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**School of
Health and
Social Care**

THE ASSET- BASED HEALTH INQUIRY

HOW BEST TO DEVELOP SOCIAL PRESCRIBING?



It's to support people with a range of emotional, physical and mental health needs to better access support, largely in the community, to improve their lives."

**Definition of social prescribing, Mick Ward,
Leeds City Council**

Report authored by Prof Becky Malby, David Boyle, Janet Wildman, Sandi Smith, Samira Ben Omar, Health Systems Innovation Lab, London South Bank University, September 2019

Acknowledgements

Collaboration is at the heart of this inquiry. As an Inquiry team we have been privileged to meet, talk, walk and sing with people who truly care about their local communities, and about the power of collaboration between professionals, institutions, people and communities.

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We wanted to be sure that in doing this work we held true to the relational approach we are committed too and were investigating in the Inquiry. We therefore really appreciate Sir Norman Lamb, who is hosting the launch of the Inquiry, taking the time to visit sites with us to fully understand what it takes for social prescribing to be the best it can be.

David Boyle, Prof Becky Malby, Janet Wildman, Sandi Smith, Samira Ben Omar

Foreword

We urgently need to start recognising the real and important social determinants of health, and then address them. Social prescribing aims to do precisely that. Approaches to healthcare other than the prescribing of medicines can be incredibly effective. At its best, social prescribing can give people a purpose in life, a reason for living. It can make people genuinely happy.

Social prescribing is therefore incredibly important because of the transformative difference it can make to people's lives, often in situations where a clinical approach does not or cannot help. It enables us to reach out to people and help them in a different way.

I saw this for myself as part of the visits we made during the inquiry, sites you can read about in this report. We went to see Alvanley Family Practice, an incredibly impressive GP practice in Stockport. I met with patients, and 'health champions'. They are doing primary care in a radically different way – engaging with the community, encouraging volunteers to step forward – often patients themselves. It provides a model for how primary care should operate. Too frequently, people are treated as passive recipients of healthcare – but not here. I applaud the leadership of all the parties involved in that practice.

I also visited Creative Minds, a charity run by the South West Yorkshire Partnership NHS Mental Health Trust and based in Wakefield. They are working in an enlightened way, engaging with and giving a role to people who are suffering from mental ill health. Our mental health system too often denies people agency and dignity. Yet in Wakefield, there was real empowerment. People were being treated with dignity and respect – treated as people who have skills and potential.

Everything I saw was admirable. There were art classes, set up by someone who had been a patient and who had had no optimism about the future but who is now flourishing – and all over the walls were displays of art from people who had benefitted from the Trust's support. They had set up a museum of mental health care, which was valuable for reminiscence for people suffering from dementia – but also for school children and many others. Their approach humanises mental health care. Seeing them in practice was incredibly impressive.

At the heart of these examples is the best of what social prescribing can do. Not only can it empower, it can also transform – both the health and wellbeing of individuals and also whole communities. It enables us to reach out and treat people beyond the confines of clinical medicine. I saw incredible examples of professionals collaborating with local citizens, bringing together a wealth of resources.

Social prescribing offers a huge opportunity for the way we do primary care. If you trust in people, and their ability to navigate the world for themselves, the rewards are immense. What an empowering and liberating vision!



Sir Norman Lamb, MP

Sir Norman Lamb has been the Liberal Democrat MP for North Norfolk since 2001. After serving as a minister in the Department for Business, Innovation and Skills, he was appointed Minister of State for Care and Support at the Department of Health in September 2012 and served in this position until the end of the Coalition Government in May 2015.

Contents

5 Introduction

7 Section 1: The Inquiry Findings

8 Background

10 Solving the problems in general practice

13 Key issue #A. Purpose: Shifting the burden or meeting complex needs?

15 Key issue #B. Measurement: Rescuing A&E versus resourcing people?

18 Key issue #C. Status: Professionals versus volunteers?

21 Key issue #D. Method: Formula versus face-to-face.

23 Key issue #E. Language: Social prescribers or community connectors?

24 Key issue #F. Scale: Big versus small

27 Key issue #G. Costs: Subsidy or homeopathic finance?

28 Key issue #Significance: Is this a new model of care?

29 Social prescribing: What it takes

32 Conclusions: How it should be done

34 Social Prescribing: What it is and what it isn't:

35 Recommendations

37 Additional resources and references

38 Appendix 1: The Visits

51 Section 2: Literature Review

52 Introduction

53 Structure of the Literature Review

54 Social Prescribing Context – What do we know about social prescribing?

62 Social prescribing and theories of change approaches

71 Tensions and dilemmas to adopting an asset based approach through social prescribing.

77 Leading Change – who are the change agents?

80 References

Introduction

Phrases like 'social prescribing' and 'coproduction' speak to missing elements from mainstream healthcare – the need for broader than pharmacological solutions (social prescribing) and for sharing the responsibilities for maintaining and recovering health (coproduction). Neither of these approaches have yet been able to make the required impact on mainstream health services.

The social prescribing initiative set out under the NHS long-term plan that is now being put into practice by NHS England (2019), is in some respects a vindication of our approach, developed by the Health Systems Innovation Lab at LSBU, where we have studied and promoted more humane approaches to healthcare, working closely with many of the pioneers of social prescribing in the UK.

But on closer examination, we were not quite so sure the match was complete. Some of the key people who have developed the most important social innovations in primary care were nervous about it. It was not clear whether they were nervous about the language of 'social prescribing' or about the organisation of social prescribing, as set out in NHS policy. We organised this brief Inquiry in order to find out, and in particular, to answer the following questions:

1. What does the research literature say about social prescribing, particularly about the most innovative and exciting versions now working well in the UK?
2. What opportunities and challenges are faced by people in primary care trying to work effectively with locals to deliver social prescribing?
3. Do collaborative or relational methods help?
4. Where does it work and what helps it work? And what lessons have been learnt on the way?
5. What conclusions can we draw about tensions, dilemmas, values behind it, and what works?
6. Will this lead to major effective change in the NHS and beyond? And if not, what should we do instead?

Those were our formal objectives. We also wanted to see what the golden thread was in examples where 'social prescribing' is sticking, by exploring issues of power, relationships, informal networks, collaborative change and the role of policy. We assert our right to recognise these without defining them, on the grounds that we know them when we see them – aware of the assumptions about what this means in practice.

Method

This is not a large inquiry. It is a close investigation of a small number of successful examples of social prescribing and coproduction in the NHS, through visits and witness interviews. We also attended the 2nd International Social Prescribing Network Conference.

The Inquiry process was framed by a literature review, which is provided in Section 2.

An invited inquiry group undertook a learning journey to four sites, which are exemplars of coproduction or social prescribing approaches to uncover the key conditions for doing real asset-based collaboration. This was augmented by a number of 'key witness' interviews with leaders of the social prescribing approach, which were transcribed and themed.

The Inquiry group made sense of the data collected from the literature review, the learning journeys and interviews.

Inquiry team

The Inquiry is lead by Prof Becky Malby with Research Director David Boyle, a former independent reviewer on public service choice for the Treasury and Cabinet Office (the Boyle Review, 2012/13). Our Research Associate is Janet Wildman.

The Inquiry team also includes Samira Ben Omar, Head of Systems Change at the North West London Integrated Care System and Sandi Smith, a citizen leader from the Health Systems Innovation Lab.

Who we are

The Health System Innovation Lab is a leading network for health professionals looking to improve and re-shape health and social care through systems innovation. Bringing together clinical and managerial, professional and citizen, the Lab provides a safe place to think openly and explore and implement change: changes in ways of working together, models of care, the redesign or combining of different services or processes – all underpinned by powerful data intelligence.

The Lab brings together people from a wide range of professions, with various skill sets and various experience of using and working in healthcare services. Its uniqueness is its use of data to clarify need and impact, and its focus on bringing the next generation of leaders into the learning process alongside current systems leaders. Using the collective wisdom of these people to view current health and social care provision, the Lab looks at it through different lenses – from the business through to the user, from the process involved to the impact in localities and with populations.

SECTION 1:

THE INQUIRY FINDINGS

Background

Let us be clear about the problem social prescribing is designed to solve: as we will argue, this is confused by the besetting sin of primary care – not understanding need. The prevailing demand-driven model creates a relationship whereby primary care is more likely to hang onto patients, increasing their dependency, without actually meeting their needs. You only have to look at the actual people who turn up frequently in general practice to see that they are often merely going round in circles (see following section).

But beyond that, there is some confusion, as might be expected in so complex a field, about the specific objectives of social prescribing. Is the main purpose, for example, to reduce the burden on GPs? To shift demand to other sectors? Or is it primarily about supporting people better and meeting needs? It certainly is all these things, but in what order of priority?

Questions are further confused by the different strands of tradition, which have gone into the idea – from end-of-life care to asset-based community development in the USA, from the coproduction movement to community development.

Then there are questions around the language. Does the term ‘social prescribing’ imply too close a relationship with the medical model, which the idea is arguably attempting to escape from? Or does that provide a useful metaphor, which can make it immediately apparent, what the whole thing is about?

For many years now, it has been clear that there are powerful and important social constraints to health. People with no friends are at least as likely to be in poor health as they would be if they were heavy smokers (Holt-Lunstad, Smith and Layton, 2010). Most studies also agree that around up to 50 per cent of GP consultations involve no clinical issues, and perhaps more (see Section 2 Literature Review). Whilst general practice has always included healing, caring, biographical and the spiritual aspects of care alongside the biomedical (Pratt, 1995), the balance of appointments (arguably the balance of need) has tipped into issues that need more than the caring concern of the GP. People struggling with life alongside their health are less able to cope with ill health, or they find themselves ‘medicalising’ this struggle in order to get help. It is clear then that

general practice may need to develop other options to support people whose problems lie outside their skills set.

When social prescribing is done well, it can have knock-on effects – multiplier effects, using economic terminology – on their family and their friends. In the Netherlands, a third of patients who were ‘socially prescribed’ become volunteers, and we are seeing a similar pattern in the UK where social prescribing is working. (Dr. Miriam Heijnders, Coordinator, SP Network The Netherlands). There are no pharmacological solutions, which could achieve this. This is its real benefit, generating opportunities for people not only to address their fundamental wellbeing needs but, in doing so, to provide a space for those same people to ‘uplift others’. This is what we mean by an asset-based approach, not a deficit-based approach.

The briefing by NHS England is surprisingly open-minded about the breadth of this agenda:

“This represents a new relationship between people, professionals and the health and care system. It provides a positive shift in power and decision-making that enables people to feel informed, have a voice, be heard and be connected to each other and their communities...”

NHS England, 2019, p4

For reasons that are beyond the scope of this report, the administration of the NHS, and sometimes parts of the medical profession itself, have been too focused on fixing people, rather than working with them or alongside them. They have therefore found it hard to see social prescribing as a solution – as if it undermined their professional skills or wasted resources, or just isn’t their business. The new constraints on the NHS, mainly financial, have perhaps meant that the case for change has now become unanswerable.

“People need scaffolding around them...”

**Chris Dayson, Sheffield Hallam University,
2nd International Social Prescribing
Network Conference 2019**

Perhaps it was inevitable, therefore, that long-standing tensions would come to the fore and be played out in the social prescribing movement – between those that favour structure and those that favour local innovation, between professionals and the administration, between primary and secondary care, and between people as assets versus people as deficits on an overstretched system.

