy Living Centre

Project	Goal to develop a single cohesive approach to social prescribing in Newcastle, 6 GPs participated in pilot working with 5 VCSE organisations with a strategic linkworker, also goal to develop a model to track patient journey and online 'Health Signpost Directory'.	Approach that offers GP-referred patients 12 weeks of one to one support followed by 12 months of group support around a particular activity.
Basic model	GPs refer to link worker who refers on to five key VCSE organisations.	GP refers to holistic service that provides a key worker, the service is person-centred and non-prescriptive, is based on co-production of path to recovery, uses a range of therapeutic tools, refers to agencies that address the range of social determinants of health, works in partnerships with other agencies when psychological or substance misuse outside the programmers expertise; is based on assets of both the person and the community, and is based on the five ways of wellbeing. Involves both 1 to 1 services and peer group support.
Outcome eaasures	SWEMWBS and a confidence scale – most did not fill out. A single recording system set up in excel spreadsheet form and submitted monthly. Also aspired to develop a tool to map the whole patient journey, but not used to full due to funding constraints.	Showed clinically significant impact on the following measures: PHQ9, GAD7, the Friendship Scale for isolation, the ONS Wellbeing measures, perceived economic wellbeing, and the International Physical Activity Questionnaire items for moderate exercise. Extensive evaluation additionally undertook interviews, and carried out a SROI study of the cost effectiveness of the programme.

	Newcastle Social Prescribing Project	Wellspring Healthy Living Centre
Challenges	Commissioning and purchasing processes were in a state of flux and still dominated by outputs and not outcomes that did not encourage innovative approaches. The transformational change required to overcome organisational and cultural issues that lead to silo working and a lack of collaboration and integrations. Difficulties measuring and accounting for the value produced by the project's approach, making it hard to convince existing sceptics of the value of the model. Only able to hire one linkworker rather than three as hoped. It was difficult to collect the data to demonstrate progress across some important outcomes areas. Referrals from health professionals did not provide any details on the patient's medical history, the health professional's view of what could realistically be achieved, or any information on additional support or treatment the patient was receiving. Referrals from health care professionals did not provide any details on the patient's willingness to change. There was no systematic way to inform health professionals of the impact in either a case by case or combined way. Each Linkworker Organisation has its own internal monitoring system and there were varying approaches to client confidentiality in the way that information could be provided to third parties. There was no single point of access to all records, individual practices were unable to extract data electronically, and there were complex issues around data sharing protocols that were unable to be resolved in the lifetime of the project. Limited take up by GPs and HCPs despite repeated engagement, 2 of the 6 practices provided vast majority of 124 referrals made, far short of project goal of 200.	Focused on broad rather than specific challenges as in other study challenges: i growing crisis in GP provision; ii need for long-term funding of the VCSE sector; and iii Need for VCSE and patient involvement in shaping national NHS discussions around frameworks for social prescribing.

	Newcastle Social Prescribing Project	Wellspring Healthy Living Centre
Enablers	Capacity was provided by staff of VCSE organisations with broadly same role, but it was found that specialist knowledge in behavior change and relevance to health and wellbeing central. Linkwork Organisations were able to participate in the project with staff funded from other sources. Linkwork Organisations worked together in a mature and collaborative way to determine the organisation best placed to take a lead support role. Linkwork Organisations deliver the one to one casework as part of their core delivery in the city so are experienced in providing the service. For linkworker: i Receiving appropriate referrals; ii first contact through home visit; and iii direct contact between link worker and referrer about case.	Need for truly holistic approach that provides highly flexible access to the full array of services needed over the full period of time needed. The usefulness of SROI analysis to show social value and help VCSE sector better understand the value they create. The current opportunities for local authorities and communities to make a difference in these discussions responding to resource scarcity and crisis in GP provision.

Both challenges and enabling characteristics of successful programmes will be further explored through the results of the survey.

What both sets of evaluations show, however, is the lack of work looking at the full impact of social prescribing on the VCSE sector, particularly in terms of increased demand on their services which is only tied to increased funding in the Rotherham model. As the Westminster report on social prescribing highlights:

> 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 (University of Westminster, 2017, p. 26).

4.4 Best practices for link workers

The link worker or navigator is the most important ingredient within any social prescribing scheme, and needs to able to successfully and independently work with a very wide range of people, many of whom will be trying to get through very difficult periods in their lives (University of Westminster, 2017). From the many models examined above, a number of best practices can be drawn for the position of link worker, particularly for those models looking to provide more holistic support for the often complex cases presented by those who tend to present most frequently to GP practices. However even for signposting or 'social prescribing lite' services, referrals are most effective when carried out via staff who have wide experience in the community and the security of long-term contracts

allowing for the development of extensive community contacts and knowledge. This, and the allocation of time for fully assessing client needs are foundational to improved outcomes. All best practices can ultimately be understood in terms of the relationships that link workers are able to build with the patients, with the GPs and other health workers providing referrals, and with the services that they are referring into. This remains true even for those models where some activities (particularly accompanying people to services and the development of new groups or activities to fill gaps in provision) are provided by other staff members or volunteers, such as health champions or peer support workers.

The first set of relationships are with patients, and the link worker must be skilled in the ways that they are able to 'engage, empathise, listen, empower and motivate individuals' (University of Westminster, 2017, p. 38). Key facilitators of link work are:

- Quick follow-up from time of referral

- Identification of the level of support needed and allocation of appropriate time, acknowledging that many of those referred will only need one or two conversations for a successful intervention but others will need longer

- Face-to-face meetings where the patient feels most comfortable (ie home, café, VCSE office)

- Time and private space made available just for listening to build rapport, understand what is needed by the patient as well as their individual and distinctive barriers to accessing services, and supporting the patient to feel in control of their own journey

- Ability to personally accompany patients to services when necessary

- Time to allow patients to access services at their own pace and support for the period of time required to make them comfortable accessing services on their own

The second set of relationships are with GPs and referrers, as well as other statutory agencies. The facilitators are:

- Good communication with GP or referrer before meeting with a patient to understand why the referral was made

- Mechanisms for feedback on patient progress

- Flexibility and ability for both sides to adapt practices based on this ongoing communication

- Where useful, attendance at weekly meetings at GP surgeries or specific meetings bringing together statutory and third-sector workers around an individual's care package

The third set of relationships are with the organisations and groups that the link worker is making referrals to, facilitators include:

- Good communication with service provider before the arrival of a patient so that someone welcomes the referral and is aware of the broader situation

- Good understanding – preferably through a visit or some period working alongside service providers – of services being referred to, to ensure suitability

- Ensuring that the person referred is responded to quickly after contacting the group or service, even if it is just to acknowledge the referral and give a timeframe for service based on the waiting list etc.

- Mechanism for feedback on progress of patients

- Flexibility and ability for both sides to adapt practices based on this ongoing communication

- Awareness of the array of services available in any area, and work towards filling what gaps exist to provide for client needs

There is also a need for clarity about the service provided. This allows link workers to set boundaries, and ensures that patients understand what it is, and that it is a supplement to GP services. The University of Westminster (2017, p. 40) report provides an extensive list of the desired characteristics of link workers, which run from the ability to organise their time to speaking multiple languages to dealing with safeguarding to being non-judgmental. There is a growing recognition of the need to better support link workers through developing local link-worker networks for peer support as well as providing counselling and flexible working to avoid burnout (University of Westminster, 2017). The role also needs to be recognised as a highly demanding and professional service that should be both well paid and without the additional stress of short-term contracts, which often leads to high turnover (Newcastle West CCG & VOLSAG, 2014; University of Westminster, 2017).

4.5 Mapping Greater Manchester

4.5.1 Survey design

The survey was developed from an initial draft provided by Salford CVS. Initially it was believed that there would be a clear distinction between those providing social prescribing (whether a GP, link worker or health champion) and those groups or VCSE organisations receiving referrals. Thus two versions of the survey were created for those working in or across GM for clarity - one focused more on reasons for referral and pathways, and the other on services provided - to make the survey as short and effective as possible. Likewise the slightly longer survey for Salford was also created in two versions but with an additional number of shared questions. The charts below thus specify whether it was answered solely by those filling out the survey targeted at 'providers', 'prescribers' or by both.

Using a stratified sampling technique, the surveys were cascaded to GPs and other medical services through CCGs in each of GM's ten boroughs, and otherwise distributed through local CVS organisations and through mailing lists of VCSE contacts across GM. Given the added focus on Salford and the partnership between the University and Salford CVS, Salford organisations were much better represented in the sample. This does not necessarily mean that a larger VCSE sector exists in Salford, although it is felt that there are distinct differences in the number or organisations and types of provision across the ten boroughs. In the current climate of cuts, CVS infrastructure organisations do not exist in all 10 boroughs. Only Salford, Bolton, Oldham, Tameside and Manchester have infrastructure organisations providing a full range of support and development services to the wider VCSE sector, and this both reflects the wider cuts and loss of services referred to in some of the surveys, but also made it more difficult to reach existing organisations.

A total of 94 surveys were completed in April and May of 2018 by staff within 78 unique organisations. The principal unexpected result was the number of organisations who identified themselves as both referring people through social prescription and providing the services referred to (see table 3). It was often arbitrary which survey was completed, and meant the survey results as presented in the charts below did not fully reflect the breadth of provision which can be seen in the map in Figure 6. Also unexpected was the lack of identification with any one model of link worker, health connecter or health trainer identified in the literature apart from that of health champion. While the surveys were primarily multiple choice, 'other' was always an option with an ability to fill in a more precise answer. Receiving surveys from various people within the same organisation also showed that agreement does not always exist at the level of the organisation. Thus the surveys provide a good start towards mapping what provision currently exists across GM, but much work remains to fully develop it.
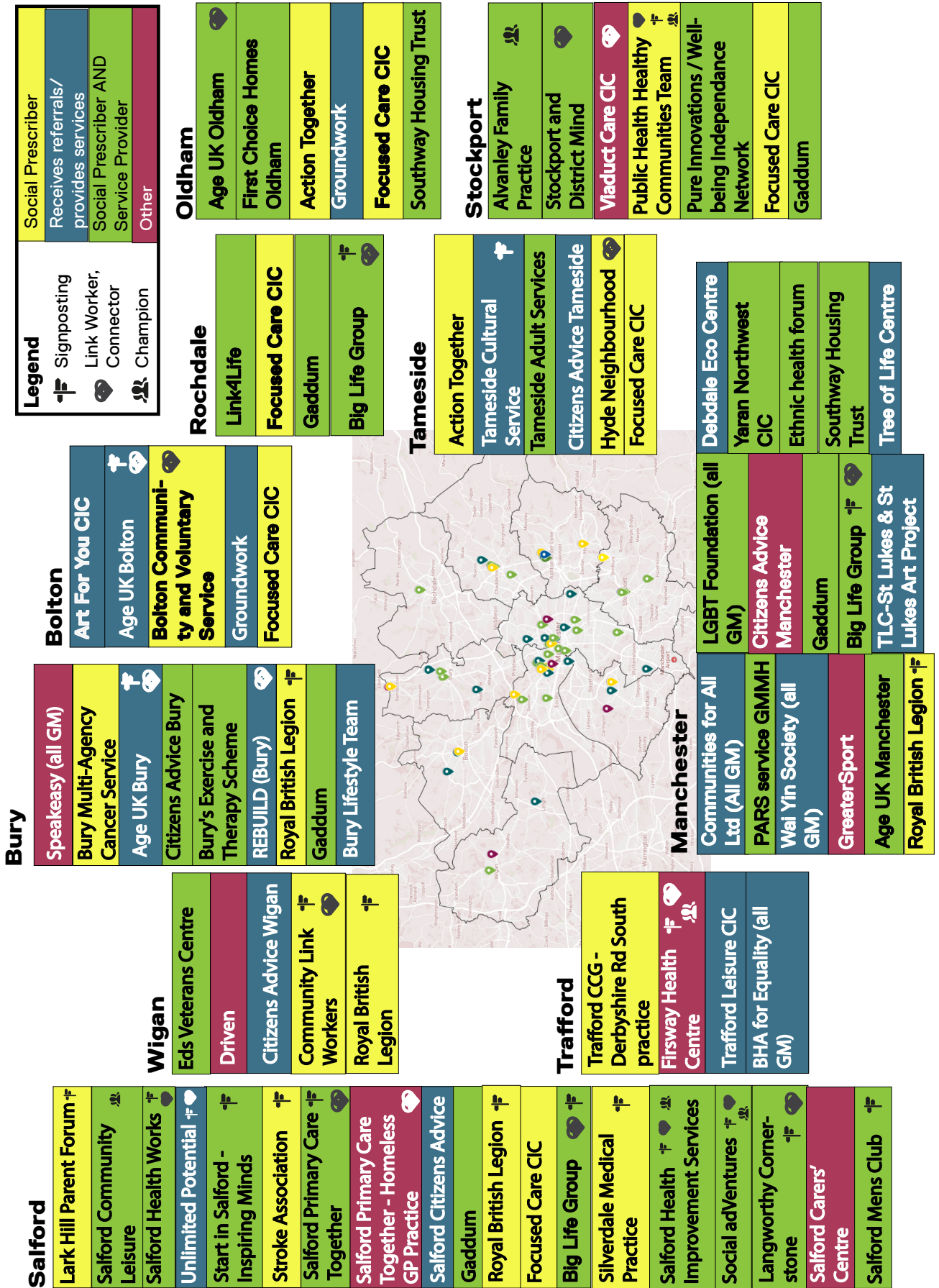
Legend

Social Prescriber
Receives referrals / provides services
Social Prescriber AND Service Provider
Other

Signposting
Link Worker, Connector
Champion

Bury

- Speakeasy (all GM)
- Bury Multi-Agency Cancer Service
- Age UK Bury
- Citizens Advice Bury
- Bury's Exercise and Therapy Scheme
- REBUILD (Bury)
- Royal British Legion
- Gaddum
- Bury Lifestyle Team

Bolton

- Art For You CIC
- Age UK Bolton
- Bolton Community and Voluntary Service
- Groundwork
- Focused Care CIC