Having talked to many of the pioneers of social prescribing, and visited some of the most successful pioneering projects – as well as talked to some of the new recruits as ‘link workers’, the NHS term for social prescribing professionals – we have reached some conclusions about some of the issues and dilemmas. And if we can’t be sure of some of the answers, we are now increasingly clear about the right questions to ask. They include:

1. Is social prescribing about shifting the burden, or is it about meeting complex needs? (*purpose*)
2. Should it be about people living well, or about reducing the burden on A&E, or on GP practices? (*measurement*)
3. Should it be carried out by professionals or volunteers? (*status*)
4. Should it be based on a national formula or on an emerging face-to-face relationship? (*method*)
5. Should it describe the new role as social prescribers or community connectors? (*language*)
6. What scale should it be based upon? (*size*)
7. How should we pay for it? (*costs*)
8. Does this amount to a new model of care? (*significance*)

Solving the problems in general practice

With thanks to Tony Hufflett,
Data Syrup and the London
Primary Care Quality Academy

The narrative of social prescribing suggests that it is the answer to people who come to general practice with non-medical needs. It is not completely clear how many people this represents. An estimated 20 per cent consulted their GP for what is primarily a social problem according to research published in 2016 (Torjesen, 2016). But more recently, NHS England report that this has shifted to half. The work of the London Primary Care Quality Academy also estimates that half those who attend frequently are either struggling with life or in a chaotic situation (Malby 2018) At the same time, the Low Commission reported that 15 per cent of GP visits were for social welfare advice. (Literature Review, p.54)

Whatever the exact figures, GP services are facing social and economic pressures that they are ill equipped to manage on their own and this has resulted in what is being described as a state of crisis. (Literature Review, p.54)

But there is another element to this overload. Most of these are people characterised as 'frequent attenders' – people who book appointments frequently at the GP surgery. Some of these are people who are 'frequently attending' across the whole range of health and care services, but not all. Research by Morriss et al found the top 3 per cent of attenders are associated with 15 per cent of all appointments, alongside increased hospital visits and mental health indicators (Morriss et al, 2012). The London Primary Care Quality Academy has shown that frequent attenders are accessing up to 40 per cent of appointments across participating practices.

The assumption is that social prescribing can free up clinical appointments in general practice, which can be used to create some space in the clinician's day, or meet other needs. Yet we also notice that there are large numbers of people on general practice lists who are hardly seen at all, primarily young people

who are, we think, being underserved with little understanding of their health needs. They represent a ticking bomb.

Detailed data analysis of attendance patterns in over a dozen London practices has led to a deeper understanding of attendance skews in general practice. By 'attendance skew', we mean the tendency of a small number of patients to absorb a large proportion of GP appointments.

The skew is very strong in most practices, commonly responding to demand in a passive and reactive way. In a given year, a mere 5 per cent of patients will take up 30-40 per cent of GP appointments. The remaining patients (95%) divide neatly into half who consume the other appointments more sparingly, and half who don't visit at all.

So here is the problem. The practice is not meeting these people's needs, but they are also spending a great deal of money in the process with repeated appointments. In a practice with 10,000 patients, the 40 per cent of appointments used by frequent attenders might then typically be 12,000 appointments or close to £500,000 of practice resource each year (at £40 a GP appointment),

We might conclude that this appointment skew is a natural and inevitable feature of primary healthcare. Yet the nature of people who attend frequently varies widely and is driven by the system practices are using. Poor continuity – consistency in seeing the same GP – also runs parallel with a high attendance.

At some practices, the people who attend frequently are an older group of patients with multiple co-morbidities. More often, though there is a complete mix by age, by type of long-term conditions, or often no long-term diagnoses at all. There will be a mix of social conditions and needs; mental health challenges, health anxiety and diverse chronic challenges.

The London PCQA has categorised these into groups that need different responses:

- People with multiple needs.
- People with increasingly complex physical needs.
- People with increasingly complex mental and physical needs.
- People with extremely complex life situations which means they can't cope with their physical or mental condition.

The fourth group is most likely to benefit from a social prescribing response. But given these other issues, social prescribing on its own is not going to meet the needs of people who turn up frequently. It has to be combined with a needs-based appointments system that targets groups of people, for example providing more continuity for complex but stable patients, more integrated multidisciplinary approaches to people with co-morbidities or physical and mental health needs. Overall, practices need a more equitable approach to their resources, not organised rigidly into ten-minute appointments given to those who demand them.

Our analyses suggest that practices create this appointment skew via downward spirals of:

- **Lower continuity** – creating high and repeat attendance through repeated appointments with multiple GPs, re-tests, looping and other repeat work because it is simply impossible for a new clinician to come up to speed in a single appointment.
- **'Bigger is better' misjudgments** – patients slip through reception and online systems more easily at larger practices and are not steered towards continuity.
- **Poor access favours the knowledgeable** – the harder it is to get an appointment, the more frequent attenders tend to dominate. They know the system and how to get through.

It is possible, but currently rare, to achieve a fairer and better distribution of appointments, allowing the practice to think more proactively about its whole population rather than having their energy absorbed reacting to the small section of highest demanding regular patients.

Throw into this our early findings that the types of people who attend frequently do not seem to be determined just by the nature of population health, but also co-created by the general practice. Practices with similar populations in the PCQA are not seeing the same people frequently. GPs themselves attract, purposefully or unconsciously, particular types of appointment demand. The solution lies both within general practice and by developing a new collaboration with communities.

Social prescribing has a chance of making a difference as part of the practice's development of the way it meets the needs of its whole population, moving from a demand-led to a needs-based

system. Social prescribing needs to target the people who turn up frequently with 'social need', but it can't meet the challenge of frequent attendance alone. As we have seen, the attendance patterns are a result of how general practice chooses to organise. We think the current model is leaving some population groups without the service they need and have the right to access.

Social prescribing could lead to general practice – looking out for, and offering services to, those who hardly attend at all, reaching out to prevent ill-health or meeting undiscovered health needs. For General Practice the solution to the experience of increasing demand and pressure can only be solved by General Practice itself changing the way it organises (starting with need not demand, differentiating the appointment system to meet needs, managing flow, reducing the work it makes for itself, being effective at collaboration and internal decision-making). Social Prescribing is only a part of this sea change.

“Social prescribing by itself is not link working, so there are different models that have not been acknowledged where the GP prescribes to somebody. You're not building any capability or resilience, you're not managing that caseload – you're prescribing...”

Christiana Melam, National Association of Link Workers, interview

At the same time taking general practice as the starting point should not be the only way. Many people (people who bypass general practice straight into mental health services; some homeless people) don't even touch general practice and they need an asset-based model too. 'Social prescribing' might feel like a primary care approach but collaborating with communities is something the whole system has to engage in. The approach taken by the NHS must also be careful not to undermine the existing social fabric and support approaches communities have developed themselves.

Key issue #A.

Purpose: Shifting the burden or meeting complex needs?

What do we think social prescribing is for? This question seems to go to the heart of the key issue. Is it primarily about shifting the unsustainable burden of demand on an exhausted NHS system, or is it – even before that – about meeting the increasingly complex needs of people who are not being served well by an overly pharmacological approach, based on a service delivery model that isn't fit for purpose?¹

Behind that is a systems question about whether it is possible to reduce demand directly, or whether – as the system thinker John Seddon suggests – that is best done by understanding that real demand better (needs) and meeting it more effectively (Seddon, 2008).

Employing a link worker in itself does not constitute social prescribing. The question is how they are to be used. And general practices where the idea is already working well, like the Alvanley Family Practice in Stockport (see Appendix), have worked it out together with their patients and community. The answers appear to start with a conversation.

“40 years using the service and no one asked me what I wanted to do.”

Debbie Teale, Creative Minds

The guidance set out by NHS England is, on the face of it, pretty flexible, and – in an NHS unused to flexibility – this can be confusing, especially if managers have to work out locally how to put social prescribing into practice. To work out how best to do it, there needs to be some kind of local discussion between stakeholders – and our impression is that these have not been taking place as much as they need to – about what the fundamental purpose of the link workers and the social prescribing approach should be.

“This is how health services are commissioned, with the very ruthless focus on one topic. When the people who you're there to serve have more than one thing going on in their lives...”

Charlotte Augst, National Voices, Interview

There is a secondary issue here, which is that, despite the clear and welcome flexibility at the heart of the guidance from NHS England, the whole spirit of the idea can certainly be undermined locally by health leaders if they fail to understand or trust it. They need some humility: even if the chiefs who run a local health service do not grasp the significance of community connections, there will be people in key jobs at every level who do.

1. See previous section, and also <https://beckymalby.wordpress.com/2018/06/05/frequent-attenders-breaking-the-cycle-in-primary-care/>

“I had always been aware of the gap between local health professionals and local authorities and the local population – which has been indifference and sometimes almost contempt. Nobody wanted to connect too closely...”

Fatima Elguenuni, Grenfell Tower Health and Wellbeing Service, Visit.

As always, there is a continuum around the objectives, between cutting the burden on the NHS and diverting patients away from formal medical services if they obviously need something else – and the more sophisticated outcome of building a supportive community around a local NHS service outpost. We tend towards the latter view, as this report will make clear. And the link worker initiative clearly provides an opportunity to link these objectives to the energy that is emerging in the social prescribing world.

Yet there is a danger that we might still snatch defeat from the jaws of victory, if the old preconceptions bite back. We have already seen too many examples of it attempting to do so, with varying degrees of success and in different parts of the UK. These range from wilful and greedy attempts to shift resources instead into pet projects, through to a failure to understand the relational social process. This can be by:

- Setting up link worker call centres.
- Re-creating dependency by referring people into other services that don't take an asset- or needs-based approach.
- Creating demand on services that don't have enough capacity.
- Resourcing posts not relationships.
- Failing to understand the right criteria for referrals, potentially overwhelming the new link workers with the wrong people.

This may indeed be the borderland between two ways of understanding healthcare, two philosophies of public service. The right question is then, perhaps, not how to prevent the old world from biting back, but how best to amplify the new world instead. The rest of this report makes suggestions about how we might do so.

“What we learnt was that it wasn't about databases. Because all the information was kind of there. It was about networks, and networks in our experience are never invested in, in the way they need to be...”

Tim Anfilogoff, Head of Community Resilience for Hertfordshire Valleys CCG and Social Prescribing Facilitator for NHSE for East of England. Interview

Key issue #B.

Measurement: Rescuing A&E versus resourcing people?

How should we measure the success of social prescribing? The answer to that question will depend on our answer to the issue of purpose. If the purpose is to rescue the NHS, it may be that the role of social prescribing is not clear enough. Either way, we are sceptical about the idea that link workers should be assessed according to the extent in which they reduce pressure on accident and emergency departments.

This is for a number of reasons:

1. There is no reason to believe, given the pressure on A&E, that – if it is relieved – will not simply suck in more people.
2. The main target of social prescribing is not the people who most frequent A&E. Some people who attend frequently turn up in every service, and they are more likely to need an integrated care response. But there are lots of people who primarily turn up frequently in primary care. We recommend any GP practice should look at their data about which patients attend most frequently and why – it can be a shocking discovery – and organise their social prescribing in such a way that it is capable of meeting the needs of their frequent attenders more effectively.²

The reasons why A&E tends to be overstretched appear to be different, according to recent research, which demonstrates that much of the problem lies within the hospital – lack of flow, A&E designed to deliver trauma services not to deal with complex co-morbidity (both of which are evident in skill sets and A&E layout) (Wyatt, 2019).

The main output measure published by NHS England is the connections made by link workers, which is set at 900,000 by 2024, the next five years (NHS England, 2019). That works out only about one a day, if the total number of link workers remains at 1,000, and does not creep up to 4,500 over the same period as planned – which would mean only about one connection a week. This should certainly be possible; but whether it will have the kind of impact needed is more questionable.

The most successful projects we have seen, where there is an absolute established belief in and commitment to an asset based approach, in fact multiply their impact by using their funding to employ facilitators and leaders who use their entrepreneurial skills to build a wider volunteer network that can increase their reach. See examples of this at Alvanley Family Practice and Creative Minds in Wakefield in the appendices.

The NHS might reasonably say that this kind of organisation takes it outside its traditional skill sets – though that is, of course, the main point. We know, for example, that singing and gardening are better than drugs in many conditions. But they are difficult to count, and the impact may make a difference over longer timescales. This implies a different set of success measures.

“There is good evidence that singing and gardening have more beneficial effects than much pain relief being prescribed, and much antidepressant medicine being prescribed. But beyond that, we can't evaluate these interventions, these community approaches, the way that we evaluate prescribing.”

Charlotte Augst, National Voices, Interview

2. See Section 3 and also <https://beckymalby.wordpress.com/2018/06/05/frequent-attenders-breaking-the-cycle-in-primary-care/>

Either way, it is not right that hospital admissions should be the main measure of success in an idea that is not primarily geared to that objective. If the social determinants of health revolve around how many friends you have, it may make sense to find a better measure around that: not Facebook friends, but real ones. For instance a 27 per cent increase in success in alcohol cessation is associated with adding a non-drinking member to the person's social network (Litt et al., 2007).

People who make good friends have better lives, as Mick Ward from Leeds City Council told us: "I think if you said to many people, that a role of the council is for people to have good friends, they'd look at you daft. But if you think about the role of a modern council, that is one of the things it's about." In Leeds, they follow this logic through by counting friendships as a performance metric in their work on Asset Based Community Development.

Equally though, it would make no sense if social prescribing used entirely different rules to the rest of the system. It isn't fair that community connection should have to prove itself in ways that GPs do not for much of the rest of what they do.

In Torbay, for example, the voluntary sector has been using asset-based community development (ABCD) for the last four years to combat social isolation among older people – basically social prescribing – and with success (SERIO, 2019). They made friends with over 1,600 isolated older people and connected them with more than 900 neighbours and natural connectors. People who agree with the statement "I am able to utilise my skills, knowledge and/or expertise for the benefit of my community" has increased from 23 to 56 per cent. Talking to neighbours is up from 19 to 35 per cent, and 83 per cent are involved in providing unpaid help to others, up from 59 per cent on entry. The key achievement is

the effects on health – and GP visits have decreased from an average of 6.9 times a year to 4.7 times. Non-elective hospital stays over have decreased from 42 to 16 percent, and 53 per cent of those taking part now report they are *not* anxious or depressed, compared to 28 per cent on entry (SERIO, 2019³).

In Leeds, they developed measures for their asset-based approach using these categories:

- Individuals and communities are better connected
- Communities identify and work to bring about the changes they want to see
- People have good friends.

In his blog, Mick Ward describes this in more detail "for the pathfinders we have a range of indicators, such as 'Community connectors have a thorough knowledge of the area', 'Number of groups formed around an interest', 'Changes that happen are initiated and sustained by local people', 'People know their neighbours' names', 'Changes to business strategies/funding agreements' and 'Number of celebration events', and so on. To get this information, we ask the sites to keep diaries, develop local asset maps, and case studies, etc. meaning we get a wealth of information, but it does mean a significant change in how we monitor, moving away from counting to understanding."⁴

But we are nervous that old-fashioned evaluation systems will hamper the required imagination. The Social Prescribing Quality Assurance Framework, published by the Social Prescribing Network (2019), recognises the need for a flexible approach, but still lists the old standbys – health and safety, safeguarding, insurance and so on. Of course we will need to be able to rely on the elements of social prescribing, but we must not pretend these have much to do with quality – any more than the various social prescribing apps on the market can actually measure success.

"The NHS has struggled with this because they like to count things, and this is a bit harder to count..."

Mick Ward, Leeds City Council, Interview

We suggest metrics along these lines that get to the heart of the intent of a primary care model of social prescribing:

- Increase in numbers of friends
- Proliferation of citizen-led not sector-led lifestyle support.
- Primary care 'coverage' to touch the whole population in a way that is more fairly and equally distributed.
- Reduced demand on general practice, meeting people's needs and better overall health.

And then there are the 'return on investment' type metrics. Debbie Teale from Creative Minds told us that taking up art and getting involved in helping others reduced her medication by such a degree that the money saved in one year on medicine would have paid for art classes for 2 years. Not only that but it literally "saved my life" as she went from a patient that no one had any hope for, to a leader, proud mum, role model and masters student.

"Can you think of a better way of reaching the 'hard-to-reach' people than by training key people in the community?"

Jenny Hartnoll, Frome Medical Centre

3. Torbay Community Development Trust was delivering the project for the National Lottery Community Fund's Fulfilling Lives Ageing Better programme.

4. See Additional Resources

Key issue #C.

Status: Professionals versus volunteers?

This is an issue that we believe is likely to emerge as social prescribing develops. It is the question of where professionals are best at doing the linking, where it is actually other neighbours or people in communities, sometimes as part of the process of their own recovery, who do most if not all of this work.

There is a quote from Edgar Cahn that is quoted by people doing great work in this field:

"No society has the money to buy, at market prices, what it takes to raise children, make a neighbourhood safe, care for the elderly, make democracy work or address systemic injustices... the only way the world is going to address the social problems that are dumped on it is by enlisting the very people who are now classified as 'clients' and 'consumers' and converting them into co-workers, partners and rebuilders of the core economy."

Edgar Cahn, 19 December 2007

David Ashton's story shows us what this means in the NHS world of social prescribing:

David had smoked 60 a day for most of his life, and had reached the stage where he was on the gold standard framework (death predicted in the next 12 months). He stopped smoking and did the pulmonary rehab, but it's the Wednesday Wander at Alvanley Family Practice that really changed his life: "I couldn't walk and I went on the Wednesday wander for the first time and it was a wonder for me, it changed my life." The Wednesday Wander goes at the pace of the slowest person. "I couldn't walk more than a few paces. I got to the bottom of a hill and I said can't do that, and Dawn took my hand and I stopped four times. Eventually, I was walking up without a stop." He is now not only able to manage his health, he is a health champion establishing the practice's allotment, a place to grow and share food. "I didn't just want it to end when I retired."

David Ashton, Community Champion, Alvanley Family Practice.

This is the lesson provided by the experience of community or practice health champions, people who are engaged, trained and supported to volunteer and use their life experience to help their friends, families, communities and work colleagues lead healthier lives.

Of course, community health champions are doing a great deal more than linking people together. They could also be described as lay health workers, health advisers or similar. What holds these roles together is that "individuals without professional training can make a difference" (South et al, 2010, p26). They don't do this by providing workshops or health promotion advice, but by inviting people to join them in activities that generate friendships and improve health, from gardening to walking to knitting to cuppas and chats. They help people live meaningful lives.

They could in other services be described as navigators, though this is usually a professional role in the NHS (Boyle, 2013). There is strong enough evidence on the positive impact of lay health workers and volunteers to justify commissioning community health champion programmes (South et al, 2010). The advantages of using volunteers include their flexibility, their ability to reach groups that are seldom heard or hard-to-reach – as well as their ability to talk equally to peers from the point of view of experience (South et al, 2010). But also it stops the medicalisation of poverty and community, and the professionalisation and institutionalisation of community relationships. This is community activism as it should be.

Jenny Hartnoll at Frome Medical Centre, who runs the huge and successful community connector scheme there, was originally a trained and experienced community development practitioner, and she was taken on to be what is now described as a link worker. A team of five professionals and more than 1,100 volunteers now cover all the surgeries in the Mendip district of Somerset. She told us she feels she was set free by her line manager to achieve this organically.

The volunteers go through only a short training compared to the health champions.

Many of our interviewees described the space between professionals and people where unexpected transformations can take place. This means that community connectors can potentially translate between sides, and understand what both of them really need and can offer – beyond the narrow range of services that general practice can normally provide. They do not have to emphasise the need, the lack which is experienced by individual patients, and can ask instead – one of the features of coproduction relationships – what people want to achieve, what they love doing, treating them as assets rather than drains on limited resources (see Section 2 Literature Review).

It is certainly true that the two worlds, the real one and the NHS one, do in some circumstances struggle to understand each other. The former UK civil servant Eileen Conn explained some of the institutional consequences:

"The differences arise from the nature of relationships in the institutional and organisational world, which are primarily vertical hierarchical, as distinct from the informal community world where the relationships are primarily horizontal peer. Lack of attention to these distinctions adversely affects the interaction of the public agencies and the community, and the community's organisational governance and working arrangements."

Conn, 2011, p1

Conn's approach makes a parallel case to ours, that to make a difference in the community – the objective of social prescribing – it needs to be organised on a more horizontal, peer-friendly basis, where people, communities and public service employees work as a system, not as 'them and us'.

That is the case for some volunteer support – the untapped resource at the heart of the NHS – and for ordinary people with the ability to care, rather than trained semi-professionals.

This is not without challenge. Expecting people to rise up to be connectors without support smacks of exploitation. Working with people who have been or are distressed who take up volunteering roles needs time and commitment and comes with some risk.

Whether or not you agree with this, there is an argument that the mixture of citizen and professional connectors – as they have at Frome or Creative

Minds (see appendices) – is the optimal mix, because it allows relationships to become reciprocal, as they need to be. It also enables social prescribing to happen at scale – with an army of volunteer connectors facilitated by a professional, or at least an employed, facilitator.

"I think the people who wash up in social prescribing themes or at least should wash up in social prescribing themes are people where that is not working. So, it's not that they have more needs, I think it's that they are less well-connected..."

Charlotte Augst, National Voices, interview

Key issue #D.

Method: Formula versus face-to-face.

In the most successful places where GP surgeries are doing social prescribing well and in an innovative way, they are going some way beyond the guidelines and what they imply. In particular, they are going beyond the normal formula – where a social prescribing link worker makes all the connections.

This is difficult territory. Measurable linkages with formal voluntary sector entities is what NHS England would seem to prefer. It is probably what the social prescribing software manufacturers would prefer. In Scotland, green prescribing takes place largely over the telephone.

The problem is that this may be too much part of the old 'service land' to do the community job effectively. Link workers are expected to spend time with patients, see what is possible and then to pass them on. But if they manage links at the 'correct' rate of around one per day, can they break out of the formula enough to make it work?

"It wasn't a starting point the question about what you need – it is about what would help you live your life in the best possible way..."

Allison Trimble, the Kings Fund, Interview

Most successful social prescribing systems we have seen usually involve lay people as volunteers or as health champions working alongside general practice staff, in fact you can't always tell who is who – the boundaries between professionals and volunteers become blurred.

It is already clear that the voluntary sector as it is currently configured could become overloaded, and find it hard to cope with the influx of patients through social prescribing referrals from GP surgeries. This alone implies a need to develop the third sector as much as it does to develop the NHS, and along

similar lines – more flexibility, less dependence and more coproduction (see the examples in the appendices).

One solution from Altogether Better is *collaborative practice*, where Health Champions work with practice staff using an asset-based approach to design, deliver and increase the number and range of offers and activities available to meet people's needs.

Others using Asset Based Community Development approaches have walked the streets to find the community connectors (see appendices on Grenfell) who can galvanise people to collaborate and volunteer, bringing the community to the general practice.