Oldham

- Age UK Oldham
- First Choice Homes Oldham
- Action Together
- Groundwork
- Focused Care CIC
- Southway Housing Trust

Rochdale

- Link4Life
- Focused Care CIC
- Gaddum
- Big Life Group

Stockport

- Alvanley Family Practice
- Stockport and District Mind
- Viaduct Care CIC
- Public Health Healthy Communities Team
- Pure Innovations / Well-being Independance Network
- Focused Care CIC
- Gaddum

Tameside

- Action Together
- Tameside Cultural Service
- Tameside Adult Services
- Citizens Advice Tameside
- Hyde Neighbourhood
- Focused Care CIC

Wigan

- Eds Veterans Centre
- Driven
- Citizens Advice Wigan
- Community Link Workers
- Royal British Legion

Trafford

- Trafford CCG - Derbyshire Rd South practice
- Firsway Health Centre
- Trafford Leisure CIC
- BHA for Equality (all GM)

Manchester

- Communities for All Ltd (All GM)
- PARS service GMMH
- Wai Yin Society (all GM)
- GreaterSport
- Age UK Manchester
- Royal British Legion
- LGBT Foundation (all GM)
- Citizens Advice Manchester
- Gaddum
- Big Life Group
- TLC-St Lukes & St Lukes Art Project
- Debdale Eco Centre
- Yaran Northwest CIC
- Ethnic health forum
- Southway Housing Trust
- Tree of Life Centre

Salford

- Lark Hill Parent Forum
- Salford Community Leisure
- Salford Health Works
- Unlimited Potential
- Start in Salford – Inspiring Minds
- Stroke Association
- Salford Primary Care Together
- Salford Primary Care Together – Homeless GP Practice
- Salford Citizens Advice
- Gaddum
- Royal British Legion
- Focused Care CIC
- Big Life Group
- Silverdale Medical Practice
- Salford Health Improvement Services
- Social adVentures
- Langworthy Cornerstone
- Salford Carers' Centre
- Salford Mens Club

Figure 6 - Survey Results Mapped Across GM

4.5.2 Mapping GM

The map in Figure 6 shows the results of the survey mapped across all ten GM boroughs. It is noted whether they work across several boroughs or the whole of GM. Those in yellow are those who identified themselves as social prescribers, those in blue as those VCSE groups receiving referrals and those in yellow organisations or groups that do both. A number of respondents described themselves as other, and are found in purple. They were primarily organisations still looking into the provision of social prescribing services, or looking to receive referrals. All those who filled out the survey geared to social prescribers were also asked to identify with a model. The great majority chose multiple options, and from this three groups emerged – those who did simple signposting, those who worked with some kind of link worker, and those who supported health champions in their practice. These are indicated by symbols as shown in the legend for Figure 6.

A larger, more usable image of each borough and survey responders can be found in Appendix D.

While the map gives a good sense of the organisations responding, the chart below gives more precise figures for the whole of GM.

Table 3 - What social prescribing activities is your organisation involved in?

WHAT SOCIAL PRESCRIBING ACTIVITIES IS YOUR ORGANISATION INVOLVED IN? (N=78)

- We signpost / prescribe people to the appropriate support and activities
- We deliver activities and support within our organisation that people are referred to
- Both
- Other
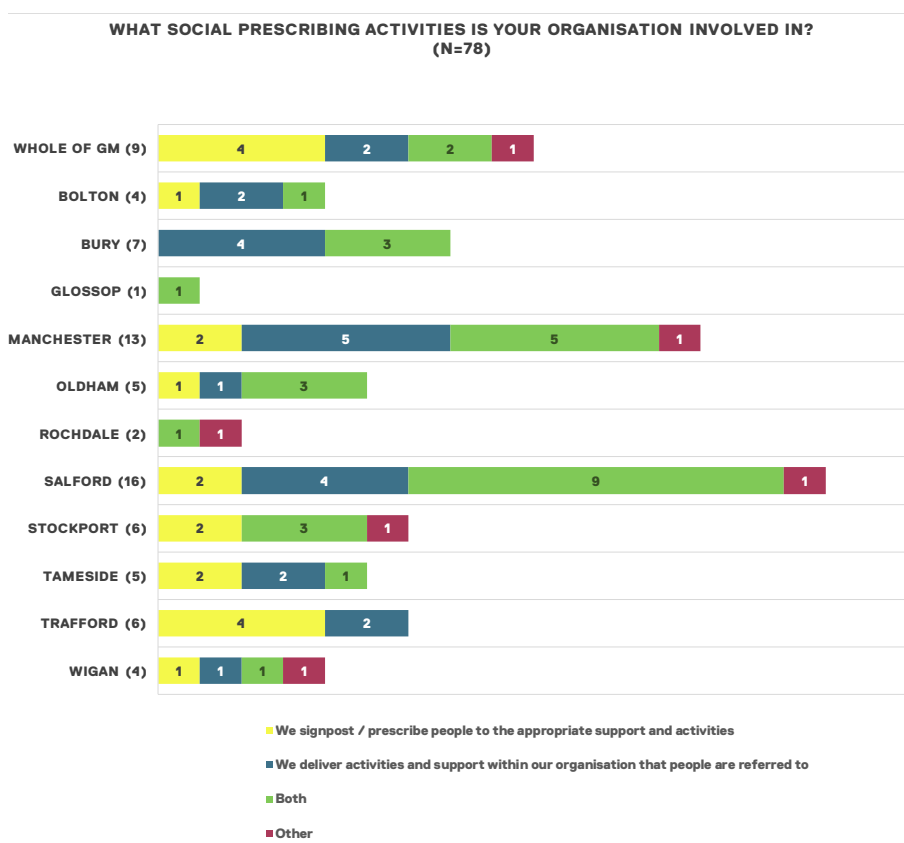
5. Findings

5.1 Understanding Social Prescribing

The bottom-up nature of social prescribing's development in each area in response to specific geographies and needs has ensured multiple understandings of what social prescribing is across the country. Thus defining social prescribing was a central concern of the first Social Prescribing Network convening in 2016 (University of Westminster, 2017). This was as true across GM as the country.

5.1.1 What is Social Prescribing?
The survey responses exhibited a spectrum of understandings, often reflecting where people stood within the process.

> 'Reducing the burden on GP & NHS services by replacing them with more appropriate advice/services'

> 'Enabling health and social professionals to refer to clinical and non-clinical services for whole person care'

> 'A one front door to services that really matter'

> 'It's a strange term for holistically approaching client needs and recognising that other services may be best placed to meet those needs'

> 'Help to resolve the root problem and social determinants of health'

All of these can be encompassed within the broader definition formulated by the newly formed Social Prescribing network:

> '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' (University of Westminster, 2017).

They also fit 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:

- 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

These map quite well onto the social prescribing activities within Greater Manchester, with the caveat that the line between Social Prescribing Lite and Medium seems to be rather gray area, and difficult to ascertain without

first-hand knowledge of the programme. Many of those responding to the services were trying to provide as holistic a service as possible within their constraints. They described their services as

> 'Support beyond signposting, many individuals need 1-2-1 support as they are often changing entrenched behaviour'

> 'We moved our service from being centre based to being more agile and working out in the community - this has removed a major barrier for some people especially initially. If we see a gap in services we aim to set it up ourselves - e.g. free counselling'

This is partly because it is widely recognised amongst those providing services, that the more holistic they are the better the outcomes tend to be, as further explored in the models studied below. Yet this category of holistic is the most difficult to pin down in terms of what it looks like, and how precisely it is provided. Kimberlee provides a number of characteristics, but notes that in the area of his study in Avon, no organisation had fully achieved a holistic model though a number were moving in that direction. The characteristics he proposes are:

- The SP provider has a clear local remit and draws on local knowledge of local services and networks to connect patients to important sources of support and aid.

- The SP intervention has usually been developed and sustained jointly over time and in its present form represents a product of joint partnership work between the primary care provider and the SP provider.

- The SP provider addresses the beneficiary's needs in a holistic way. A patient may be referred to a SP project to improve e.g. diet, but in doing so the SP project will look at all patient needs and may offer support in terms of e.g. budgeting, nutrition, addiction, loneliness, access to employment etc.

Table 4 - Which model do you identify with?

- There are no limits to the number of times a patient is seen on a SP intervention. Time parameters may be set but the number of sessions offered can be more or less depending on the patient's needs discovered in the holistic approach.

- SP interventions seek to improve beneficiary's wellbeing (Kimberlee, 2015, p. 17).

The literature falls broadly into two categories on the question of such diversity of definition. For those seeking primarily to quantify results, particularly for those seeking to evidence effectiveness using models drawn from medical fields, this complexity and lack of clear definition is encountered as highly problematic (see Bickerdike (2017) among others). Other studies, however, point to the many strengths of having numerous locally-tailored and sensitive programmes that have grown organically to meet specific community and health needs. Such diversity also reflects the person centred, salutogenic philosophy that influences the social prescribing approach. Arguably, 'standard' models and approaches risk straightjacketing innovative, creative and person centred practices, particularly where the assets are predicated on community needs and preferences. However, there is still a perceived need to better understand this variety, so as to streamline the terminology, improve cooperative working and ensure good practice. This is not understood as a need to discipline or constrain local innovation into a certain number of pre-defined models (see Kimberlee (2015) and Ward (2016) among others).

In terms of precise mechanisms, those few organisations who identified with only one model tend to be those providing either simple signposting, or supporting health champions. Both models were incorporated in wider activities in a handful of organisations however. On the whole, most respondents provided signposting and in addition had a link worker, though these were known under a variety of names.

Do you identify with any of the particular models below? n=40 'presrcibers and Salford 'providers'

Model	Value
Active signposting	35
Community navigator	26
Link worker	22
Care navigation	21
Connector	20
Health coach	19
Health trainer	19
Other	15
Health champion	15
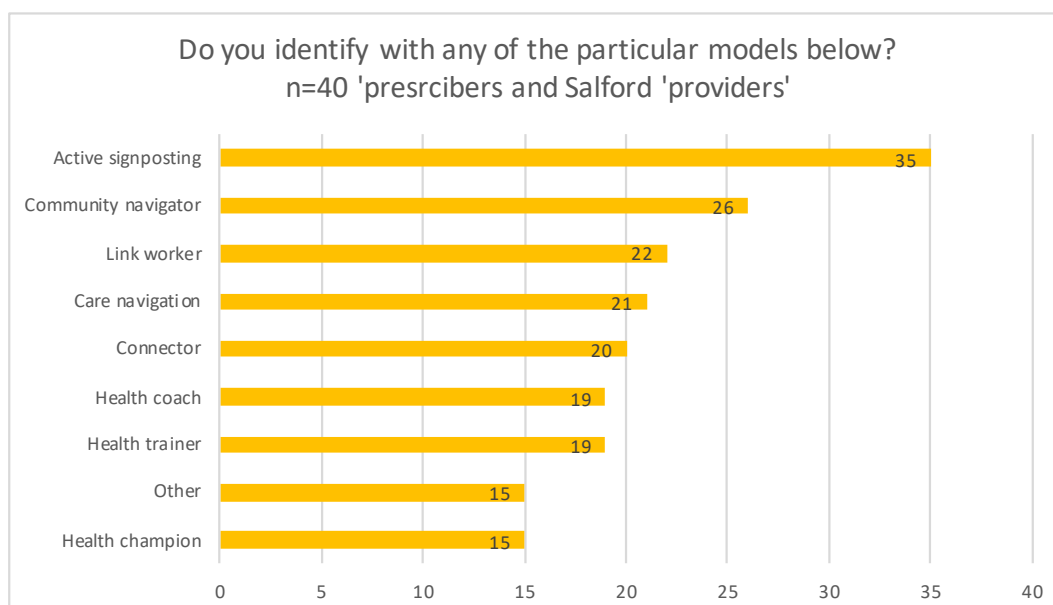
5.2 A diversity of activities

The activities prescribed to 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. Social isolation is the most common across GM, and a lack of wellbeing only slightly less so. Both were more common than direct referrals for mental and physical health, though they are clearly central to health.

These mapped fairly well onto responses outlining the kinds of services being referred to.