"So people don't get referred, which is one of the big differences. Their job is to walk the streets, to go to every event going, to every coffee morning. The ones in Gipton sat in the pub on a Thursday night; you can meet them there. Just try and make connections, and find people willing to give of their time and gifts."

Mick Ward, Leeds City Council, Interview

Or they have set up formal partnerships between the NHS and third sectors (see appendices on Creative Minds) to develop reciprocal experiences with people who are struggling with their health and wellbeing. For many of these, the benefits have outstripped

expectations, reaching more people, finding more resources, and being more rewarding than they expected. The surprise and reward has been felt by those taking part from the partner organisations, who have benefitted personally as well.

All of the successful approaches we saw and discussed relied on local people working together to find a local collaborative approach. In this case, face-to-face implies you can use a kind of informality and equality between NHS staff and people, which we can confirm changes what is possible.

It also means that GP practices may have to grow their own volunteering around themselves, and their own supportive community. Finally, it means the voluntary sector also needs to adapt and change much like general practice needs too. As Mick Ward said to us: "Putting old people in buses and driving them seven miles to a social centre is hardly going to solve loneliness".

One final reason why it is vital to embrace face-to-face relationships, not the formula, is that it provides some safeguards against medicalising social isolation. It means that the most important thing has to be the individual rather than the target they represent.

"The lowest value connection is a leaflet; the highest value connection is Dave in Alvanley taking Florence to a singing group, introducing her to three people, sitting down and having tea with her, singing with her from the songbook."

Alyson McGregor, Altogether Better, interview

There is a broad spectrum between that and being given a leaflet, and official policy is only beginning to understand or embrace that. In some areas, as we have seen, it appears to be going down the most simple, mechanical route of a call centre with a social prescribing pad.

"How you move away from the kind of them and us scenario, and start to talk about a more mutual, collaborative, honest, congruent relationship where the feedback and the challenge isn't all one way, for example..."

Allison Trimble, the King's Fund, interview

Key issue #E.

Language: Social prescribers or community connectors?

Everyone in this field agrees that language is important. It does not mean they agree what the language ought to be. There are good arguments on both sides.

"I am interested in how you move, say, the kind of them and us scenario, and start to talk about a more mutual, honest collaboration..."

Allison Trimble, Kings Fund, Interview

This is where the language can be important. *Social prescribing* language implies that it is supporting people to have a broad range of options, using what is in communities already. It implies that the NHS professional has the power, and the individual must comply. *Community connecting* implies something about nurturing communities and collaboration – living better lives together. Both have different starting points.

"'Prescribing' implies you go to the GP and ask for help. 'Connecting' is so much more empowering, promotes community and self resilience and allows voluntary sector and the community to feel much more engaged as they're more likely to be delivering and creating the initiatives around this. The power of a word."

PCN clinical director

Social connecting implies people and relationships versus turning the enterprise into an official *project*. But it is not the only argument. The term 'social prescribing' has been very useful in persuading a reluctant NHS establishment that this is a useful extension to their service. It can also support the space between the institutional offer (an appointment) and the community, with the social prescribing pad being an artifact they helps people access new relationships and activities.

Our conclusion is that, although language is important, it is useful to describe what is happening here in a range of different ways, until the various strands begin to settle down, or separate off. Perhaps, as Allison Trimble suggested to us, this would make possible the kind of local conversation we need in order to decide between the various approaches, and different underlying philosophies.

"I don't think we should get our knickers in a twist about the intellectual purity around language. We can sometimes be a bit holier than thou about these things..."

Charlotte Augst, National Voices, Interview

Key issue #F.

Scale: Big versus small

It is not quite clear why NHS England chose the scale it has done for social prescribing, perhaps because it makes it easier to distribute funds to primary care networks of around 30,000 patients. Nor is it clear what problem it is that PCNs (Primary Care Networks) are the solution too, with PCNs having a range of purposes from securing extended hours to meeting complex needs (Malby 2019).

Where there are many welcome elements to the official advice – the informality about the plans, for example – the rigidity of scale does imply an unhelpful inflexibility and formality. Nor is it possible for one link worker to know all the GPs or primary care staff in their patch, or to build the kind of relationships that a smaller neighbourhood would allow.

We are nervous that this inflexibility of scale may ride roughshod over the small successes. We are aware of examples both of Primary Care Networks that are sensitively incorporating what is already happening, just as we are aware of those that are not.

It may be that innovative and entrepreneurial link workers will be able to build out on a neighbourhood basis, but many will not. The bigger scale also makes it hard to build the kind of reciprocal and enabling space in which social prescribing thrives. When management is old-fashioned, reluctant or confused about the objective of community connection, slavishly attempting to follow instructions from the centre, too rigidly measuring the links that are made – then link workers will not be as effective as they need to be.

We are aware of one London borough where two new link workers are expected to cover 14 surgeries. At that scale, it will be difficult to convince patients that the service will still exist in a year's time. The initial co-ordination may be where the local authority is unitary and they and the CCG have coterminous boundaries.

There is also an issue around scale when it comes to linking up with the formal voluntary sector, which tends to be organised across cities rather than across neighbourhoods – certainly not across the scale of PCNs.

What we have seen from the examples where there is a successful approach at the larger population scale (Leeds, Frome, Creative Minds, see appendices) is that the way they organise is different. What definitely doesn't work is taking the model of social prescribing that works at practice scale and assuming the same work can be done at PCN scale.

Where there is a social prescribing model at scale, the role is very different – providing facilitation and support for local social prescribers and volunteers, and bringing them together for collaborative decision-making.

“The task becomes, how do you connect, how do you create the conditions? How do you create the environment for that kind of relational capacity?”

Allison Trimble

Where it is working well, we are seeing these layers of support, which have been locally generated and build out from self-defined communities:

Table 1: The roles in a social prescribing system

Position	Scale	Examples	Roles
Paid community leaders	Hubs / larger geographies – could be federation, or locality. Bigger than a practice.	Creative Minds project workers are responsible for supporting the development Creative Minds projects. This includes supporting and developing mechanisms for working in partnership with a range of creative partners both internal and external, including service user and carers, community organisations /groups, local authority and other NHS bodies.	<ul style="list-style-type: none"> • Act as supervisors, facilitators, developers and connectors. • Support ethical collective decision-making. • Develops partnerships. • Ensure probity with funding.
Volunteer community leaders /connectors / champions connecting people to other people through activities or taking a relational approach by inviting people in, rather than referring on.	At the scale of the community – these volunteers come from a community and support that community. They may be ‘homed’ with a GP practice or a Charity or a locality or a third sector. Their scope of work is not a GP list, but the community they serve and live in.	At Alvanley there are 18 champions who act as the first point of contact, and who support local people to join in and to set up local groups. The champions have secured an allotment, and funding for a shed, and collaborate with a local café to help people cook from fresh ingredients.	<ul style="list-style-type: none"> • Requires some training. • The group takes ownership of the wellbeing / social prescribing approach and co-creates it. • They self-organise, and have a collaborative collective approach to decision-making. • May well set themselves up as an entity (e.g. charity). • May bid for funds for local activities. • Are properly supported in their role
Employed GP practice level social prescribers / Health and Wellbeing workers. Seeing people who need a range of non-biomedical services and navigating the person through these. Sometimes refers to other agencies.	GP practice (depending on size can be working across more than one practice in a group).	Health and Wellbeing officer funded by a Federation to work across a few practices offering a range of services from CBT to benefits advice. 1 hour appointments to really listed to the person's needs.	<ul style="list-style-type: none"> • Working as a professional, seeing patients through self-referral or GP referral, to help people manage their complex life situations.
Volunteers running their own activities – ones that they enjoy and care about	At the scale of the community they live in.	A mum leading a walking pram group.	<ul style="list-style-type: none"> • Pure volunteer

Behind this is the issue about whether the NHS is anyway the best structure to organise social prescribing. We saw examples of sustained approaches to 'social prescribing' in terms of supporting people to live healthy lives coming from the voluntary sector, local government and the NHS, all following very similar approaches (Leeds, Frome, Creative Minds).

"I think the easiest mistake to make always, with this sort of disparity of size, is that you assume there's nothing there, this fantasy of the empty space that you act into..."

Charlotte Augst, National Voices, interview

Key issue #G.

Costs: Subsidy or homeopathic finance?

Social prescribing is happening already. It is difficult to claim, therefore, that its development is being held back from any lack of funding. On the other hand, some small funding may be vital for the smaller, more informal patient groups to get off the ground. Our Inquiry suggested a paradox here, summed up by Mick Ward from Leeds: "If you give a third sector organisation 60 grand a year, and monitor it, they will spend 60 grand a year. If you give an NHS organisation £1.2 million, they will spend £1.3 million. You give two women 50 quid to set up a knit and natter group, they will stretch the money forever."

We are unaware whether this phenomenon has been researched in a health services context, but anecdotally we see something along these lines happening all the time.

The danger is that, if the support is only bottom up – and the attention in public services tends to go where the larger sums get spent – then these fantastic models can sit alongside old-style working and not spread at all. Alvanley Family Practice shares premises with three other surgeries, which are showing little interest in their innovations, whilst practices further afield are keen to learn and collaborate.

An emergent issue is where the new funding for primary care network link workers, ends up supporting a 'referral' or service model, which undermines the existing local asset based approaches. In Leeds, the council's work on Strength Based Social Care, Asset Based Community Development and 'Better Conversations', is being networked with the NHS funded existing social prescribing model, and they have worked hard to make sure these initiatives work together to develop and support individuals and communities. The new PCN link workers are another layer to be networked into this, and, across our examples it has been a challenge. A more localised approach to link workers that builds out of local asset based initiatives, rather than NHS policy prescribed posts with prescriptive remits, would be more helpful. Local flexibility to support the innovators is needed in these places. A one size fits all model where there

is such a range of contexts from little or no experience to years of development could drag the innovators back.

The real question around current funding is whether it should go primarily to help the ones that are doing it well to spread it more widely, or whether it should go to posts which are catapulted into supporting what is, in effect, a deficit model of care? Or whether there should be multiple approaches to fit the range of contexts?

Funding seems to be needed for three things:

1. Start-up to help get social prescribing off the ground where services need the headroom to have the conversations it needs, and to support the measurement of impact (however that is determined).
2. Scale, to secure the facilitation, supervision and relationships needed to support on the ground social prescribing in communities.
3. Spread, to share and grow social prescribing from the great examples that currently exist.

Funding pre-determined PCN posts where there is already considerable experience and expertise, with collaborative models already developed, is not the right approach. What would help, on the other hand, would be to fund them to amplify the proven success of their existing schemes.

Key issue #Significance:

Is this a new model of care?

If social connection is increasingly networked and dovetailed alongside local authority provision, and it seems to be, then does social prescribing imply a whole new model of health and social care? New models of care are population-based, collaborative, locally generated, relational, and they change the boundaries of roles.

“Social prescribing is a Trojan horse for the sort of change the way we do healthcare...”

Dr Mike Dixon, 2nd International Social Prescribing Network Conference 2019

The NHS is in crisis, so we need the new model of care that community connection implies. Mike Dixon's famous “Trojan horse” remark also implies this will not be a sudden change; it will open the door to innovation inside the liminal space between the NHS and social world. If we projectise it, we will reinforce the old model of care, which means that change will be more difficult to achieve.

If it works well, it should improve the capacity of general practice to meet the whole population needs, not just those that present at the front door. A social prescribing system (epitomized by the range of roles above) can therefore catalyse or complement internal change in primary care and third sectors, leading to a new model of care.