The surveys also made clear, however, that there is a large breadth of provision across Greater Manchester far beyond the categories provided. This was seen across three axes:

- Service provision for particular populations, generally working across all of GM (LGBT and gender questioning communities, the elderly, those who are homeless, BME and immigrant communities with specific language and cultural needs)

- Service provision to particular localities, rooted and well-connected with neighbouring organisations

- Service provision targeting particular health issues (cancer, obesity, etc)

Table 5 - What are the most common reasons for referral?
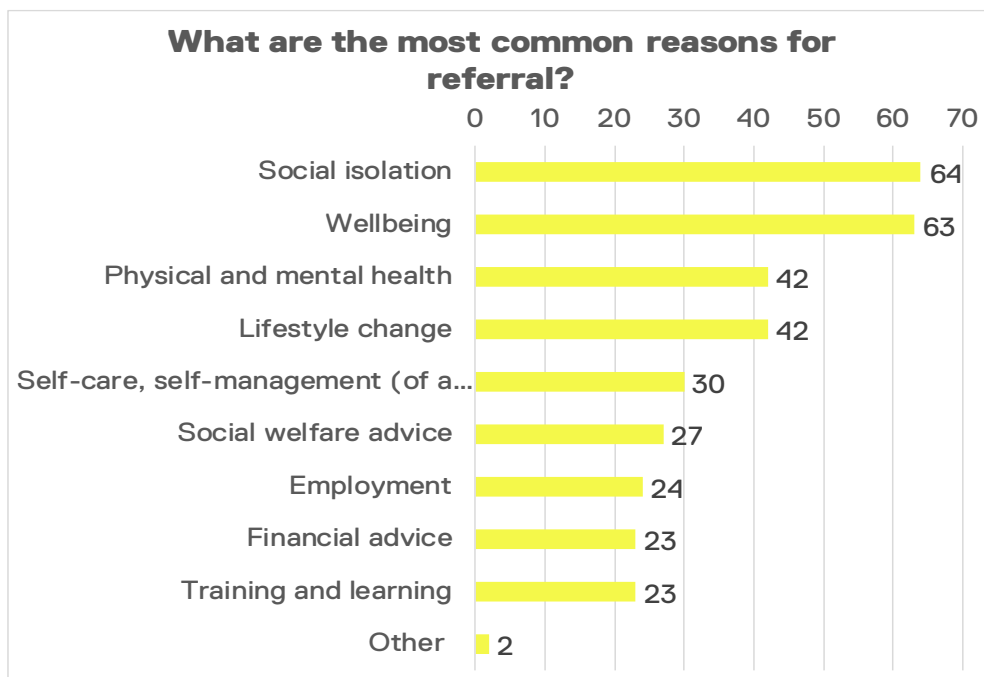
Table 6 - What types of support are included in the service?
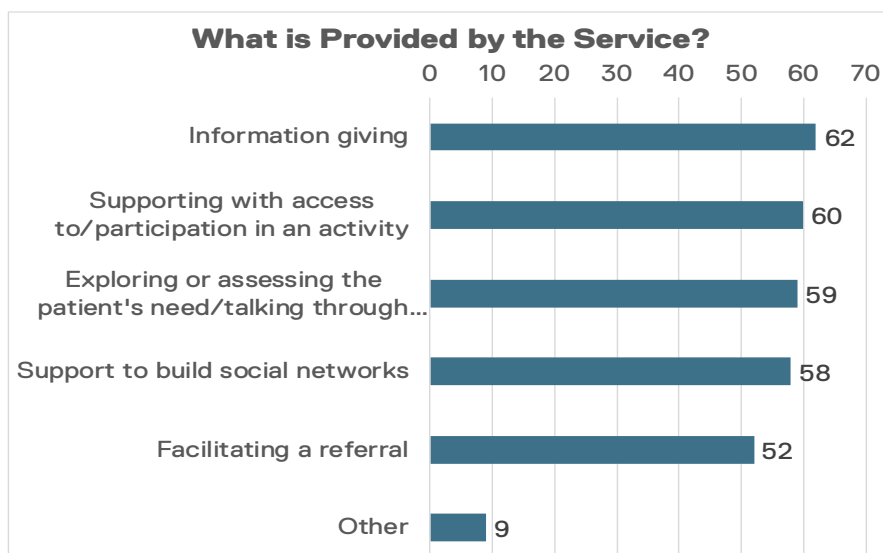
Again, such a breadth of provision makes it more difficult to categorise, but provides the important levels of support for individuals with a wide variety of needs.

This is seen as a strength of social prescribing more broadly, with four of the five models discussed in section 4.1 designed to be able to support and refer to such a diversity of provision, and start up new groups where there are gaps. This is also highlighted by the work of Jo Ward (2016) in creating a typology of social prescribing activities that include the following:

- Information support or advice on prescription
- Bibliotherapy
- Eco-therapy or green prescriptions
- Arts on prescription
- Exercise on prescription or exercise on referral
- Volunteering and community groups
- Learning prescriptions
- Museums in health or museums on prescription

Above all, this diversity that has organically grown up across the country in response to local need requires a vibrant and well-funded VCSE sector and funding being made available to support new groups as they form according to need.

5.3 A wealth of partnerships, and the need for communication

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 many more organisations and partnerships still remaining to be added. This remained one key area identified by the surveys for increased work, with two interlocking areas identified by respondents as places where improvement could happen. The first was more clarity in what was being provided where, both for ease of referral and to ensure there was no duplication of service:

'Communication - Ensuring information on services is kept up to date and GPs, professionals are aware what is available'

'Making services clear, transparent and ensuring they don't overlap so that it is easy for people to see what is the right service for them'

The second issue was simply ongoing connections between referrers and link workers or services - a number of people raised the issue that referrals to programming often tends to fall away. In the words of one respondent:

'More work needed with GPs, works for a bit, then fades away'

One of the proposals for improving this was to develop improved ways to share information:

'We would love to have access to an IT system so we can send patient results back directly into the patient record'

One of the principle barriers was seen as the wider funding context within which people were operating, both the steady cuts to the NHS but also the impacts of a context of austerity on VCSE sector organisations:

'People want to work in partnerships, but with scarce resources a lot of resistance to sharing certain things'

These were also raised in the plenary discussions, where the importance of moving to more holistic work was highlighted. To do so, networks needed to be built and improved and services needed to shift without overwhelming the work itself. In the end it came down to funding.

## 5.4 The importance of funding

In both the many evaluations examined here and in the longer surveys which asked questions about challenges, the lack of stable, long-term funding was central. A slight majority were providing commissioned services.

Table 7 - Is your social prescribing activity commissioned?

If you currently deliver social prescribing activity, is it commissioned activity?

Yes 39
No 35
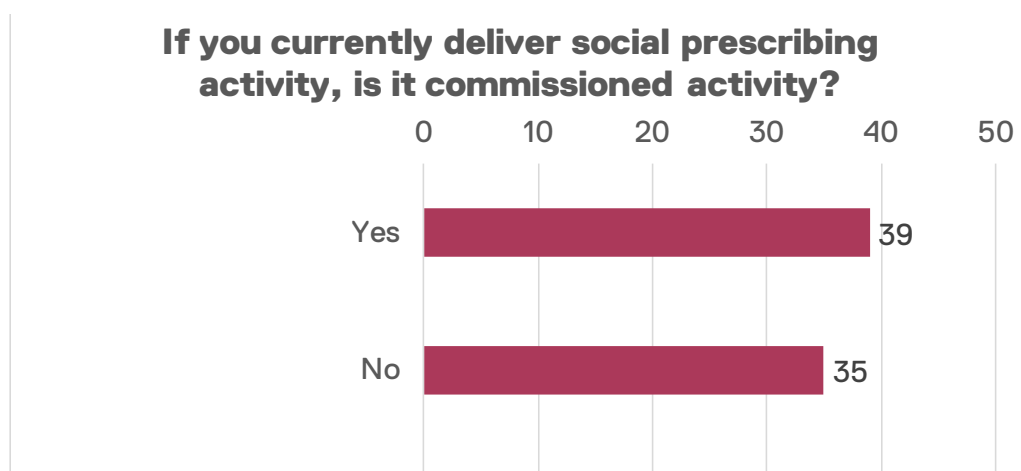
For those who were not commissioned, or who were working to supplement their funding, the principal source was grants:

Table 8 - How else is your service funded?
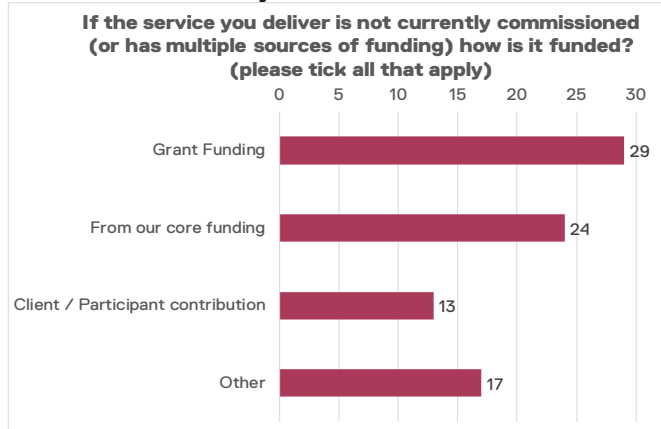
We also wanted to see whether funding followed an individual after their referral – one mechanism to ensure that the services to which they are being referred on to can remain sustainable. This was not the case for the majority of respondents, though some did provide grant funding themselves to support services.

Table 9 - Does funding follow or support the individual?
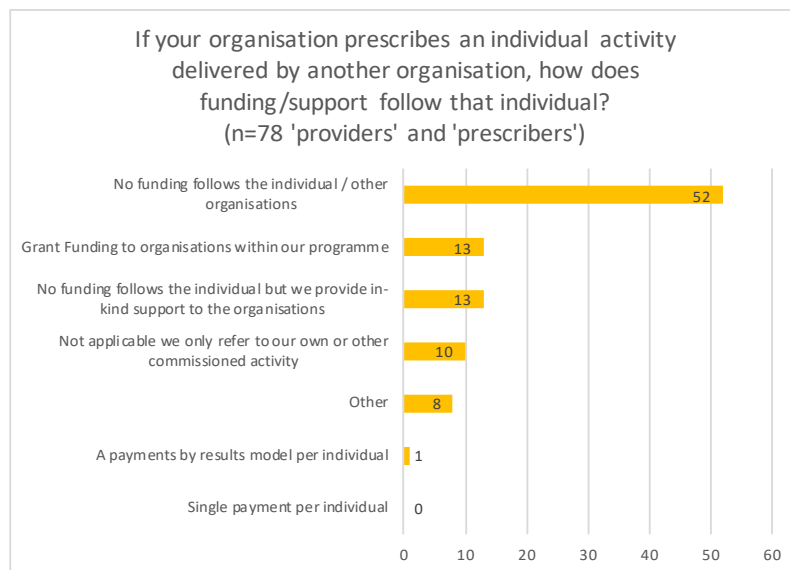
The issues surrounding funding were made very clear through the Salford deep dive, where a slightly longer survey gave respondents to the opportunity to discuss their principal challenges. They are eloquent:

> 'Capacity, we only have one health improvement worker who works one day a week, we could actually do with at least one full-time...We are looking at some volunteers and befrienders to work with [them] but this will take resources, training and DBS checks for volunteers'

This was also found to be a central issue for discussion in the plenary. As in the literature, there were issues noted with organisations/services starting up and then failing

and often a high turn-over of staff, which made keeping up to date with services and people very difficult. The need for both research and action was noted around the following two central questions:

> What is needed to shift commissioning and investment models in NHS, what is possible now and what are the barriers (ie more around how GPs are paid, how things are commissioned)?

> What is needed to get long term funding, particularly for the VCSE side, ie shifting how other funders are working?

5.5 Measuring outcomes

The difficulty in getting, and maintaining, stable long-term funding has been a principle driver for the ongoing discussion of how best to measure outcomes – as well as a major challenge in evaluating outcomes at all.
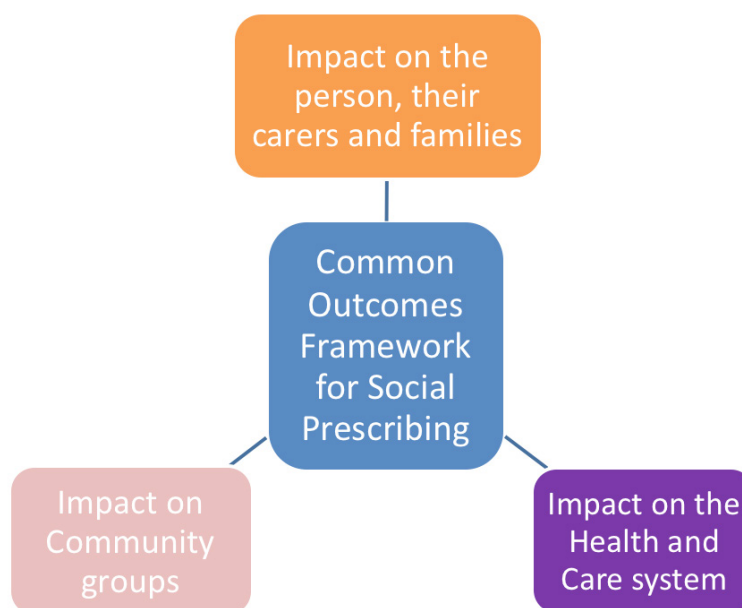
> In-depth academic evaluation for schemes that mainly have low and short- term funding levels is challenging. SP services haven't been able to prove themselves sufficiently through metrics to win sufficient funding to permit long term strategic development and on-going long-term evaluation. Yet services continue to be run across the country staffed by committed professionals determined to make a difference to their communities. Qualitative research demonstrates the high value placed on the service by both patients and referrers (Bromley By Bow Centre, 2016)

Many of the evaluations of the models examined here reflect the desire of most organisations to know how their work is helping people achieve a better sense of health, connectedness and wellbeing, as well as to see where improvement is needed to better help that to happen. In the discussions and workshops, however, it was also clear that people understood with some frustration that funders and commissioners looked for other, primarily quantitative, indicators as to the success of a programme.

The difficulty partly lies in that fact that a wide variety of models and activities can be described under the umbrella of social prescribing, which means there is also potentially a very large range of outcomes. In the academic literature these tend to be described as long-term, diffuse and often difficult to measure, which again proves particularly problematic to those working from a medical standpoint and more comfortable with the large-scale randomised control techniques used to prove causality within medicine (Bickerdike et al., 2017). In fact Bickerdike et al (2017) are fairly scathing of existing evaluations, and the conclusion they come to in their systematic review is that 'current evidence fails to provide sufficient detail to judge either success or value for money'. However, most other reviews (see Polley et al. (2017)) agree that all indications show that social prescribing is much valued by practitioners and patients, and that it will in the long run reduce demand on GPs and emergency services. Moreover, Chris Dayson (Principle Investigator for the Rotherham Social Prescribing evaluation) at the first International Social Prescribing Network Research conference (2018) argued that the tyranny of the positivist paradigm should be extinguished, as there is more than enough qualitative and mixed methods evidence to support social prescribing. The challenges associated with capturing outcomes measures are predicated on the diversity of the service offer and the population needs. This was echoed at the first meeting of the Social Prescribing Network in 2016 which mapped out the following outcomes, showing the broad range of effects that social prescribing can have on individuals and communities, as seen in Figure 7.

Figure 7 - The benefits of Social Prescribing (University of Westminster, 2016)

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

Figure 8 - Draft common outcomes framework from NHS England

A developing framework from NHS England has since themed these outcomes in the ways that they impact on the three main groups involved in Social Prescribing: the NHS, the VCSE sector, and patients, their carers and families.

The various evaluations listed here are grouped below in the impacts and outcome measures they employ. Most obvious is the absence of work on the impact of social prescribing on the VCSE sector itself, rather than just community cohesion.

Impact on the Person, carers and families: A number of studies used a version of WEMWBS (Age UK Humber, Dundee Equally Well), though a number had tried these measures and found them more difficult than useful (Bromley by Bow, Health Connections Mendip, Newcastle Social Prescribing Project). One used the New Economic Foundations Five Ways to Wellbeing (AllTogether Better) and another a very similar bespoke wellbeing tool of eight measures. The Wellspring Healthy Living Project also trialled a number of other measures such as the PHQ9, the GAD7, ONS Wellbeing, and the Friendship Scale for Isolation, and is perhaps the most useful study for exploring how the different measures work in context.

Impact on the Health and Care System: A large focus of the systematic evidence reviews cited was looking for studies evidencing reduced strain and demand on GPs in particular, and the NHS more generally. Of the models examined here, West and Wakefield used GP dashboards and NHS data on admission, lengths of stay and A&E visits. Rotherham undertook an NEF cost-benefit analysis, and Wellspring a more comprehensive SROI analysis.

Impact on Community Groups: This was nowhere studied specifically. Such impact was something examined in general terms through focus groups and qualitative analysis evaluating the different programmes. It was also to some extent taken into account by the CBA and SROI, however their main focus was on broader cost savings to the NHS. This absence of direct attention was true even in the two studies based on examples of social prescribing being managed from the VCSE sector. This study did not find a robust evaluation of how (and if) a rise in volunteering occurred and how that impacted on organisations, nor a great deal around the impacts of any rises in demand. This signals a key area for future research.

Our research as undertaken in GM corroborated the need for better, and more easily collected, evidence to prove the efficacy and scale of programs to ensure funding. There was also a desire to better understand how people move through various systems after their referral, and what the various journeys to improved health look like. Many described this as a unique and non-linear process for each individual. This identified a clear need for evaluation measures to be able to measure improvement and understand people's journey towards wellbeing more holistically, capturing the complexity of such social interventions.

This, it was felt, stood in opposition to the desires of a majority of medical partners and commissioners/funders. There was agreement that commissioners wanted to see quantification of results and calculations of money saved – despite a generally held feeling that most such SROIs or CBAs were imprecise and often highly subjective in how values were assigned. Overall, qualitative research was felt to be the only way to show real causality in improved health and wellbeing, and a better understanding of the journeys people made would be most useful to organisations themselves.

Thus, at the plenary, one goal emerged to identify a few very simple measures that might be captured across GM to show breadth of impact, while at the same time providing a counter to other demands. Broadly speaking this was captured in the following question:

> What would it take to come up with a very simple shared outcomes framework based around wellbeing for patients? There is a need to push back against some of the RCT kind of demands and just work to create very crude measures of broad reductions in NHS access (in thinking about NHS impacts), and how to evidence the impact on the VCSE sector.

This resonated deeply with some of the thinking emerging from other studies. Eleven years ago, Janet Brandling and William House were asked to do the preparatory work needed to undertake a randomised control trial of social prescribing, and in their results stated:

> The aim of the study was to prepare for a multicentre randomised controlled trial (RCT) examining outcome and cost effectiveness for a new social prescribing service compared with usual care in patients making above average use of NHS resources...it became clear that this method of further research was not in the best interests of the patients, staff and stakeholders and that this would not provide a sustainable service (p. 6).

> [T]he limitations of such a controlled study defied the highly varied and organic nature of social prescribing work, including the underlying philosophical assumptions of the project, the type of intervention under study as well as the resource implications and limited sources of funding opportunities (Brandling & House, 2007, p. 9).

Over all, the principle areas to develop, and for further research, were 1) increased communication, better relationships between GPS and link workers/VCSE sector and better knowledge of available services; 2) increased, long-term funding for the VCSE sector and changes in commissioning; 3) some simple shared outcome measures, and an understanding that basic showings of reduction of demand for NHS services should be enough for commissioners, as the complexity of any social prescribing activity means causality cannot be adequately proved through traditional medical frameworks such as RCTs.

5.6 Mapping of Social Prescribing through a Salford 'Deep Dive'

The map below shows the results of the mapping for Salford, with twelve respondents centred in Salford itself, and another four organisations providing services providing targeted services in Salford among a handful of neighbouring boroughs.

Figure 9 - Mapping of Salford results

1. Silverdale Medical Practice
A link worker works with patients initially then sign-posts them to community facilities. The Health Improvement worker, works from the practice but can go out into the community with patients.

2. Salford Community Leisure
The service receives referrals from a number of sources and patients are routed into the most relevant programme based on their long term health condition.

3. Salford Health Improvement Service
We provide initial sessions of one to one behavioural change, motivational support and confidence building to encourage individuals to access community group support provided through our own service or through another.

4. Salford Health Works
Referral by GP, and initial assessment carried out. Appointments on average every 2 weeks over 20 sessions. Meetings are held within GP surgeries and community centres/Gateways.

5. Unlimited Potential
There is an initial intensive programme, followed by introduction or referral to mainstream activities/services for the person to continue independently.

6. Start in Salford - Inspiring Minds
Referrals are received from a wide range of organisations, given a mentor from the staff team and then engage with the activitiy programme. They are also signposted to other services.

7. Stroke Association
We work with stroke survivors, carers and families, take referrals from clinical settings, self referrals and families. An initial home visit in most cases followed by phone support or home visits.

8. Salford Primary Care Together
Generally the service starts following a consultation with a medical practitioner . The Care Navigation programme supports referrals as identified and when appropriate.

9. Salford Citizens Advice
Any health care staff can refer clients to the service. There are particular arrangements around end of life care patients, maternity services, and children with disabilities.

10. Lark Hill Parent Forum
volunteers and families meet weekly. Outside agencies have an open invitation to join weekly meetings

11. Social adVentures
A one to one service based from our centres, with two projects doing outreach in the community with an aim to remove as many barriers as possible

12. Salford Primary Care Together - Homeless GP Practice
Currently scoping Care Navigation across practices

13. Langworthy Cornerstone
We provide a wide range of services and activities and our staff encourage participation and also have a good knowledge of services elsewhere. We also have a triage system to make referrals easy for GPs etc

14. Salford Carers Centre
We provide a specialist service to unpaid carers. All workers have a specialist skill set to support this group with knowledge on how to address their needs.

15. Salford Mens Club
We are a mental health, referral-only mens group

Big Life Group (Manchesterm Rochdale, Salford)
2 SP models. 1.) Provision of a coach, assessment, and between 6 and 12 meetings. 2) More casual via active signposting through our centres and working with users to develop services which meet their own needs where they don't exist

Gaddum (Bury, Manchester,Rochdale,Salford,Stockport)
Each person accessing our services is assessed holistically and has a package of support to meet their needs.

Royal British Legion (Bury, Salford, Wigan)
Referral is from Advice or Casework staff to community groups or activities

Focused Care CIC (Bolton,Manchester,Oldham,Rochdale,Salford,Stockport,Tameside)
Focused Care is based in universally accessible GP surgeries across GM. We offer holistic care to vulnerable individuals and households based on an agreed care plan with the patient. We work with the patients through home visits and trust-based relationships to enable them to have healthy outcomes.

LGBT Foundation (Whole of GM)
Pride in Practice (PiP) is a social prescribing model for primary care services and lesbian, gay, bisexual and trans (LGBT) communities that strengthens and develops between GP practices, dental practices, optical practices and pharmacies and their LGBT patients in GM

Wai Yin Society
We offer community events, activities and advice to the community and also offer training and skills to the community at the centre.

Communities for All Ltd (All of GM)
e offer community events, activities and advice to the community and also offer training and skills to the community at the centre.

Yaran Northwest CIC
We receive referrals for middle Eastern Farsi speaking residents across greater Manchester. Our services is offered by qualified bilingual accredited therapists who are IAPT trainer. We run a range of one to one and group therapy sessions.

Ethnic health forum
We rely on a GP Practice to refer clients.

Legend

Icon	Meaning
Signposting	
Link, Connector, Trainer	
Champion	

Colour	Category
Yellow	Social Prescriber
Blue	Receives referrals/ provides services
Green	Social Prescriber AND Service Provider
Pink	Other

An additional nine organisations provide services across GM, making them available for prescription as well. These include the Stroke Association, Communities for All Ltd, GreaterSport, Yaran Northwest CIC, Speakeasy, the Wai Yin Society, the LGBT Foundation, the Ethnic Forum and BHA for Equality.

The Salford Deep Dive consisted of an extended survey and short interviews with a number of organisations active in Salford undertaken primarily by Anne Lythgoe of Salford CVS, with support from Dr Andrea Gibbons of the University of Salford. This work identified three different 'levels' or categories of care and support into which individuals are being 'prescribed':

Commissioned services – mental health, healthy living centres, carers' support, stop smoking, health improvement, weight management etc (CCG and PH funded), as well as Skills and Work or Work and Health services (funded by the City Council and GMCA)

- Wider VCSE activities – funded through grants, fundraising, trading, and often led by volunteers, including community groups, charities and small social enterprises

- Informal voluntary activity – not in constituted groups, but through family, friends, carers, and local community contacts

The aim of this system is to move people from primary and secondary care into self-care, using these levels, but it is clear that there is no obvious pathways through these levels. Thus multiple prescriptions, or more simply referrals and informal connections, are being made at each level. Patients might be referred directly to commissioned services, who might then refer them on to support with a local community group.

This means there are also multiple diagnostic discussions taking place in any patient journey as an individual moves between services and support. These may be structured and recorded when provided by commissioned services, but much more informal when provided in a community setting. Initially it was imagined that the prescription

would always move outwards from the official prescriber across the various tiers, Figure 10 shows the model updated to show the additional referrals that are taking place:

The interviews also revealed, however, that a community group might in turn connect a patient back to a different commissioned or more formal VCSE activity. Both findings help make sense of the survey findings, where multiple organisations saw themselves as both a service provider and a social prescriber. It also highlights the need for communication and feedback looks as patients 'step up' through the levels as well as stepping down as seen in Figure 11.

This is impacted by the recent budget cuts that have greatly reduced the scale and scope of the second sphere of commissioned services which can be prescribed into. This has been particularly felt with cuts to the Public Health budget. As one respondent wrote:

> 'We have had our service budget cut every year for the previous six years which has significantly reduced our staffing capacity. This means we have less and less resources to deliver both the one to one, and the group support necessary for effective social prescribing'

This has increased demand for grant funding to support services into which social prescription takes place, requiring VCSE providers to seek other funding sources to enhance their services and 'top up' support which was once commissioned. Overall, a number of organisations in the sector have shifted their work, with many of the medium sized VCSE providers now sit between the commissioned services 'level' and the 'wider VCSE activities' level as shown by Figure 12 below.
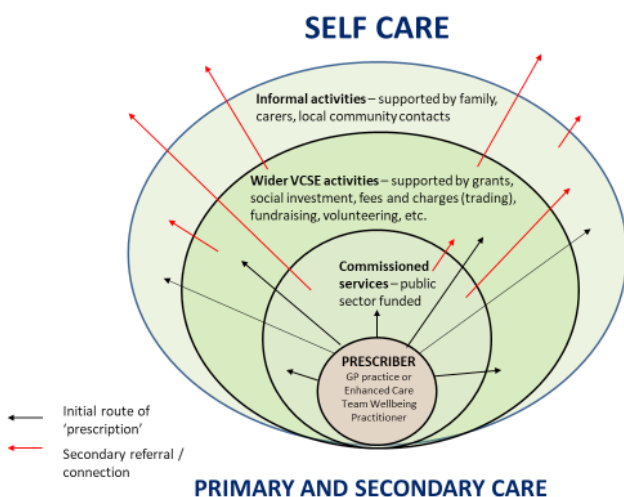
Figure 10 - Starting model of Social Prescribing, updated to show further prescription
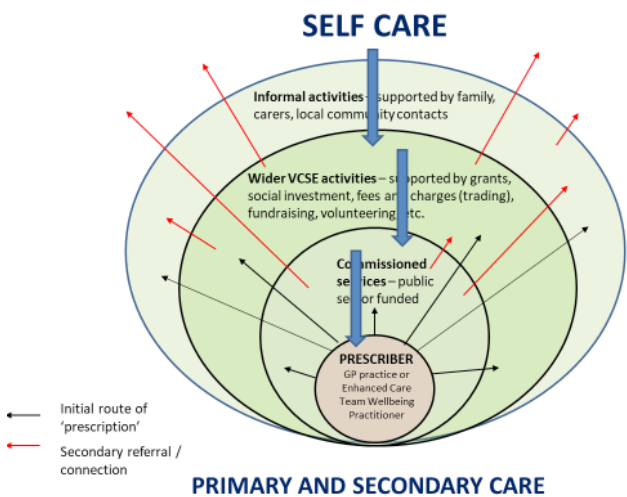
Figure 11 - 'Stepping up' and 'Stepping down' through the referral process

At the same time, most VCSE activities – particularly commissioned services – have multiple and often complicated referral routes as shown in Figure 13. Many providers noted that this caused considerable problems, both to themselves and to their service users. These included:

■ Inefficiencies – increased staff time in receiving referrals and establishing referral contacts

■ The need for multiple diagnostic sessions

■ Service users make additional journeys and have to attend additional diagnostic meetings