“Asset-based work is about valuing diversity, valuing people's insights, experience and skills and what everybody brings. It's not one thing. But coming from a values base and an ideology which says we're better when we're together.”

Alyson McGregor, Altogether Better, interview

Social prescribing: What it takes

The following ‘top 10 tips for doing social prescribing’ are some reflections emerging from the inquiry. Our understanding was that much of the ‘how-to-do’ social prescribing – so that it changes culture and meets need – relates to the ideas of ‘Leading Adaptive Systems’.⁵ The complex nature of social prescribing requires a multi-dimensional approach that is ‘bottom-up’, ‘inside-out’ and ‘outside-in’ (Harrison et al 2019, Kimberlee 2013, 2016, Polley et al 2017 1&2)⁶.

Our interviews and visits built on the literature review to generate a deeper understanding of what it takes for social prescribing to make a difference:

1. Start with listening

Starting points matter. If you start by pre-determining the focus or outcome from a partial perspective – from one profession or service viewpoint – you will be less likely to achieve the collaboration you need to generate better lives. If we think we already know the problem we may miss the opportunities in front of us, or risk putting in a sticking plaster solution. The starting point is to ask people what matters to them, and what makes a good life for them. This stops primary care medicalising poverty. Out of these non-agendered conversations come needs and offers. This is the foundation for social prescribing.

2. You own what you create

Start by bringing together primary care services, community organisations and local people to discuss how, together, you can meet people's whole needs. It is hard to ‘lift and drop’ a model from somewhere else. It has to come out of the real relationships between services and people. This can only be generated in conversation and dialogue, not by email or directive.

We need to foster relationships so that new capacity can emerge. People will tend to innovate and generate solutions by talking and working together. Bringing together all the people involved in the issues, with diverse views and ideas, is more likely to lead to solutions that have been generated and resourced locally. They are also more likely to stick.

Invite people in, don't restrict membership. In all the examples we saw, we were surprised who had the ideas. The task for social prescribing is to generate the relationships and connections for better things to happen. Gardening clubs, knit and natter groups, singing for the brain have to be discovered locally.

3. “Culture eats strategy for breakfast” (Peter Drucker)

Social prescribing as a *policy* seems unlikely to be able to change the model of primary care unless there is a change in its culture. Primary care needs to shift from managing demand, creating dependence and seeing the problem and people through the lens of deficit – to understanding and meeting need, enabling connections to meet those needs, and seeing the problem and people through the lens of their talents and abilities.

Not all primary care teams are ready for culture change. The lack of investment in general practice development and the lack of motivation for self-scrutiny does not lend itself to this kind of openness. The burning platform of the workforce ‘crisis’ and the overwhelming recognition that more of the same isn't working could be a catalyst for change. But this kind of change requires investment in the skills and capabilities at general practice and voluntary sector as well, away from creating dependence to catalysing assets.

4. Do what matters to people where it matters to people

Taking an asset-based approach means no one part of the system can decide arbitrarily where to

5. See Leading Change in Section 2 Literature Review

6. See Section 2 Literature Review

start. There is also no 'right' place as long as it is collaboratively generated. You start where it matters to people to start – and you decide this together, and then you follow through.

This has to be supported by data so that you are not reinforcing prejudices or old patterns of 'seeing' the problems. If we look at where primary care spends its time, it devotes hardly any resources and time to young people. This might be something that the community and primary care care enough about to decide it is a place to start. Or it could be the data shows who is in the primary care 'hamster wheel', going round and round getting nowhere (see Section 3), and you could collectively decide to start with them.

Where social prescribing takes place is as important as *who* it is for. Taking it out of clinical NHS settings appears to make it possible to access the wider assets people can bring. It can mean activities in libraries, schools or community – wherever it makes best sense for your objectives.

5. Foster relationships as a core capability for social prescribing so that new capacity emerges

These relationships are based on a 'being-in-it-together' mentality with everyone having an equal voice and a contribution to make. This means working hard at what it means to be collaborating together. It is vital that everyone can be clear what they hope for, how they are going to relate, where power lies and why and how they are going to redistribute it (move from Old Power to New Power).⁷

That means moving from referrals to relatedness, and connecting people to solve problems together. It means shared, honest conversations about what might be possible to do together. This in turn needs time and space to develop collaborative relationships.

“Move away from the kind of them and us scenario, and start to talk about a more mutual, collaborative, honest, congruent relationship where the feedback and the challenge isn't all one way, for example”

Allison Trimble, the King's Fund, interview

6. Build outwards from communities

Communities know the parameters of their community. Services cannot prescribe a community population size. Identity is critical to gifting volunteer time – people give to and in communities where they feel a sense of belonging. They are invested in that community for the long haul. The social prescribing process needs to have the same emotional and relational investment, and not just for the length of time a post is funded.

“When I talked earlier on about the gardening on prescription, it wasn't just a short term six week thing. It was, you become a member of that group. You become a part of that community.”

Allison Trimble, the King's Fund, interview

7. Stay humble.

Taking an asset-based approach means giving up your own assumptions about knowing what is going in local communities. It means not assuming you know what people need, and being open to an honest conversation about both need and the possibilities that people can generate. This is more congruent with servant leadership than heroic leadership.

8. Learn to innovate together

There is no perfect model of social prescribing. Instead, it needs to be allowed to grow and adapt. It can only do that if there are 'feedback loops' that enable the social prescribing system (people, services) to review both what is working, and why.

This community of practice is a thread throughout the 'how'. Our hope is that doing this learning at a borough scale will give access to enough experience to learn well together. Places need to experiment to develop their own social prescribing approach, but must do so informed by data and evidence, not just by hunch and the usual traditional assumptions.

9. Sustainability spread and scale

Social prescribing will wither if there is no attention paid to sustainability – how to maintain the approach as you develop it. Or to spread – how to adopt ideas from other places; or scale – what it takes to secure coverage across the whole of a region, or across the NHS.

There are many places where social prescribing has been pioneered, developed, tested and grown. These should be the starting places for spread, sharing their learning and mentoring new starters. They can offer advice, share practices and peer review the new adopters approach. They can hold the hands of the new starters, and walk alongside them as they set up their own schemes.

The innovation approach in complex systems is to amplify what works, to help the early adopters be

the catalysts for the next generation. The funding has so far been for posts, not learning or spreading innovation. Early social prescribing sites generated their model out of their own concerns and attention to local needs, not as a result of being funded for a post.

10. Starting points really matter.

Social prescribing isn't amenable to 'lift and drop'. The start-up phase really matters, where all parties listen, learn and develop constructive, productive collaboration.

Social prescribing is part of the significant changes needed in primary care to meet need rather than manage demand. High performing health systems all have robust primary care teams at their heart (Baker and Denis, 2011). This means social prescribing, and collaborating with communities, is part of the change process – but not the whole of it. PCNs could help general practice be the very best it can be, with better flow, less failure demand, services provided around population need rather than historic provision, data-enabled prototyping and quality improvement, and a real understanding of when people need more than the practice can provide on its own, and where it needs to work with other practices in the PCN to help people live well in their home.

“At its worst, it was very much a signposting. Which for some people, still had a benefit, but they were just signposting people to services. So it wasn't fundamental changing ... Where I'd like to see it more is understanding that line between signposting, support, coaching, supporting people to go.”

Mick Ward, Leeds City Council, interview

7. See Literature Review, Heiman and Timms (2018)

Conclusions: How it should be done

At the heart of these questions is a dilemma: whether social prescribing is primarily a role or a set of beliefs. The answer is, of course, it is both. It has to be to make it effective – just that we also believe the role will increasingly be carried out, not by professionals, but by local people themselves, while some of the professional aspects of the role shifts from linking to shaping a supportive community.

Those practices we have seen which are doing social prescribing effectively have in some ways stumbled upon these answers, but they have done so out of a deeply held belief in relational practice. The Alvanley Practice described this discovery in terms of a perfect storm – a combination of their own values about general practice as family, the desperation of the doctors, their determination to do something differently, the arrival of key staff with a positive part of the answer, as well as the willingness of local people to share the role.

In other words, people we have seen who carry out the role well, don't just link people up, they become a catalyst for change, and they are willing to change themselves. Having seen them at work, we believe social prescribing is indeed a potential Trojan horse, which might be used to change the system, humanise it, and to make it more effective. Judging by their success, and based on the argument set out in this report, we conclude their success is based on some of the following elements:

- a) *(Purpose)* Holistic and based on genuine needs – starting with asking the question about 'what makes a good life' for individuals. Also new practices or habits, which allow health professionals to meet complex needs more effectively.
- b) *(Measurement)* Success measured in terms of meeting those needs, and shaping a system that can be capable of meeting those same needs sustainably in the future.
- c) *(Status)* Carried out by a mixture of entrepreneurial professionals and local people who understand each other and have generated their approach together.

- d) *(Method)* Based as far as possible on emerging face-to-face relationships, with everyone taking part willing to change themselves.
- e) *(Language)* Describing the role increasingly as *social or community connectors*, without getting too precious about it.
- f) *(Costs)* Using small amounts of money to support local people to create the local necessary networks of support. Invest in the development of primary care, and voluntary sector to enable an asset-based model. Fund facilitation at scale, so that social prescribing on the ground can benefit from supported link workers, volunteers and connectors.
- g) *(Scale)* Managed as far as possible at the level of the identifiable community – usually a neighbourhood or practices – networked across whatever area seems appropriate.
- h) *(Significance)* Understood by those taking part as a new model of care – as far as possible, by shifting responsibility to include people working alongside practice staff, and local collaborators (third sectors, community led enterprises and clubs, arts organisations) using the concept of New Power.⁸

Our experience suggests that success will depend partly on recruiting the real connectors, those who are already known in the community as the 'go to' people, as well as inviting people who have talents – or simply a human ability to care – but maybe not the confidence to volunteer; and partly also on leaving some of the old health management baggage behind.

If management is defined by checklist and KPI, then social prescribing will probably fail. If, on the other

hand, management is based on entrepreneurial, face-to-face, human scale relationships, it is more likely to succeed. Those most successful schemes appear to be those where health staff deliberately changed their identity and relationships (see the Grenfell example in the appendices).

We are only too aware that this is not going to be easy. The path is not clear, straight or fast, because so much time is used in building relationships, which inevitably means more false starts. Yet the work accelerates, usually, when the right conditions are in place. "This way of working is still deeply counter cultural (even when a formal system might claim to have embraced it)," said the 2015 evaluation of the Altogether Better practice health champions programme (Pratt et al, 2015). "Senior leadership needs to provide genuine top cover and demonstrate 'courageous patience' and visible support." This was a sentiment deeply held in Grenfell (see appendices), and also demonstrated in Wakefield where the long-term commitment to and understanding of Creative Minds by board leaders has been key to its sustainability.

"The system does have the capacity to self-organise. It depends critically on the quality of the relationships developed. As a 'rule of thumb', the stronger/deeper the relationship between champions and the organisation, the more the work was transformative – i.e. both the practice/service and the citizens who engaged with it adapted. Where relationships were weak, the champion work was more of a useful project on the side..."

National Evaluation of Health Champions, 2015

Our work on this inquiry also allows us to name another paradox: the system will benefit the whole, but only if social prescribing concentrates on personal outcomes for those involved – for citizens as well as clinical staff. Whether this will produce short-term savings for government is not clear, but – by beginning the process of sharing responsibility across services for re-building community – the idea may be capable of building foundations for long-term savings by reducing need rather than persistently not meeting demand.