■ The reliance on personal contacts and knowledge of available support services

■ High drop out rates
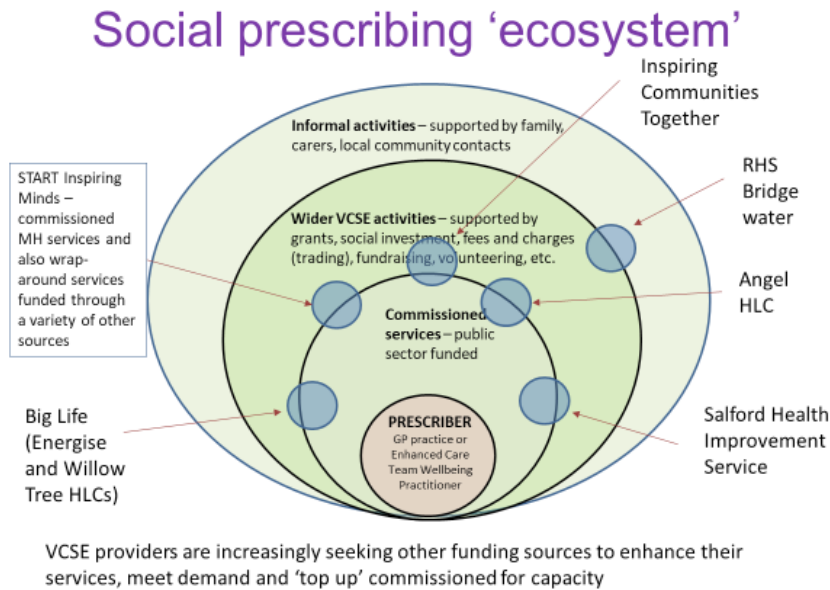
Figure 12 - The Social Prescribing 'ecosystem'
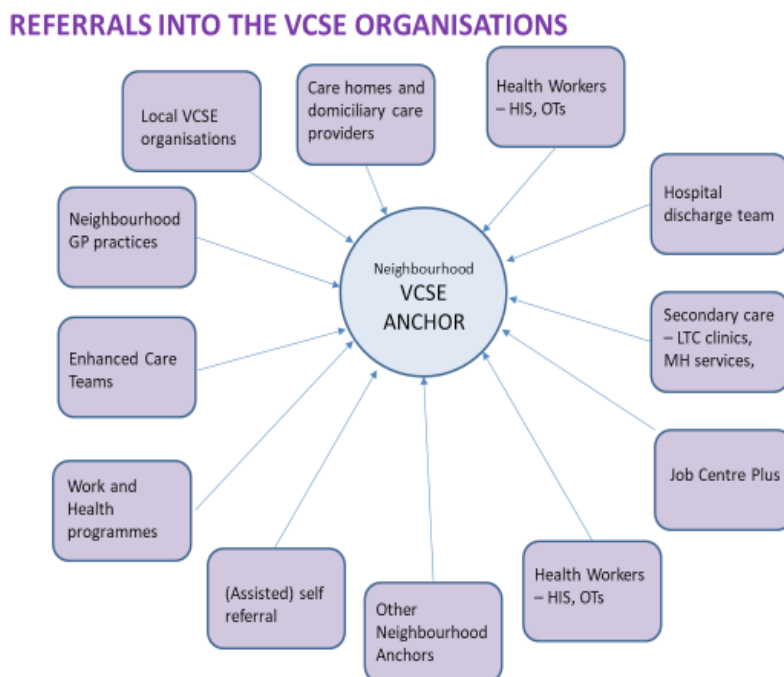
Figure 13 - Referrals into the VCSE

There was also perceived to be an issue with programmes being funded for a very short period, and then falling away. As one respondent described, it was central to:

> 'Ensur[e] that GPs know, understand and trust what we provide, there is very often confusion resulting from the number of other, often short term, wellbeing services that are commissioned causing confusing and duplication'

An additional issue with funding was that it had been withdrawn from lower tier 'universal' services, above all 'lifestyle' services, and yet these are precisely the tiers central to social prescribing, expected to take the pressure off of clinical and acute services. They also described a lack of support for more holistic support:

> 'One to one work isn't supported by commissioners because it costs more, but it is what we provide because it is what is needed'

There is a clear tension here; likewise, the extensive cuts to VCSE sector-based programmes ensure a clear gap in services to prescribe into. Some funding thus needs to shift into lower tier and community service provision for the social prescribing model to have the effect desired, as shown in Figure 14. Community based interventions can in some cases have a lower cost, particularly those which are more informal and require very small pots of money.

Unsurprisingly, these findings strongly echo the recommendations emerging from the work of the Social Prescribing Network, as the dynamics in Salford are to be found in many communities nationally (University of Westminster, 2017).
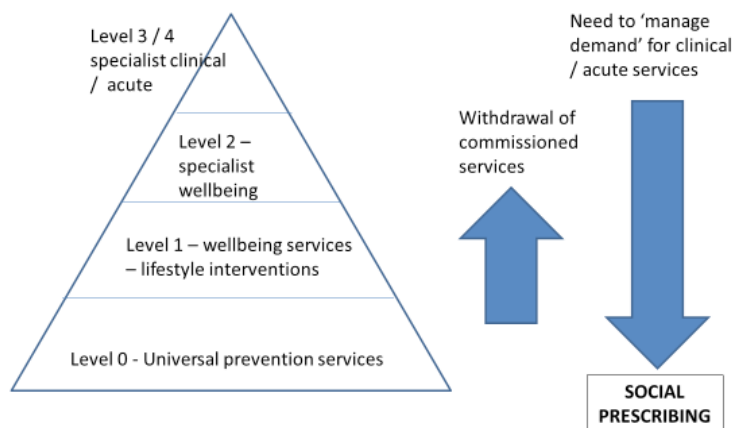
Figure 14 - Public health triangle

6. Conclusions and Recommendations

These key findings from the survey and deep dive resonate with two already-established key sets of principles for person-centred care: the ten key actions developed by Nesta and The Health Foundation to 'put people and communities at the heart of health and wellbeing', and the Social Prescribing Networks's six core principles. Both highlight the need to establish person-centred approaches, formulate key shared outcome measures, ensure funding and capacity within the VCSE sector, and develop strong networks and collaborative working with partners (NESTA & The Health Foundation, 2016; University of Westminster, 2016). Both argue these are necessary to supports success in both bottom up and top down approaches, and emphasise the importance of meaningful engagement of key stakeholders.

The National Social Prescribing Network has developed the core six principles working with NHSE and GP leads. They are:

1 Funding commitments

2 Collaborative working between sectors

3 Buy-in of referring healthcare professionals

4 Communication between sectors

5 Using skilled link workers within the social prescribing schemes

6 Person-centred service

This latter principle; 'Person-centred service' resonates with key questions being asked by the NHSE reflect whether an individual is better able to be more active, in control, able to manage health and wellbeing and more connected to others. There is also clear resonance with the Salford and GM models working within a PCCA model, ensuring that the community and individual are at the heart of service development and outcome. Within the context of the health and care system, the impact includes changes to GP referrals, reduction to A&E attendances, changes in hospital bed stays. In particular, the outcomes framework taskforce has identified suggested outputs to encourage a consistent approach which include a range of indicators that capture referral rates, demographics, referral criteria, intervention costs and resource expectations with an emphasis on how social prescribing models and interventions are able to become sustainable. It is purported that the National consultation will result in key recommendations to ensure that data is shared to facilitate follow up of people accessing social prescriptions, and, an agreed pay band for link workers

6.1 Enablers

While the challenges are great, there is clear evidence for what works in providing the best outcomes for patients, in improving community connection and cohesion, and in reducing demand on medical services. Key to this is the need for a good VCSE local infrastructure that can help to a) shape service provision around population need, b) act as a main liaison between VCSE and external partners, c) support communication through the link workers, connectors and Salford Together. The main enablers are summarised briefly below to feed into the recommendations that follow.

Holistic, joined up services

- Some only need basic signposting and referral, for all others the more holistic the service, the better the outcomes and satisfaction tend to be. Kimberlee's (2015) description of this in 6.1 offers a clear view of what this entails. Some specific findings that emerged from the research include:

- 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.

- The absence, where possible, of time limits as time is needed to build the relationship, and to allow people to make change at their own pace, which is the only way change will be successful.

Good relationships

- Relationships are central at all levels of service (CCGs & funders, GPs, link workers and/or champions, VCSE sector, community members)

- Regular communication/feedback facilitated these relationships as well as continuous adaptation and improvement

High levels of flexibility

- provision needs to 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

- Bespoke CPD activity

Up to date resource mapping

- This is best facilitated by knowledgeable staff

6.2 Challenges

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.

- Recognition is needed that after years of austerity, resources within both the NHS and VCSE sector are much reduced, and need to be built up again for long-term success

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. Some literature is highly critical of the lack of scientific rigour in evaluations, particularly the absence of Randomised Control Trials (Bickerdike et al., 2017), but there has been a sustained counter-argument that such methodologies are highly unsuitable for community-based interventions, many of which are also critical of how social value is quantified through CBAs and SROIs (see Brandling and House (2007) and Polley et al (2017)). This conflict in understanding of what constitutes acceptable evidence of impact needs to be mediated, and a strong evaluation methodology further developed.

- Both studies and surveys have also described difficulties in using formal wellbeing and other health measures such as WEMWBS, which are found to be too cumbersome

- 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.

6.3 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)

6.3.1 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

Figure 15 – Visual representation of recommendations at GM and locality level
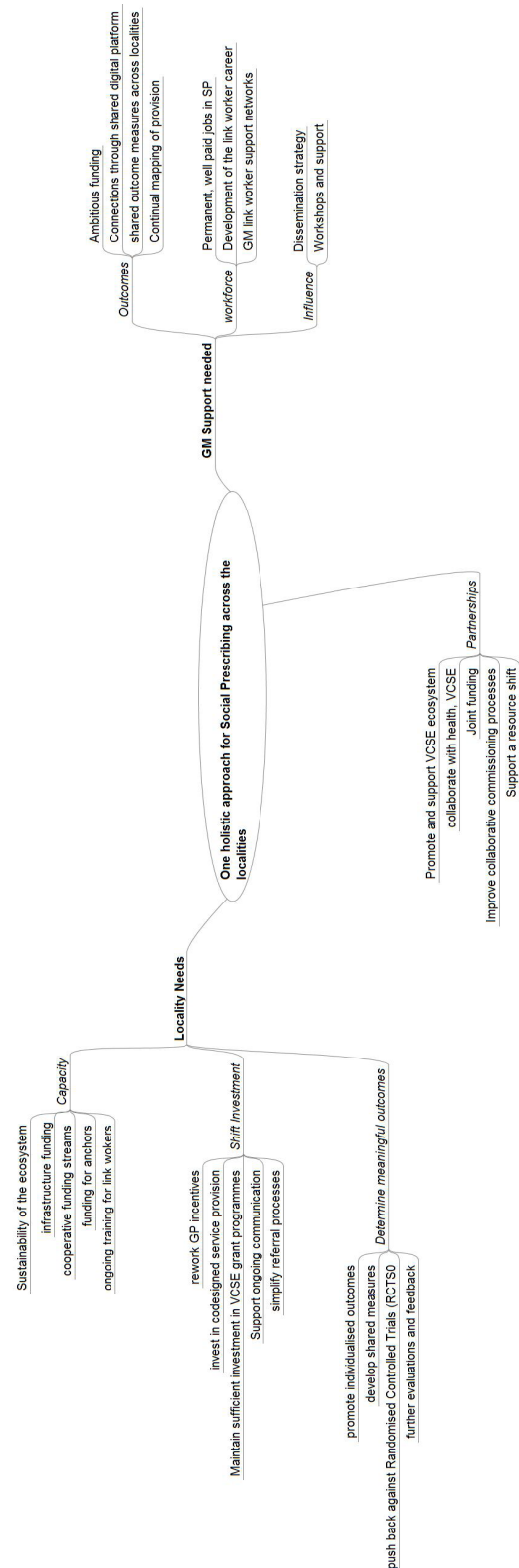
6 Simplify referral processes, and develop shared information systems to reduce need for ongoing replications of 'diagnosis' (but also recognising that 'diagnosis' will not always be final and that it often takes time for underlying issues to be recognised and for a patient to be ready to act on them)

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

6.3.2 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

6.3.3 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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Appendix A: Systematic Reviews of Social Prescribing

Stage 1: Identifying the research question

The research question as agreed by the research team after the initial scoping research:

What are the current systematic or scoping reviews of the literature around social prescribing that exist nationally, and is there any emerging consensus around definitions, typologies or best practices?

Stage 2: Identifying relevant studies

A robust approach to the literature searches for evidence was taken to ensure that existing reviews of the literature that could contribute to a better understanding of current perspectives relating to social prescribing were identified.

Literature searches

An experienced information specialist conducted the literature searches. A time frame of 1990 onwards was set to capture evidence from the last 25 years. Searches were undertaken in April 2018.

Resources searched

Resources searched included Cochrane library, BioMed Central, Ovid Medline, ASSIA, SpringerLink, CINAHL, Science Direct, PsychInfo and both the National Institute for Health and Care Excellence (NICE) and Social Care Institute for Excellence (SCIE) databases as well as Google Scholar to identify grey literature. Search terms included variations of "social prescribing", "community referral", "community connector", "systematic review" and "scoping review." Further studies were identified by searching reference lists of all relevant articles and systematic reviews.

Stage 3: Study selection

This study included all results that were systematic or scoping reviews of what could loosely be described as 'social prescribing' practices, defined broadly as patients linked to non-medical interventions in community or green spaces. The primary search focus was on the process of social prescribing (also described as community referral or linking) itself, however a secondary set of systematic reviews were also included around

what Chatterjee et al (2017) describe as the primary interventions of social prescribing, or arts on prescription, exercise on prescription, advice provision and green care. Also included were a number of reports providing a level of overview of the field and current practice, though none had the comprehensiveness of a systematic review. Excluded were all articles not in English, not centered on UK practice, and written before 1990.

Also excluded were reports providing evaluations of a single project, however, based on the analysis of the selected comprehensive review, all such reports and articles cited two or more times and available to the research team were downloaded and analysed to provide further details around practice and outcome evaluation.

Stage 4: Initial Results

Nine systematic reviews focusing on social prescribing as a practice were analysed after the selection process. An additional twenty-one reviews include a number of systematic reviews focused on particular interventions with information on the social prescribing role or pathways from a primary care context into the community context.