"How can people who are care professionals or caregivers, in the intentional sense, how can we create enough space for people to develop those relationships? That takes time. It's not a quick fix, and it's not a signposting either. It's a relational thing..."

Allison Trimble, the King's Fund, Interview

Social Prescribing: What it is and what it isn't

It is: Independence creating	It isn't: Dependence creating
Local knowledge	A service
Increasing connections so people have good friends and people to call on and gift too	What you already do
A conversation where you listen to people's needs	A pad
A commitment to meet need not shift the burden or pass the buck. 'Zero tolerance for flailing around' (Tim Anfilogoff)	A database
Open access (not just GP referral but self referral)	A referral
Deep knowledge of the local community, the things going on and how to connect them too that	An asset map
A community builder that has a home base (organisation) that facilitates local volunteers to connect people with needs and their community	Signposting to overburdened services with no investment
A long term relationship	A short term post
A way of addressing inequality	Provision for those that generate the most demand
Part of a new way of delivering all of primary care	An addition to the traditional model of general practice

Recommendations

It seems to us that social prescribing as currently envisaged sits on a knife edge between being the Trojan horse to change healthcare to make it more effective, more sustainable and more humane, and being subsumed into the old way of doing things, which keeps it safe – or apparently safe – but ineffective. The following recommendations are therefore important and urgent:

1. Investing

To support effective, human-scale public services, the NHS needs to invest in building communities – measuring the success by metrics that matter to people.

- Using small amounts of money to support local people to create the local necessary networks of support.
- Invest in the development of primary care, and voluntary sector to enable an asset-based model.
- Fund facilitation at scale (primary care network/ borough), so that social prescribing on the ground can benefit from supported link workers, volunteers and connectors.
- Provide support within communities for those that are taking the lead in volunteering as connectors, champions, and volunteers.

It also needs to invest in developing general practice so that it:

- Understands its population's need, rather than just meeting any demand it is presented with.
- Develops a mixed offer designed to meet this need, by varying the length and continuity of appointments, and the types of services it can offer.
- Avoids creating work for itself (failure demand) by managing flow within the practice.
- Shapes its own luck by knowing and working with local people and services.

The nature of funding matters too. When it does arrive, all too often the money comes in arrears or long after the deadline has passed. It is all very frustrating for those trying to develop long standing embedded approaches that take time.

Changing culture requires resources. Those behind the early social prescribing scheme known as Creative Minds, based in Wakefield, originally believed they could shift the system by providing one per cent of their budget for social prescribing. We also believe the greater the resources, used not only to set up social prescribing but to spread and share those approaches that work, the greater the beneficial impact on the system as a whole.

This comes with a health warning: larger organisations are equipped to bid for funding when smaller organisations tend to find it harder. This approach has to be funded equitably and purposefully. Specifically, that means setting an objective of putting one per cent the NHS budget towards community connection.

2. Evolving

Social prescribing should be widely understood, not as an endpoint, but as a framework that will allow it to evolve. That means carving out spaces where it can develop into something different, together with other services or other voluntary sector organisations, if it can. If it is to take a whole population coverage approach, then primary care might not be the best starting place for all people who need it. People with mental health needs often bypass general practice, as do people who are homeless. The models we saw in Frome and Creative Minds need to be part of the solution too.

These developmental spaces might be:

- Designated areas, which will have freedom to experiment, and the funding to share and spread learning.
- Designed to spread the best innovations – actively supporting those that are doing well,

and providing funds for them to share their approach with others.

- Provided with security over 5–10 years, and certainly more than one year. People will commit to support the idea, but only if the NHS commits too.
- Including meeting needs that don't currently touch general practices.

3. Safeguarding

The safeguard that is required here is against the old world biting back. NHS managers and NHS England must create the possibility of experimenting, to welcome it and to lead it. This is partly about leadership having the humility to learn from community connectors; but it is also about the way that link workers and connectors are employed:

- Imaginative and entrepreneurial link workers, connectors and health champions, who are able to make things happen – a critical skill in the world that is emerging – need to be supported to evolve social prescribing, perhaps with the launch of a new institute of community collaboration where they will be members alongside disciplines from all sectors.
- Provide support and reward long-term to volunteers with recognition, training and qualifications.
- Link workers and social prescribers working with self-defined communities (not NHS defined communities), supported at scale by a facilitator to help them connect together and for learning and spread

Measuring the impact of this investment must enable the intent of the approach. What you measure determines what you do, so the metrics matter. We suggest these metrics for social prescribing:

- a) Increases in numbers of friends.
- b) Proliferation of citizen-led not sector-led lifestyle support.
- c) Primary care 'coverage' to touch the whole population in a way that is more fairly and equally distributed.

- d) Reduced demand on general practice, meeting people's needs and better overall health.

4. Transforming

We believe social prescribing as envisaged here has the potential to transform primary care, and to form the basis of a revival in effectiveness across public services. This kind of social prescribing *plus* (see our list of what it is and what it is not) will work best if it reaches outside the medical and health sector, and primary care, and directly into the surrounding community. Again, this means deliberately working with local people who can connect and catalyse innovative local activities and relationships, as community connectors, as employees and as volunteers.

Starting points matter. Taking the time to develop a relational approach based on the principles described in the above section 'Social prescribing what it takes' from the outset:

- Start with listening
- You own what you create
- Do what matters to people where it matters to people
- Invest in culture change in primary care and voluntary sectors away from creating dependence to catalysing assets
- Foster relationships as a core capability for social prescribing so that new capacity emerges
- Build outwards from communities
- Stay humble
- Learn to innovate together
- 'Design in' sustainability spread and scale

Social prescribing is a cultural and social change not a person or project. It is a way of 'doing business', not a service provided. Transformation starts with the professionals and leaders of social prescribing looking at their own practice and behaviour. Taking time to develop professionals' assumptions, attitudes and willingness to collaborate is a key first step, alongside finding the latent potential within communities.

Additional resources and References

Additional resources

If you are interested in reading more about how Leeds City Council has developed an asset based approach, and the impact it has had for local people, you can read the story here:

<https://www.nurturedevelopment.org/blog/abcd-practice/proliferation-the-implementation-of-abcd-in-leeds-part-1/>

<https://www.nurturedevelopment.org/blog/abcd-practice/proliferation-the-implementation-of-abcd-in-leeds-part-2/>

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APPENDIX 1: THE VISITS

The Alvanley Way

“I want to thank so many of you here for everything you’ve been doing,” says Dr Mark Gallagher, on the new allotment. “And to thank you all for being my friends.”

Dr Gallagher is a partner GP at one of the most innovative surgeries in the UK, Alvanley Family Practice in Stockport, and we were there partly to watch their new allotments opened by the mayor of Greater Manchester, Andy Burnham.

It has been a joint effort. David and Julie Ashton are ‘Practice Health Champions’ at the family practice and came up with the allotment idea. The council donated the land and a local builder provided apprentices to clear the site. Stockport Council investment fund also provided £10,000 towards the allotment hut.

It is unusual, of course, for GP practices to preside over the creation of new allotments – though since the famous Peckham Experiment in the 1930s, not unprecedented. But there is also something about the informal style of Mark and his practice partner Jaweeda Idoor – without side or pomposity, calling their patients ‘friends’ that might raise a few eyebrows in professional circles.

Even so, in a period when general practice is struggling with dwindling GPs and rising demand, Alvanley has bucked the trend. It has managed to reduce demand and at the same time to begin to nibble away at some of the causes of ill health.

It wasn’t just a technocratic business of tackling rising demand either. Mark is an immensely popular local GP, as his unassuming speech at the allotments implied. He had been overwhelmed with the cards and cakes provided by patients after a recent heart attack. The changes in the way their surgery works was partly a response to his own exhaustion, and that of his practice partner Jaweeda.

“I remember, we had our heads in our hands,” she says now. “We had 200 letters to reply to and piles of test results. We were thinking of giving up. Then a few things happened.”

The problem was that the practice was faced with an increasing number of people coming for appointments that were struggling with life, or had needs that a GP can’t meet – primarily the social determinants of health – through an appointment, and were looking for a new way of collaborating with the community to support them.

The doctors describe the events as a ‘perfect storm’, which led to the radical shift in the way things are done. The first of these was Jaweeda becoming Chair of the GP Federation and beginning to think practically about the long-term sustainability of general practice – and not just theirs. The second was the arrival of Kay Keane as business manager. She was clearly a breath of fresh air. “We said to each other, after we interviewed her – she’s just like us,” said Jaweeda.

“I remember, we had our heads in our hands. We had 200 letters to reply to and piles of test results. We were thinking of giving up. Then a few things happened.”

Thirdly, the local people who were already trying to do something about supporting people struggling with their lives locally, like Nicola Wallace-Dean at Star Point Café, and her mum, Ann, at the local fish and chip shop using their profits to invest in the local community from a credit union to train young people.

The last part of the jigsaw was the arrival of Altogether Better, the Yorkshire-based innovators behind the idea of ‘health champions’. They were part of a Pilot funded by Public Health Director, Donna Sagar, she appealed for practices in Stockport for their experiment, Jaweeda and Mark applied successfully, and soon they were writing to their patients, sending them individual invitations to help.

There was a huge response, says Jaweeda. "They love the practice."

Three years on, not all the original 18 health champions are active, and Altogether Better has moved on elsewhere. But the effects are still rippling out and there is now a long list of activities which the champions run – from singing and walking through to allotments – which can help us, perhaps, imagine what 'social prescribing' could and should be.

There is a view that the very name gets in the way, emphasising a medical model, when we know that – certainly in Alvanley – at least one in five GP consultations have no strictly medical purpose. That is not their opinion here. In fact, they even use a special social prescriptions pad. They find it helps GPs draw the conversations to a close, by formally introducing patients to the practice health champions who invite them to take part in the kind of activity that might help them.

On the other hand, this is prescribing that emerges out of a doctor-patient relationship. If there is no relevant activity that suits, they might even encourage a patient to become a health champion and set up their own activities. People can also 'refer' themselves, and activities are offered in a creative and inviting way on their Facebook page.

Whatever their specific formula, it seems to work. I met a patient on the walk who no longer needs her

"I think the idea of using the skills of your population to improve the wellbeing of your population is something that is key. Switching to a champion model has reinvigorated everything about the way we communicate and interact with the community."

inhaler to get to the top of the hill. I sang 'Happiness' and waved tickling sticks in the packed Starting Point café – where the manager Nicola has become a friend of Jaweeda's and the practice – and felt glad to be alive.

I could if I have visited for long enough also taken part in coffee and conversation, new mums social events, pram pushers, Knit and Natter, IT training, phone support, Veg on Prescription, exercise sessions, Feed the Birds, arts and well-being and training in community organising and listening. All organised by this collaboration between the practice, the health champions and the local community. It works for the patients, and perhaps especially those who give their time as 'practice champions'. "I think the idea of using the skills of your population to improve the wellbeing of your population is something that is key," says Kay. "Switching to a champion model has reinvigorated everything about the way we communicate and interact with the community."

It also works for the staff. The receptionist told us her work had massively improved in quality, from the tough work of sorting appointments first thing to a more sustainable workload and better relationships with patients, other staff and the community. She was joining in with some of the clubs and groups run by the community champions. There was a blurring of boundaries within the model. One of the staff had set up group for staff and local people. The practice nurses also seemed joyful about their work, also joining in with the activities.

So what is it about Alvanley that has made this approach so successful?