An additional set of key reports undertaking a broader based analysis of social prescribing was also identified as useful in discussing definitions, models and best practices over the years. These included:

- *Making Sense of Social Prescribing* (University of Westminster, 2017)

- *Social prescribing at a glance: A scoping report of activity for the North West* (Ward, 2016)

- *Developing Asset Based Approaches to Primary Care: Best Practice Guide* (Greater Manchester Public Health Network, 2016)

- *Just what the doctor ordered: Social prescribing – a guide for local authorities* (Local Government Association, 2016)

- *Social prescribing for mental health – a guide to commissioning and delivery.* (Friedli, Jackson, Abernathy, & Stansfield, 2008)

Systematic Reviews

Title	Citation	Description	Findings
Facilitators and barriers of implementing and delivering social prescribing services: a systematic review	(Pescheny, Pappas, & Randhawa, 2018)	A systematic literature review of studies assessing SP services based in general practice and involving a navigator. Data synthesis built on a narrative synthesis, using thematic analysis for categorising data. The focus was on barriers to implementation.	8 articles reviewed: Facilitators and barriers were related to: the implementation approach, legal agreements, leadership, management and organisation, staff turnover, staff engagement, relationships and communication between partners and stakeholders, characteristics of general practices, and the local infrastructure. The quality of most included studies was poor and the review identified a lack of published literature on factors that facilitate and hinder the implementation and delivery of Social Prescribing services.
Social prescribing: less rhetoric and more reality. A systematic review of the evidence	(Bickerdike et al., 2017)	A systematic review of social prescribing evaluations of programmes where patient referral was made from a primary care setting to a link worker or facilitator.	15 evaluations of social prescribing programmes. Most were small scale and limited by poor design and reporting. All were rated as a having a high risk of bias.
Non-clinical community interventions: a systematised review of social prescribing schemes	(Chatterjee et al., 2017)	A systematised review protocol of United Kingdom social prescribing schemes published in peer-reviewed journals and reports, appraising primary research material evaluating social prescribing schemes published 2000–2015.	86 schemes located including pilots, 40 evaluated primary research materials: 17 used quantitative methods including 6 randomised controlled trials; 16 qualitative methods, and 7 mixed methods; 9 exclusively involved arts on prescription.
A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications	(Polley et al., 2017)	A systematic review of the economic impact of social prescribing -- a) be UK-based, b) describe a social prescribing service that involved referral of a patient from primary care to a 'link worker' who would connect the patient with relevant non-medical interventions in the third sector and c) report either i) quantitative data on demand for healthcare services and/or ii) evaluation of social and economic impact of social prescribing.	14 papers examined – the evidence for social prescribing is broadly supportive of its potential to reduce demand on primary and secondary care. The quality of that evidence is weak, however, and without further evaluation, it would be premature to conclude that a proof of concept for demand reduction had been established. Similarly, the evidence that social prescribing delivers cost savings to the health service over and above operating costs is encouraging but by no means proven or fully quantified.
Preparing the prescription: a review of the aim and measurement of social referral programmes	(Rempel, Wilson, Durrant, & Barnett, 2017)	A literature review undertaken as part of the 'Collaborating to Deliver Social Prescribing in Bath and North East Somerset' project, with a focus on project aims and outcome measurement.	41 articles and reports examined, using 154 different kinds of measures or methods of evaluation. Of these, the most commonly used individual measure was the Warwick-Edinburgh Mental Well-being Scale, used in nine studies and reports.

	Authors and date	Scope	Articles Reviewed and Conclusions
Evidence to inform the commissioning of social prescribing	(Centre for Reviews and Dissemination, 2015)	This briefing is a rapid appraisal and summary of existing sources of synthesised and quality-assessed evidence, primarily systematic reviews and reports of formal evaluations.	Broad summary of lack of evidence in the field, more detailed examination of 5 evaluations.
Exploring the components and impact of social prescribing	(Kilgarriff-Foster & O'Cathain, 2015)	A systematic review of the evidence base for social prescribing, mapping its key components and potential impact.	24 studies examined -- all diverse in terms of their methodology and the service. It found that stakeholders viewed social prescribing as improving patient well-being and reducing use of health services. Found limited quantitative evidence of effectiveness and only one robust evaluative design. This gap needs to be addressed
A scoping review to understand the effectiveness of linking schemes from healthcare providers to community resources to improve the health and well-being of people with long-term conditions	(Mossabir, Morris, Kennedy, Blickem, & Rogers, 2015)	A systematic review focused on the linking mechanisms of social interventions which facilitate patient access to a range of community-based resources. It sought: ☐ To identify key components of social interventions linking participants from healthcare settings to community groups and services. ☐ To identify facilitators and barriers to delivering an intervention of this nature. ☐ To identify key benefits provided to participants in relation to their health and well-being.	7 papers reviewed. It found that: ☐ The roles of health professionals and intervention facilitators are vital for legitimising social prescribing as a health management strategy. ☐ Participation in wider community-based activities has a positive impact on patients' psychosocial well-being. ☐ A methodologically flexible approach is required for assessing the impact of social prescribing as empirical evidence is limited.
Social Prescribing: A review of community referral schemes	(Thomson, Camic, & Chatterjee, 2015)	A broad, only slightly academic review of the conditions under which social prescribing has arisen and looking at the efficacy of different referral options. Its objectives are to provide definitions, models and notable examples of social prescribing schemes and to assess the means by which and the extent to which these schemes have been evaluated. Contains a long list of social prescribing schemes by geographic area.	Described a number of positive health outcomes of social prescribing, as well a success in encouraging patients to become proactive in decisions about their own health, increasing social contact and support in local communities, and reductions in levels of reliance on primary and secondary care. The benefits have been particularly pronounced for marginalised groups. The most successful schemes have favoured the use of a link worker or referral agent acting as a 'one stop shop' for referrers from general practice, health and social care services and, potentially an array of other professionals working within the community.

Systematic Reviews on Specific Community Interventions or Conditions

Arts on Prescription			
Arts on Prescription: A review of practice in the UK	(Bungay & Clift, 2010)	Broad review of existing evidence and practice establishing benefits of Arts on Wellbeing	N/A
Advice Services			
The Role of Advice Services in Health Outcomes Evidence Review and Mapping Study	(The Low Commission, 2015)	An evidence review outlining key findings from 140 research studies in the field, with an overview of 58 Integrated health and welfare advice services.	The provision of good welfare advice leads to a variety of positive health outcomes and in addition addresses health inequalities highlighted in the Marmot Review 2010. The effects of welfare advice on patient health are significant and include: lower stress and anxiety, better sleeping patterns, more effective use of medication, smoking cessation, and improved diet and physical activity.
Exercise			
Moving on Up	(Myron, Street, & James, 2009)	The evaluation of a small number of exercise referral schemes across the country. This report investigates the successes and barriers in place in sites currently running exercise referral schemes and presents the key recommendations and lessons learned. The report also revisits what GPs currently think about exercise referral four years on from the first report.	
Effectiveness of exercise-referral schemes to promote physical activity in adults: systematic review	(Williams, Hendry, France, Lewis, & Wilkinson, 2007)	To assess whether exercise-referral schemes are effective in improving exercise participation in sedentary adults.	Eighteen studies included: six RCTs, one non-randomised controlled study, four observational studies, six process evaluations and one qualitative study. Two of the RCTs and two of the process evaluations also incorporated a qualitative component. Results from five RCTs were combined in a meta-analysis. There was a statistically significant increase in the numbers of participants doing moderate exercise with a combined relative risk of 1.20 (95% confidence intervals = 1.06 to 1.35). This means that 17 sedentary adults would need to be referred for one to become moderately active. This small effect may be at least partly due to poor rates of uptake and adherence to the exercise schemes.

Green Care			
Good practice in social prescribing for mental health: the role of nature-based interventions	(Bragg & Leck, 2017)	This study engages local authorities and health commissioners to identify best practice in a range of social prescribing services referring people to nature-based (green care) interventions in light of: □ The NHS ambitions to focus on individual and community involvement in healthcare. □ The shift to more local delivery of health and care services. □ The under-utilisation of existing green care services. And □ The vast potential to increase the scale of green care provision.	Review of evidence around prescribing to green care, 5 case studies
What evidence is there to support the impact of gardens on health outcomes? A systematic scoping review of the evidence	(Howarth, Brettle, Hardman, & Maden, 2018)	□ How gardens can improve physical, mental, health and wellbeing outcomes □ A 'map' of the literature in relation to the benefits for particular conditions, types of garden, and health outcomes □ The gaps in the literature in relation to particular conditions, garden types and health outcomes □ Gardens as an intervention within the social prescribing movement □ Infographics and a logic models, which capture the data in a simple way. These can be used to inform the future development of the RHS therapeutic garden and for organisations interested in green care or nature-based activities	67 (Dementia (14), Mental Health (21), General Well Being (23), Nutrition (9)
Nature-assisted therapy: Systematic review of controlled and observational studies	(Annerstedt & Währborg, 2011)	Systematic review of evidence of how 'nature's potentially positive effect on human health may serve as an important public health intervention'.	38 (3 meta-analyses, 6 'high grade' studies, 29 'low to moderate' evidence grade
Cultivating our humanity: A systematic review of care farming & traumatic grief	(Gorman & Cacciatore, 2017)	A systematic review of evidence for care farming as an intervention in relation to traumatic grief.	8 studies examined, found that whilst understudied, the success of care farming as an intervention for other populations experiencing psychological distress demonstrates the huge potential for care farming as a means to therapeutically engage with individuals experiencing traumatic grief.

Green Care cont…			
Effectiveness of animal-assisted therapy:A systematic review of randomized controlled trials	(Kamioka, Okada, et al., 2014)	Summarised the evidence from randomized controlled trials (RCTs) on the effects of animal-assisted therapy (AAT). Studies were eligible if they were RCTs. Studies included one treatment group in which AAT was applied.	In a study environment limited to the people who like animals, AAT may be an effective treatment for mental and behavioural disorders such as depression, schizophrenia, and alcohol/drug addictions, and is based on a holistic approach through interaction with animals in nature.
Effectiveness of horticultural therapy: A systematic review of randomized controlled trials	(Kamioka, Tsutani, et al., 2014)	Summarised the evidence from randomized controlled trials (RCTs) on the effects of horticultural therapy (HT). Studies were eligible if they were RCTs.	Four studies met all inclusion criteria. The language of all eligible publications was English and Korean. Target diseases and/or symptoms were dementia, severe mental illness such as schizophrenia, bipolar disorder, and major depression, frail elderly in nursing home, and hemiplegic patients after stroke. These studies showed significant effectiveness in one or more outcomes for mental health and behaviour.
Diabetes			
Searching for Real-World Effectiveness of Health Care Innovations: Scoping Study of Social Prescribing for Diabetes	(Pilkington et al., 2017)	A systematic review of evidence from evaluation of social prescribing for type 2 diabetes in the United Kingdom and Ireland, comparing information available on publicly available websites with the published literature.	40 projects identified, with 24 evaluations; 11 as published papers, 12 as Web-based reports, and 1 as both a paper and a Web-based report. These evaluations report generic improvement in a broad range of outcomes and provide an insight into the criteria for the success of social prescribing services.

Academic Case Studies Distilled From Systematic Reviews [2]

	Age UK (Yorkshire & Humber) [3]	Amalthea Project, Avon [4]	Doncaster 'Patient Support Service' [5]	Dundee Equally Well [6]
Project	General practitioners referred 55 older people who had mild to moderate depression or were lonely and socially isolated to the Social Prescribing service at their local Age UK.		GP project trialled use of volunteers to refer and support people to community based services	A holistic project to address mental health and health inequalities through partnership working, public engagement, raising awareness and capacity building leading to behaviour change.
Basic Model	GPs, nurses and other team members refer to a central VCSE contact who then refers on to appropriate contact.	GP practices refer to three project facilitators. Gave initial assessment within 7 days, followed up to support and encourage attendance. Referred to local VCSE, some statutory services, formed new support groups.	GPS refer to two volunteers, one who explored their needs, the second arranged appts with community services. Held in practice 4 afternoons a week, 2 hour appts.	Created a local Wellbeing working group working with community, health and service providers, community groups and planning and piloted social prescribing.
Time	2011	1997-1998	2001-2002	2008-2011
Patterns of Participation	Not noted	Not noted	200 patient appointments, with 132 attenders and 68 non-attenders.	Not noted
Sector Findings		□ Found that it improved wellbeing, reduced anxiety and other emotional problems □ Cost of care higher – same use of services, more mental health medications prescribed	□ For volunteers, felt pressure to be counsellors, needed follow up time with patients referred, counselling and mental health found to be greatest need	□ Community had much greater awareness of support available and improvements in mental health and wellbeing □ Increased and improved partner-ships in VCSE sector □ GPs positive, better understood connections between community activities and mental health

2 Please note that none of the four studies engaged with challenges, but rather focused on enablers which are presented here
3 (AgeUK, 2011)
4 (Grant, Goodenough, Harvey, & Hine, 2000)
5 (Faulkner, 2004)
6 (Friedli, 2012)

	Age UK (Yorkshire & Humber) [3]	Amalthea Project, Avon [4]	Doncaster 'Patient Support Service' [5]	Dundee Equally Well [6]
Outcome Measurements	Improved wellbeing – some use of WEMWBS	161 patients split between 'control' and those referred to facilitators. Measures used were: psychological wellbeing, assessed with the hospital anxiety and depression scale, and social support, assessed with the Duke-UNC functional social support questionnaire. Secondary outcomes were facets of quality of life, assessed with the Dartmouth COOP/WONCA functional health assessment charts and the delighted/terrible faces scale	Focus groups – very small sample	Used Contribution Analysis theory to test impact of the site and overall project. WEMWBS used for SP pilot
Enablers	☐ Referral forms should be brief and easy to complete. ☐ The referral mechanism should fit with other referral systems in the practice i.e. phone, fax or postal. ☐ Regular communication with the GP practice is important, including providing case study examples to show the benefits of the service for older people. ☐ Provide feedback to the referring health professional after the initial assessment and at appropriate times during the older person's contact with Age UK.	☐ this capacity was to be made up by staff of VCSE organisations with broadly same role, but it was found that specialist knowledge in behavior change and relevance to health and wellbeing central ☐ Linkwork organisations were only able to participate in the project due to the availability of staff funded from other sources ☐ Linkwork organisations worked together in a mature and collaborative way to determine the organisation best placed to take a lead support role. ☐ Linkwork organisations deliver the one to one casework as part of their core delivery in the city so are experienced in providing the service. ☐ For linkworker: – Receiving appropriate referrals ≡ first contact through home visit ≡ direct contact between link worker and referrer about case		

Appendix B: Survey Questions

Introduction

The aim of this survey is to map the range and different models of social prescribing activity across Greater Manchester. The information from these surveys will be used not only to map the work of the VCSE sector within GM, but also to help ensure that future work and funding bids surrounding social prescribing build on current activity. We are looking to explore what social prescribing means to different groups who are either referring patients or are accepting referrals, and hope that this research will support a better understanding of existing challenges as well as begin to establish best practices across GM.