Well, the key to the alchemy appears to be the mixture of respect and informality of the relationship with the doctors. Dr Gallagher is always known as 'Mark'. Otherwise, it appears to have been a 'perfect storm', which includes the recruitment of Kay, the energy and commitment of local volunteers – people who love their community – and the fact that Mark and Jaweeda are so widely loved, and have been there tilling the local soil – even before the allotments – for two decades,

They are doctors who keep more than one eye on the big picture, who know that saving general practice means real commitment to change, not tinkering around the edges. They met as medical students at Dundee University in 1986 and have been together ever since. They changed the name to 'family practice' twelve years ago. "We wanted to everyone to be treated like a family member, staff and patients," says Jaweeda.

Except that they operate no triage system (the receptionist offers a range of appointments from GP to Health and Wellbeing and, in effect, the patients triage themselves), Alvanley looks much like other surgeries. They probably only reach for their social prescribing pads about five times a week. Yet the intense health champion volunteering, or mutual support in the community, may – so they believe – divert patients enough to cover the workload of one GP. It may not be much compared to what is needed, but imagine the impact in every practice in the land.

It is fair to say, there is some local doubts about whether the same climate could be achieved in a place where poverty and crime is higher. There is something old-fashioned about this corner of Stockport. But parallel approaches have been tried elsewhere with some success.

What they are doing is not exactly under threat – it is hard to see what could pose a threat to this kind of energy. But, equally, the imposition of a particular form of social prescribing by the NHS is causing some worries.

So is the one-size-fits-all approach to social prescribing under the Primary Care Network rubric. They fear that one particular interpretation of social prescribing is forcing collaborations on far too big a

scale. This may prove important – and not just in Stockport.

Alvanley also shares the huge new health centre with three other practices. Alvanley is very popular and, although the health champion and volunteer activities are open to anyone local, some aspects (access to health and wellbeing services where the practice has employed a professional to support patients, for example) require patients to be on the practice list. This may affect the others, of course, who see the per capita payments affected.

Jaweeda also told me about a conversation she had with a doctor in one of the other practices as she headed out.

"Going singing?" he said. "I'm doing proper medicine."

And there you have it: the great hurdle we have to overcome – it is the difficulty of innovation, wherever the medical profession sees this new relationship as a threat rather than an opportunity. Primary Care Networks, the long term plan and asset-based working are now putting population health in the hands of new Clinical Directors. This type of innovation may well now be possible on a grander scale.

Lessons

The central importance of operating on the right scale to build relationships.

The need for ambition.

The importance of an informal, non-deferential approach to doctoring.

The Frome Connections

Picture the scene. A 'health connector', an employee of the Frome Medical Centre, finds a man on a park bench in Glastonbury and they get chatting. He has been drinking. In what other community apart from Mendip would the man on the bench be signed up and trained as a community connector?

But then, as says Jenny Hartnoll, he talks to a lot of people there. "Can you think of a better way of reaching the 'hard-to-reach' people than by training key people in the community?" she says. "I knew people would say 'is it safe?' But what isn't safe about it? People talking to each other and letting each other know about how to access support and get involved in their community."

His training only took twenty minutes or so giving him what he needed to get help – this isn't the approved nine-hour training for official 'health champions'. It is a sign that this is an ambitious programme, not just of patient volunteering but also service integration, that has all the hallmarks of success: it reflects the innovative personalities behind it – Jenny and her line manager, Dr Helen Kingston.

Jenny describes this as a sense of trust. She is trusted by Helen and, in turn she trusts her staff to innovate on park benches or wherever they happen to be. Also, after some effort, the local social care team trusts the medical team enough to join in with weekly meetings of the 'hub' to discuss vulnerable cases – and to share each other's records.

Trust is the key, and that is a scarce resource in the modern NHS. Yet Health Connections Mendip now

"The absence of social relations are more effective than anything else at reducing length of life and wellbeing. They are fundamental to our health."

covers 11 practices, covering a population of 115,000 and employing 12 workers. The team's remit was to understand what mattered to in the individual in front of them and to do what was best for that individual. Following human instinct rather than protocol and seeing the human being in front of them, this was invariably the right course of action.

"The gift that Helen gave me was to trust me," says Jenny.

So, when they began – along with the opening of the new health centre in front of the hospital in 2013 – she sat in cafés reading noticeboards, talking to everyone, to get the information she needed to build up some kind of social prescribing guide book for the website. They now have 400 groups and services – 2,000 was too much, as it turned out, and just confused people. The site got 73,700 hits last year. Not that they rely on the Internet – they have five talking cafes a week, a manned phone line and a monthly local radio slot.

Where there were obvious gaps, Jenny was able to set her small group of professional health connectors to start groups to fill them. They also do on-to-one interviews with patients, starting the conversation – as it so often does in coproduction – with asking not what they need, but what they want in life.

They are supported by nearly 1,200 'community connectors', trained as volunteers across the Mendip district, navigating people where they need to go. Or presiding over the talking cafés. Jenny calculates that, if all the community connectors have twenty conversations a year that amounts to reaching out to 23,000 people every twelve months. This community movement has far greater reach and scope than a small number of paid employees could ever achieve on their own.

Health Connections Mendip is part of a highly ambitious Frome Model of Enhanced Primary Care aka Compassionate Frome that also manages to co-ordinate across health and social care, and meets in the 'Hub' at the health centre to go through each other's databases to see who needs a visit and who needs other kinds of support.

It also works. They reckon that the number of emergency admissions to hospital among Frome patients has gone down by 16 per cent, which they rose by 30 per cent during the same three-year period. The figures are disputed by the local CCG – since the hospitals are still full, it implies that success of Frome has created spare capacity, which is simply taken up by others. But they accept that there has been an impact.

The point here is underlined, as it so often is, by medical research into the importance of face-to-face relationships.

"The absence of social relations are more effective than anything else at reducing length of life and wellbeing," says Dr Julian Abel. "They are fundamental to our health. If this was a tablet, it would be an absolute medical miracle. Empirical science has developed ignoring emotions, and it is an enormous blind spot, because we can't measure them." (See Pinker (2015), *The Village Effect*).

So what is it about Frome that makes this possible here? One success factor has to be the huge modern surgery building, built by PFI and including two practices, district nurses, dementia support and all the panoply of the modern primary care, opened in 2013. With 30,000 patients, they are big enough to make a difference – yet paradoxically, covering only ten per cent of the population of Somerset, they are also small enough to innovate.

There is also the independent town council, which is determined to push the boundaries of what might be possible at this level of government. Julian told us there was a local T-shirt with the slogan, in typical dry English humour, proclaiming, "Let's make Frome shit again!" This is a place with innovation in the air.

"The building is always busy full of support groups. When you walk in, it's like a mixed environment. You might find people sitting in the café, eating cake."

The other factor has to be Dr Helen Kingston and her trusting relationship with Jenny, with her background in community development in London, and the staff team. That building of relationships and mutual trust now extends between the practice and the community teams around them, local social care and other local teams and institutions. Collaborative working across silos has helped ensure individuals do not fall through the gaps. Building relationships between those working and volunteering in the community is as important a part of the project as the care it provides to individuals.

"It also changes it into health and well-being centre," says Karen, the practice manager. "The building is always busy full of support groups. When you walk in, it's like a mixed environment. You might find people sitting in the café, eating cake."

There are some other peculiarities that might go some way to explaining its success.

My life plan. The health connectors start their interviews with patients in coproduction style with the question 'what's important to you?' This forms the basis of a 'my life plan' for everyone, which sets out a scheme that covers every aspect of their lives from medical to social.

The mix of professional and volunteer staff. They employ 5.5 health connectors to cover the 115,000 population. They might be clinically trained, but "it was more important to get the right kind of people," says Jenny. They now also tend to employ people with experience of motivational interviewing.

"We can just get on with it, because we have a staff member," she says. Nobody has to wait for permission to start, for example, a pet therapy scheme (30 dogs awaiting assessment for going into people's homes).

Building on what is there already. The health connectors are the catalysts that have encouraged the emergence of self-help groups to fill the gaps – including those covering people living with leg ulcers, COPD, macular degeneration, ME, MS, strokes, dementia, and damaged hearing. One patient recently asked if he could start a metal-detecting group. They go where the energy is.

No criteria other than clinical impressions. They shun sophisticated data to help them identify the right groups of patients who would benefit the most from some kind of intervention. They use their impressions of the people they see face-to-face.

Doing the best for the patient. In the same way, they are sceptical of compliance or KPIs as a motivation for action. They commit to doing whatever is best for the patient before them. The Frome system doesn't have to fit into organisational diagrams. "We are much more fluid than diagrams suggest," says Jenny.

"You have to do all the elements together to have the effect," says Julian. "It is about taking an integrated and holistic approach" explained Dr Helen Kingston

The scheme is worryingly dependent on funding, which tends to be short term.

"We were fortunate in 2013 to work in an enlightened and financially healthy CCG that enabled devolved leadership to the local neighbourhood team. This allowed us to begin our journey. Times and circumstances have now become harder but a

"We need more pooled budgets and shared budgets, not different workstream budgets. We need more of a whole population budget."

whole community approach remains. We are working together and what is happening is embedded in the community. It is the beginnings of a movement that continues to grow."

On the brighter side, PCN funding for social prescribing will help.

"We need more pooled budgets and shared budgets, not different workstream budgets," says Karen. "We need more of a whole population budget."

We sit in on a presentation the same team gives various visiting commissioners and health officials from other parts of the UK. It gives us something of an insight into why this is difficult to organise everywhere. "We have been talking about this for four years," says one group from an urban area. "We are now utterly fed up with talking..."

Lessons

Would more whole-population budgeting help?

The need to find better ways of gauging success.

The critical importance of trust and how individuals drive it.

The importance of face-to-face relationships, within and between disciplines and for people accessing services too.

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Grenfell: After The Fire

The burning of Grenfell Tower, and the death of 72 of its tenants, is difficult to imagine unless you were there. Fatima Elguenuni was there, though she was in the process of moving to Morocco at the time.

Her son and daughter-in-law and their children lived on the eighteenth floor and were the last people who got out of the tower block alive. Fatima describes her daughter-in-law's mother, who lives in one of the blocks so close to Grenfell that you feel like you could almost reach between them, who could see her pregnant daughter in her flat as the fire rose in intensity, but couldn't reach them.

The young men were being arrested for their own safety downstairs as they tried desperately to get through the cordon to rescue loved ones. The night of 14/15 June 2017 was a desperate one – but it seems to have left a legacy in local services, and primary care teams are among those now doing things differently, and more effectively.

Fatima is one of those responsible. She had worked for nearly nine years locally as an NHS psychologist, trying to break down the barriers between the mental health services and the local Arab community, who did not really trust them. Grenfell was in her catchment. She took early retirement in 2013.

Then came the fire – and two of her client families died. Only days afterwards, the phone call came asking her to come back – because the authorities were suddenly aware that their peculiar circumstances were going to be even tougher without her on side.

"I had always been aware of the gap between local health professionals and local authorities and the local population – which has been indifference and sometimes almost contempt. Nobody wanted to connect too closely."

Torn between this challenge and the need to look after her family – still in comas back then, though they have since recovered and her daughter-in-law has given birth to a healthy baby girl – she agreed to help.

Now two years on, she knows everyone and is so deeply rooted in the community that she has been told by NHS managers that she has a 'conflict of interest'. But the chief executive of the local mental health service has backed her. She is also a formidable operator.

"I wouldn't like to get on the wrong side of Fatima," said one admiring local official.

She says: "I had always been aware of the gap between local health professionals and local authorities and the local population – which has been indifference and sometimes almost contempt. Nobody wanted to connect too closely."