Please take time to read the attached participant information sheet (v3, dated 03/04/2018) carefully. If anything you read is not clear or you would like more information please contact one of the project team (details below) and ask as many questions as you want. Take time to decide whether or not to take part.

Consent

I have read the participant information sheet (v3, dated 03/04/2018) and had opportunity to ask questions (Y/N)

I understand that by completing and submitting this survey I am consenting to take part in this study (Y/N)

Section 1: About Your Social Prescribing Offer / Service

1. Are you delivering a social prescribing service or activity or are you in discussions about one with a commissioner / grant funder?

■ Yes, I am delivering a social prescribing service activity

■ Yes, I am in discussion about a social prescribing activity with a commissioner / grant funder

■ No, I am not involved in the delivery or commissioning of a social prescribing activity but I am interested in finding out more about social prescribing

2. Could you say in just a few words, what social prescribing means to you? (open question)

3. Where is the social prescribing service/activity based? (please tick all that apply)

■ Bolton

■ Bury

■ Manchester

■ Oldham

■ Rochdale

■ Salford

■ Stockport

■ Tameside

■ Trafford

■ Wigan

■ Whole of GM

4. What social prescribing activities is your organisation involved in? (please tick all that apply)

■ We signpost / prescribe people to the appropriate support and activities

■ We deliver activities and support within our organisation that people are referred to

■ Other (please explain)

FOR PROVIDERS ONLY:

5. What types of support are included in the service? (Tick all that apply)

- Health and well-being, healthy lifestyle support
- Community activity and social groups
- Befriending service, volunteering
- Social welfare, legal advice, money management
- Adult learning, skills and development
- Employabilityand employment programmes
- Face-to-face coachingbased support
- Other (please tell us more)

6. Where do you get your referrals from (tick all that apply)

- Primary care (e.g. GPs)
- Secondary care (e.g. hospital / clinical specialist)
- Local Authority
- A specific link worker (work coach, health coach etc – please state)
- Another VCSE organisation
- Self-referrals (including friends and family)
- Other (please state)

7. Which of the following does the SP service provide?

- Exploring or assessing the patient's need/talking through personal circumstances or specific challenges
- Information giving
- Facilitating a referral
- Supporting with access to/participation in an activity
- Support to build social networks
- Other (please specify)

8. Who else is involved in the social prescribing service?

- GPs
- Other VCSE organisations
- Community health care professionals
- Other Public Sector (please state)
- Link workers
- Care navigators
- Community coordinators/facilitators
- Other frontline professionals (please state)

FOR PRESCRIBERS ONLY

9. There are currently a number of different models and terminologies related to Social Prescribing, do you identify with any of the particular models listed below? (tick box question)

- Care navigation
- Active signposting
- Link worker
- Health trainer
- Community navigator
- Connector
- Health Coach
- Health Champion
- Other (please provide)

10. What are the most common reasons for referral?

- Physical and mental health
- Wellbeing
- Lifestyle change
- Self-care, self-management (of a LTC)
- Social isolation
- Social welfare advice
- Financial advice
- Other (please tell us more)

FOR ALL

11. What are the most common reasons for referral to your service or activity? (please tick all that apply)

- Physical and mental health
- Wellbeing
- Lifestyle change
- Self-care, self-management (of a LTC)
- Social isolation
- Social welfare advice
- Financial advice
- Employment
- Training and learning
- Other (please specify)

12. Which of the following options do you feel best describes your organisations' social prescribing referral or point of interaction with patients?

- Primary care

- Secondary care

- Community services

- Self-referrals

- Other (please state)

13. What tier of delivery would you consider your service or activity covers?

- Universal Services and Activities

- Tier 1 – Community Based Health Programme

- Tier 2 – Specialist Health Support Services

- Tier 3 – Clinical Based Services

- Unsure / Don't know

14. Please describe how the service operates and anything you think makes your service unique. For example if it is based on a link worker type role how frequently do they meet, how are needs assessed (if at all), where do meetings happen and what the referral pathway is?

15. If you currently deliver social prescribing activity is it commissioned activity?

- Yes

- No

- Previously but not currently

16. If the service you deliver is not currently commissioned how is it funded? (please tick all that applies)

- Grant Funding

- From our core funding

- Client / Participant contribution

- Other (please state)

17. If your organisation receives a referral from another organisation. How does funding / support follow that individual?

- No funding follows the individual / comes from the other organisations

- Not applicable it forms part of our commissioned service

- No funding follows the individual but we receive in-kind support from an organisations

- Single Payment per Individual participating

- A payments by results model per individual

- Grant Funding to from the referral organisation

- Other (please state)

ADDITIONAL QUESTIONS FOR SALFORD RESPONDERS:

18. Where is the social prescribing service/activity based? (please tick all that apply)

- Ordsall (including Langworthy, Seedley and Weaste),

- Swinton,

- Broughton,

- Irlam (including Eccles and Cadishead),

- Walkden (including Little Hulton)

- Whole of Salford

19. Can you please give a little more detail of how the service provides for and supports mental health?

20. Can you please give a little more detail of how the service provides for and supports older people?

21. Can you please give a little more detail of how the service provides for and supports long term conditions?

22. What are the top three challenges of social prescribing in your view?

- Are there any particularly good examples of troubleshooting any challenges that you could share?

23. What are the top three benefits in your view?

Appendix D: Maps For Individual Boroughs

1. Art For You CIC
Projects are based within a community room of a health centre. In agreement with GPs, specific patient groups are referred to the projects e.g. Carers, women with fibro myalgia, women experiencing depression or anxiety.

2. Age UK Bolton
Working in partnership with Bolton CVS and four other local VCSE organisations with relevant expertise or specific area to deepen, broaden and embed knowledge of community based services, identify gaps in provision and develop solutions.

3. Bolton Community and Voluntary Services/Community Designed to connect the health and social care workforce to the diverse voluntary and community sector offer in Bolton. In addition to providing a simple access point to the voluntary and community sector, a key focus is around building capacity in the voluntary and community sector to better engage and improve population health through promoting prevention and self-care across the borough.

Groundwork (Bolton, Bury, Oldham, Rochdale)
Provision of outdoor activities.

Focused Care CIC (Bolton,Manchester,Oldham,Rochdale,Salford,Stockport,Tameside)
Based in universally accessible GP surgeries. We offer holistic care to vulnerable individuals and households based on an agreed care plan with the patient. We work with the patients through home visits and trust-based relationships to enable them to have healthy outcomes.

Bolton

1. Speakeasy (Whole of GM)
Pioneering support for people affected by aphasia, co-led by professionals and members, personalised goal driven activity which is purposeful, meaningful

2. Bury Multi-Agency Cancer Service
Hub and spoke model with a Single access point and a infrastructure of supportive services from public third and voluntary sectors. Built around a referral pathway from primary and secondary care.

3. Age UK Bury
Mostly informal non-contractual arrangement. between statutory partners and ourselves, exceptions are a) Bury Multi-agency Cancer Pathway service and b) Friends Together Service

4. Citizens Advice Bury
we have different services offering advice in primary care, taking referrals from the Living with and Beyond Cancer Service, referrals from psychiatric wards.

5. Bury's Exercise and Therpahy Scheme (BEATS)
Integrated wellness model ensures social prescribers have one channel of referral / signpost rather than various services

6. REBUILD (Bury)
Practical work placement or volunteering opportunities with our unique blend of on-going emotional support.

Royal British Legion (Bury, Salford, Wigan)
Referral is from Advice or Casework staff to community groups or activities

Gaddum (Bury, Manchester,Rochdale,Salford,Stockport)
Each person accessing our services is assessed holistically and has a package of support to meet their needs.

Bury Lifestyle Team
The Link Worker works with all groups - delivers training and constantly encourages new pathways and links to and from services

Bury

Manchester

1. Communities for All Ltd (All of GM)
We offer community events, activities and advice to the community and also offer training and skills to the community at the centre.

2. PARS service GMMH
Exercise on prescription and a one to one service

3. Wai Yin Society
We offer community events, activities and advice to the community and also offer training and skills to the community at the centre.

4. GreaterSport

5. Age UK Manchester
Three day centres (Gorton, Openshaw, Wythenshawe). Each is a local hub for older aults from which people can access the whole range of our services: Advice and counselling , Day care , Home Care , Residential care and access to a wide range of clubs , groups and activities offered through our Ageing Well Programme

6. Royal British Legion (Bury, Salford, Wigan)
Referral is from Advice or Casework staff to community groups or activities

7. LGBT Foundation (Whole of GM)
Pride in Practice (PiP) is a social prescribing model for primary care services and lesbian, gay, bisexual and trans (LGBT) communities that strengthens and develops between GP practices, dental practices, optical practices and pharmacies and their LGBT patients in GM

8. Citizens Advice Manchester
Our advice in prescription service is accessible in over 30 Manchester GP practices. People access the service by free phone telephones in GP practices or via electronic referral via EMIS.

9. Gaddum (Bury, Manchester,Rochdale,Salford,Stockport)
Each person accessing our services is assessed holistically and has a package of support to meet their needs.

10. Big Life Group (Manchesterm Rochdale, Salford)
2 SP models. 1.) Provision of a coach, assessment, and between 6 and 12 meetings. 2) More casual via active signposting through our centres and working with users to develop services which meet their own needs where they don't exist

11. TLC-St Lukes & St Lukes Art Project

12. Debdale Eco Centre
Most needs assessed by a referee who knows our service. The will be a taster attendance session with us with a care/support worker if relevant to gauge suitability of activities

13. Yaran Northwest CIC
We receive referrals for middle Eastern Farsi speaking residents across greater Manchester. Our services is offered by qualified bilingual accredited therapists who are IAPT trainer. We run a range of one to one and group therapy sessions.

14. Ethnic health forum
Takes referrals from GP Practices.

15. Southway Housing Trust
To develop a Social Prescribing Scheme (SPS) and electronic referral system for older people in Old Moat/Withington and surrounding areas

16. Tree of Life Centre
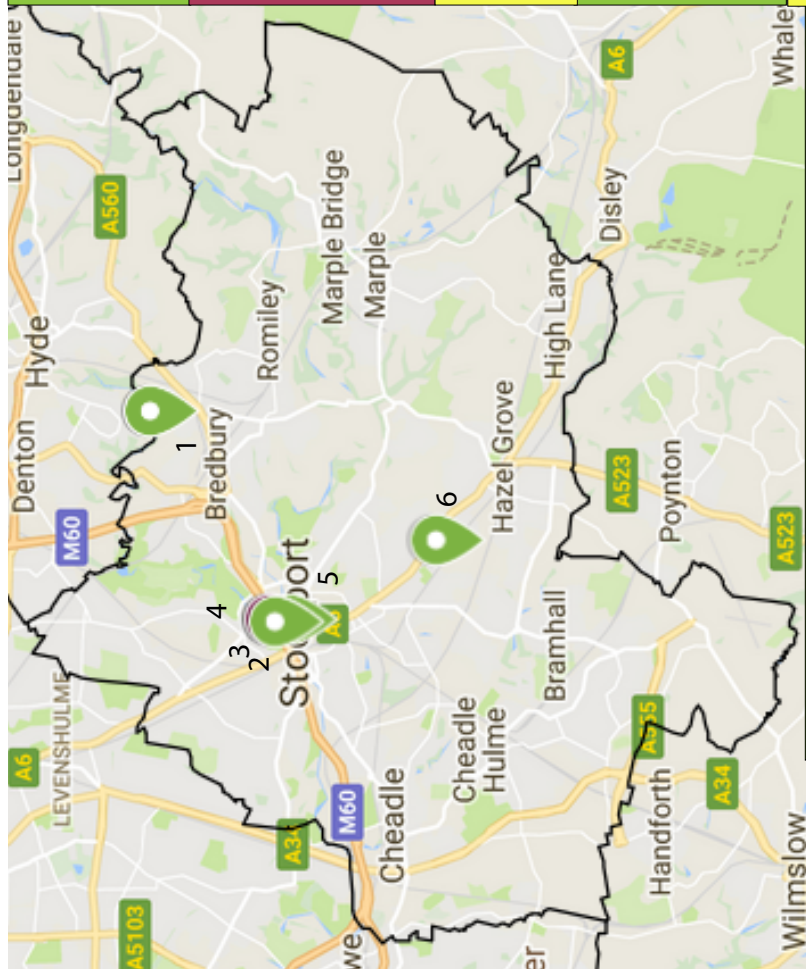Service lead by Health & Wellbeing Coordinator who takes self-referrals or referral from health care professionals, they offer a programme of activites.

1. Groundwork (Bolton, Bury, Oldham, Rochdale)
Provision of outdoor activities.

2. Age UK Oldham
Promoting Independent People Service receives referrals from health care professionals for holistic support through handholding (generally 6-8 weeks) for socially isolated people to re engage back into the community. We also refer to other health/community services.

3. Action Together
We have a community connector role, working from a GP's surgery. We are also asset mapping the local community using a membership offer.

4. First Choice Homes Oldham
Healthy Homes works with people in private sector housing to assess non-clinical needs, hospital2home and A&E2home services, housing options and independent living services work with elderly and disabled tenants, homeless services

5. Focused Care CIC (Bolton,Manchester,Oldham,Rochdale,Salford,Stockport,Tameside)
Focused Care is based in universally accessible GP surgeries across GM. We offer holistic care to vulnerable individuals and households based on an agreed care plan with the patient. We work with the patients through home visits and trust-based relationships to enable them to have healthy outcomes.

Southway Housing Trust
To develop a Social Prescribing Scheme (SPS) and electronic referral system for older people in Old Moat/Withington and surrounding areas

Oldham

1. Link4Life
We run a variety of programmes but one contract is for our staff to work as an Integrated Neighborhood Team with NHS District Nurses, Physios, Care Navigatoes & other VSCO

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Gaddum (Bury, Manchester,Rochdale,Salford,Stockport)
Each person accessing our services is assessed holistically and has a package of support to meet their needs.

Big Life Group (Manchesterm Rochdale, Salford)
2 SP models. 1.) Provision of a coach, assessment, and between 6 and 12 meetings. 2) More casual via active signposting through our centres and working with users to develop services which meet their own needs where they don't exist

Rochdale

1. Silverdale Medical Practice
A link worker works with patients initially then sign-posts them to community facilities. The Health Improvement worker, works from the practice but can go out into the community with patients.

2. Salford Community Leisure
The service receives referrals from a number of sources and patients are routed into the most relevant programme based on their long term health condition.

3. Salford Health Improvement Service
We provide initial sessions of one to one behavioural change, motivational support and confidence building to encourage individuals to access community group support provided through our own service or through another.

4. Salford Health Works
Referral by GP, and initial assessment carried out. Appointments on average every 2 weeks over 20 sessions. Meetings are held within GP surgeries and community centres/Gateways.

5. Unlimited Potential
There is an initial intensive programme, followed by introduction or referral to mainstream activities/services for the person to continue independently.

6. Start in Salford - Inspiring Minds
Referrals are received from a wide range of organisations, given a mentor from the staff team and then engage with the activitiy programme. They are also signposted to other services.

7. Stroke Association
We work with stroke survivors, carers and families, take referrals from clinical settings, self referrals and families. An initial home visit in most cases followed by phone support or home visits.

8. Salford Primary Care Together
Generally the service starts following a consultation with a medical practitioner. The Care Navigation programme supports referrals as identified and when appropriate.

9. Salford Citizens Advice
Any health care staff can refer clients to the service. There are particular arrangements around end of life care patients, maternity services, and children with disabilities.

10. Lark Hill Parent Forum
volunteers and families meet weekly. Outside agencies have an open invitation to join weekly meetings

11. Social adVentures
A one to one service based from our centres, with two projects doing outreach in the community with an aim to remove as many barriers as possible

12. Salford Primary Care Together - Homeless GP Practice
Currently scoping Care Navigation across practices

13. Langworthy Cornerstone
We provide a wide range of services and activities and our staff encourage participation and also have a good knowledge of services elsewhere. We also have a triage system to make referrals easy for GPs etc

14. Salford Carers Centre
We provide a specialist service to unpaid carers. All workers have a specialist skill set to support this group with knowledge on how to address their needs.

15. Salford Mens Club
We are a mental health, referral-only mens group

SALFORD

Big Life Group (Manchesterm Rochdale, Salford)
2 SP models. 1.) Provision of a coach, assessment, and between 6 and 12 meetings. 2) More casual via active signposting through our centres and working with users to develop services which meet their own needs where they don't exist

Gaddum (Bury, Manchester, Rochdale, Salford, Stockport)
Each person accessing our services is assessed holistically and has a package of support to meet their needs.

Royal British Legion (Bury, Salford, Wigan)
Referral is from Advice or Casework staff to community groups or activities

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LGBT Foundation (Whole of GM)
Pride in Practice (PiP) is a social prescribing model for primary care services and lesbian, gay, bisexual and trans (LGBT) communities that strengthens and develops between GP practices, dental practices, optical practices and pharmacies and their LGBT patients in GM

Wai Yin Society
We offer community events, activities and advice to the community and also offer training and skills to the community at the centre.

Communities for All Ltd (All of GM)
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Yaran Northwest CIC
We receive referrals for middle Eastern Farsi speaking residents across greater Manchester. Our services is offered by qualified bilingual accredited therapists who are IAPT trainer. We run a range of one to one and group therapy sessions.

Ethnic health forum
We rely on a GP Practice to refer clients.
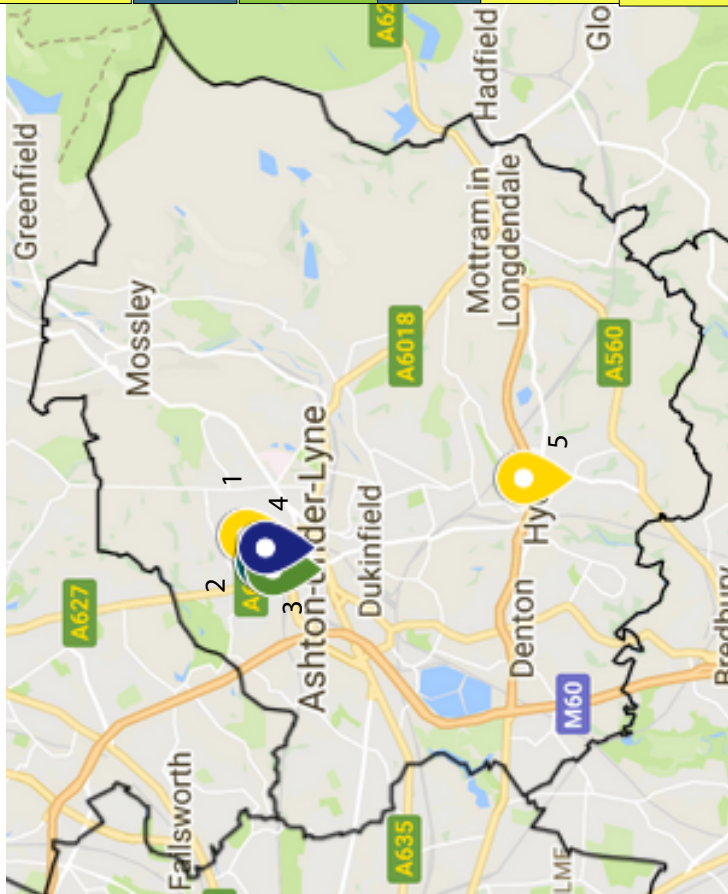
Salford

Stockport

3. Wellbeing Independance Network
A network of 3rd sector partners who operate as one system to provide support to people who are at risk of social isolation. We work with individuals with any kind of disability as well as carers and older people.

4. Viaduct Care CIC
Launching this summer, a new service that combines the connector/navigator role with health coaching support for people with long-term conditions. 16 fte Wellbeing and Self-care navigators will attached to the eight Neighbourhoods, delivering one to one and some group support working from GP practices.

5. Public Health Healthy Communities Team, Stockport Council
Informal conversations with individuals and groups in General practice, libraries, support groups etc

6. Pure Innovations / Wellbeing Independance Network
A bespoke solution for individuals suffering from the debilitating effects of social isolation, looking at volunteering, employment, social and civic activity, physical and training. There is a specific team for carer support and also Peer Support with access to over 40 groups.

Focused Care CIC (Bolton,Manchester,Oldham,Rochdale,Salford,Stockport,Tameside)
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Gaddum (Bury, Manchester,Rochdale,Salford,Stockport)
Each person accessing our services is assessed holistically and has a package of support to meet their needs.

1. Alvanley Family Practice
We refer using a Wellbeing Prescription, the first in the country, and coproduced with our Practice Health Champions

2. Stockport and District Mind
We take referrals for people coming out of secondary care, assigning them a link worker, who carries out a person-centred, informal assessment to empower and support. We also offer social groups, drop-ins, workshops (e.g. emotional resilience, confidence building). We work closely with Pennine Care NHS Trust (other VCSE / community groups and take self referrals.

1. Action Together
We take referrals from health and social care professionals for anyone living with a LTC. We work with individuals for up to 16 weeks, meeting people in the community or in their homes.

2. Tameside Cultural Service
Adult services refer people to our sessions.

3. Tameside Adult Services
This is a new service and we are building the community links and cohesion

4. Citizens Advice Tameside
Adult services refer people to our sessions.

5. Hyde Neighbourhood (Thornley House Surgery)
Have just started a referral pathway through GPs, initially through fax and email.

Focused Care CIC (Bolton,Manchester,Oldham,Rochdale,Salford,Stockport,Tameside)
Focused Care is based in universally accessible GP surgeries across GM. We offer holistic care to vulnerable individuals and households based on an agreed care plan with the patient. We work with the patients through home visits and trust-based relationships to enable them to have healthy outcomes.

Tameside
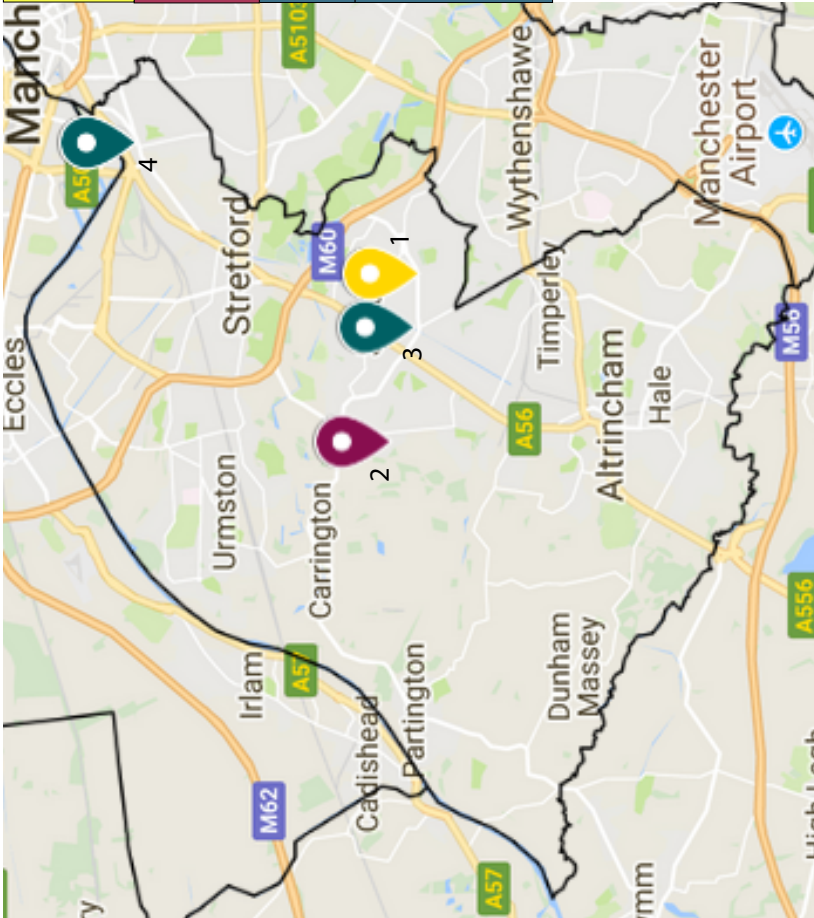
1. Trafford CCG - Derbyshire Rd South practice
Currently in the process of developing the link worker role

2. Firsway Health Centre
Health and community Centre

3. Trafford Leisure Community Interest Company

4. BHA for Equality (Whole of Manchester)
Community outreach workers and a link worker based in Primary care, culturally designed for a particular population group. Black people living with HIV, Asians diagnosed with latent TB and Roma families.

Trafford
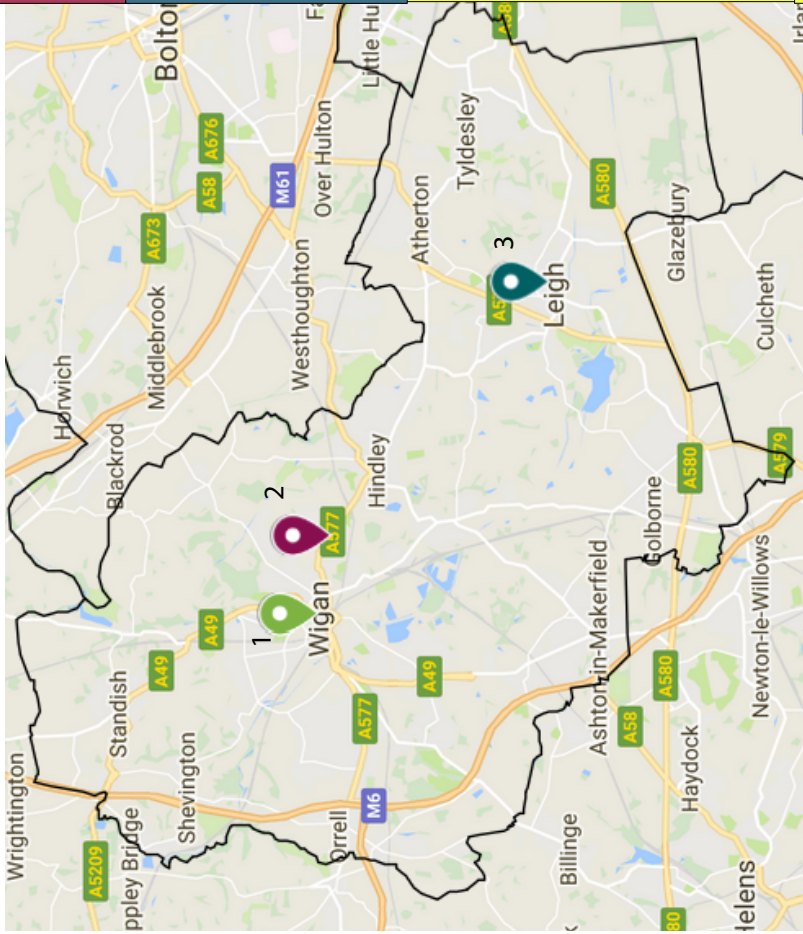
Wigan

2. Driven
A volunteer car scheme to help lonely and isolated people get out and about.

3. Citizens Advice Wigan
Direct delivery of advice & information within GP practices. People can drop in to the service or be referred by a community link worker, GP, nurse or receptionist or via our own internal referral system. Patients are directed to the service. If we aren't in that day they can leave their details with the practice receptionist for a ring back from our advisers.

Community Link Workers
Wigan Borough is developing an asset based approach across all health partners to empower frontline staff to undertake person-centred conversations that address the holistic needs of individuals. Staff are support to connect individuals to assets, services and support within the community through a number of resources- Healthy Routes, Community Link Workers and the Community Book (online resource)

Royal British Legion (Bury, Salford, Wigan)
Referral is from Advice or Casework staff to community groups or activities

1. Eds Veterans Centre
Our organisation operates a centre for ex armed forces personnel to access support, services and activities.