But partly as a result of the fire, that has begun to shift. And the heavy shifting is being carried out by the new Grenfell Health and Wellbeing Service.

Working with this service Fatima describes herself as "human and optimistic". "I know that systems need time to change," she says. "My role is building bridges so both sides can understand each other."

The Service is part of a multiplicity of local services striving to find more effective approaches. Like the Community Living Well service, the umbrella body for the Grenfell one. It is modelled partly on traditional religious care outreach, which has clearly also provided a model for Fatima.

She also took the Curve – the new block of luxury accommodation taken over by Kensington and Chelsea Council immediately after the fire as a centre for the homeless, their families and the bereaved – and gave it a voice by making sure it was managed independently and with local trustees.

“People are anxious about doing things differently. NHS people get anxious when they are offering something outside Nice guidelines. Local authorities are nervous about their policies. It’s getting there, but very, very slowly.”

“It is a face-based service, collaborating with the local authority and various statutory organisations and delivering together,” she says. “People are anxious about doing things differently. NHS people get anxious when they are offering something outside Nice guidelines. Local authorities are nervous about their policies. It’s getting there, but very, very slowly.”

Kensington & Chelsea has frighteningly wide health and wealth disparities. The northern wards are among the poorest in London, while the borough as a whole is the richest in Europe. Yet Fatima also paid tribute to those wealthier neighbours, often connected to churches, who gave generously in time, money and effort. Her inter-faith networks are clearly part of her inspiration again.

All this has meant that NHS services have not been overwhelmed by need after the fire, though we hear from doctors at the nearby Golborne Medical Centre about the unexpected way in which it affected some survivors, with one collapsing from rage in the corridor of their surgery.

Many of the local doctors have also been attempting to broaden their way of working. There have been ‘navigators’ and link workers, who have worked tirelessly. Changes have also been made to local services; some of which have helped some of which have not. GPs are working imaginatively using money made available for Grenfell to not only support the affected population but also to reinforce the long-term support of critical areas of care such as Cancer.

This means, not just that the benefits will be narrowed down to a tiny proportion of patients, but that the vital additional value you can get from mixing patients with different needs and abilities gets lost.

Golborne Medical is part of the North Kensington Neohealth Network of GPs; working together to support Grenfell affected patients since the fire on 14th June 2017. At Golborne, social prescribing is has evolved with support from Family Action, with the role being paid for by the pot of money crowd funded by a teacher at the local school.

Golborne is a small family practice with huge ambition. “We offer everything that everyone else offers,” says Dr Yasmin Razak. “We are known for creating change because we have a higher need. We offer our patients innovative solutions⁹ and manage their needs with local services, which means our patients have continuity of care, a one-to-one connection with their GP and a reduced need for unnecessary hospital interventions, which they really value.”

She says all the local surgeries have been affected in the same way, and with the same emotional turmoil.

“It’s been quite a difficult time for all of us. I mean, GPs talk all the time, but it tends to be about the mechanics, how to prescribe, but not how it affects us personally.”

“We offer our patients innovative solutions and manage their needs with local services, which means our patients have continuity of care, a one-to-one connection with their GP and a reduced need for unnecessary hospital interventions, which they really value.”

9. For instance radically improving diabetes care by checking their assumptions through data review and collaborating with their patients to develop a new approach.

Their approach to social prescribing follows on from the understanding of the emotional turmoil their patients have experienced. It isn’t, for example, about giving out leaflets. “It’s about patients who are seeing me regularly, crying on my shoulder, and for whom we are part of the support – but while we are supporting them as doctors, we are not really helping them move on. So now we have Imam...”

Imam is a counsellor, and the practice’s Family Action supported social prescriber. She explains that the patients who are referred to her by Dr. Razak come with an initial sense of trust, because they are referred by their GP who knows them well. Imam is based in the surgery, which makes it easier for patients to access her. The innovation in patient-centric solutions that this arrangement has allowed is illustrated by a simple case. An elderly Portuguese-speaking patient was not only affected by Grenfell, but when she went to Portugal for a brief holiday, she witnessed the wildfires and the devastation they caused. This compounded her distress. On return to the UK, she was isolated partly because of the language barrier. Imam identified this lady’s needs and interests and then connected her into her local community through activities such as art that didn’t require extensive verbal communication.

It is a very successful operation, but it is small-scale and can be stressful for those who run it as a result.

“I feel deeply for our patients, especially those who have been affected by Grenfell,” says Dr Razak. “As a GP I’m going to be here for the next 30 years, so I feel it is the responsibility of all of us to get the systems working.”

Lessons

We can learn from more traditional, faith-based models.

Small scale certainly does not mean less efficient – but it can put a strain on individuals. Partly because it works, of course.

Face-to-face services need to be available widely.

Socially connected ways of working can be transformative.

“I feel deeply for our patients, especially those who have been affected by Grenfell. As a GP I’m going to be here for the next 30 years, so I feel it is the responsibility of all of us to get the systems working.”

Wakefield: Dancing Down The Corridors

When the chief executive of a Yorkshire mental health trust began to shape his vision of social connecting and prescribing, he began by bringing together all the people who might potentially block or corrode his efforts.

In the early weeks of the mental health project that became Creative Minds, Steven Michael invited all the possible blockages into the same room – health and safety, safeguarding, facilities, finance – to let them know the scheme had his backing, so that they might not just say ‘no’ in the grand tradition of inspectors, but might think instead how the request might be possible – to find a way forward.

“You know what it’s like – it can be easier to say no rather than finding solutions,” says Phil Waters, Creative Minds strategic lead. “I think the meeting really helped.”

But one of the health and safety officials came up to him afterwards, and asked him about the boat they had been doing up through the Safe Anchor Trust, now run by one of the Creative Minds partner organisations. Had it been inspected?

“If people can dance and move, if they can sing – if they can be creative in any way, it is an expression of well-being. If they can have access to singing, movement, poetry, it can be an indication that they getting better, which will facilitate their discharge and ability to cope on their own.”

“Just tell him I’ve seen it and you don’t need to inspect it – everything is fine,” Steven advised him later.

And it was – everyone agreed. It was only after six months, when the dust had settled, that he heard that they had inspected the boat after all. “He could breathe easily then,” says Phil. “He couldn’t sleep at night until he’d seen it.”

The story underlines both the problem and the opportunity in the NHS. Because, nearly a decade later, creative minds is a charity hosted and managed by the South West Yorkshire Partnership NHS Trust, based at Fieldhead Hospital in Wakefield and also working across local authority areas of Barnsley, Calderdale and Kirklees.

It has never quite reached Steven’s original plan that it would be funded by one per cent of the trust’s total budget, but they have been funded over the past eight years out of the trust’s innovation fund since they launched in 2011.

Steven’s interest in the arts was clearly a key element in the development of Creative Minds, but also the practical impetus came in the relationship between two of trust employees – Phil and Richard Coaten, a dance movement psychotherapist and clinician. Both of them are now on the governance group.

“If people can dance and move, if they can sing – if they can be creative in any way, it is an expression of well-being,” says Richard. “If they can have access to singing, movement, poetry, it can be an indication that they getting better, which will facilitate their discharge and ability to cope on their own.”

One resource every hospital has is corridors. He said he had invented ‘corridor dancing’, jazz or rock and roll up and down the corridors. “Sometimes we have a bit of a conga,” says Phil.

Richard’s next project is to set up a live arts café in Calderdale, one of the towns which are hubs for Creative Minds.

“I was a service user when I joined the trust,” says another of their team, Alex Feather, who runs the programmes in another of the towns, Huddersfield. “I trained as a librarian, worked as a DJ, worked for an artists’ co-operative. I’ve always plugged a different approach: it isn’t just talking and tablets, when actually there is a much wider offer and this is part of it.”

They are, for example, now working with Barnsley Football Club, who approached Creative Minds to say they had a big archive of their history and that it might make a good reminiscence group – and we said yes to all that. Our services said: ‘what do they know about dementia?’ But actually, they do. Now, those who go there love it and the services love it.”

They are also now doing reminiscence around rugby in Kirklees, and there is a similar project in Castleford. This is how social prescribing could use local resources. “The community has all these resources,” says Phil, “and they know what the local issues are – and they want to help.”

Only don’t call it ‘social prescribing’ near Creative Minds – “it is medicalising the model and will kill it,” says Richard. We work with a lot of people who can be described as hard to reach and are very often rejecting a medical approach.

It is also a partial answer to the question asked constantly about the new ‘link workers’ employed by the primary care networks – what are they going to link to?

“We work with a lot of people who can be described as hard to reach and are very often rejecting a medical approach.”

Creative Minds devolves their budgets to the hub towns, and the local collectives in the hubs are run jointly by participants and staff, who make all the decisions.

They can fund groups up to £5,000 in match funding if they meet the right criteria. For peer-led groups, they can fund up to £1,000 and they don’t need to match it. It is, after all, difficult enough running a peer-led support group without being expected to scabble around for match funding.

But the groups do grow – like Joan’s choir, which started with six members and now has fifty. And, what’s more, they just won the Duke of York’s Community Award. She describes how their concerts are free, but sometimes people are asked to pay £3 for strawberries and cream (and she’s asking the local Tesco, where they are singing, for the strawberries and cream).

That is what you might call ‘thrill’.

“Last year, we turned down a group from Wakefield,” says service user from there. “Because they weren’t really connected; they wouldn’t really have helped people from the trust.” Now they have a checklist to help with funding decisions and we always try to help ideas to work.

“A lot of them fall down on how to connect into the service, but we can help with that. We set some parameters around the services we know people

need. We want projects to think about accessibility for what they do, how people will get there, how they will reassure people who are anxious, and so on.”

Phil sets out the basic description of Creative Minds: “People say we have one foot inside and one outside the trust.”

They are certainly active outside, but being inside makes secure funding easier. This may now prove more difficult given that the trust has to make a surplus every year – it is a foundation trust – and this is now difficult.

Yet they are still being funded and they keep steadily on, trying to avoid jumping onto bandwagons or to be anyone’s flavour of the month.

And slowly they believe that attitudes and entrenched professional demarcations are beginning to shift. Phil tells the story of a health worker who, some years ago, asked whether he could bring his guitar onto the ward and was told he could, “as long as it doesn’t interfere with your day job.”

The fact that senior people understand the links between the creativity and recovery in mental health – so that these sort of attitudes have began to dissipate, and the Creative Minds approach has begun to spread across the West Yorkshire and Harrogate Integrated Care System – is partly down to ten year’s graft by the pioneers at Creative Minds, supported by a succession of Board level leaders.

“...many of the Board members including the CEO, Chair and I joined the Trust partly because it had invested in approaches that are supported and delivered through Creative Minds”

**Salma Yasmeen, Director of Strategy,
West Yorkshire Partnership Trust**

Lessons

Being outsiders and insiders at the same time may be a future model.

The value of social prescribing outside general practice.

There are huge resources and willingness to help in local communities.

Somebody needs to be building the links the link workers are going to link to.

SECTION 2:

LITERATURE REVIEW

Introduction

This Inquiry seeks to investigate the unrealised potential of people and communities as a unique force in tackling health and care challenges, and how that translates into the emerging models of ‘Social Prescribing’. Social prescribing is one among many practical strategies used to address the gap between clinical and non-clinical services (Blickem et al. 2018, Bull et al. 2013, Foot & Hopkins 2010, Harrison et al 2019, Husk et al 2019, Kimberlee 2013, Morgan et al. 2010, Rütten et al 2009).

Policy change goes well beyond this to address changing interpretations of whole population approaches to health and care, community development and person-centred approaches, culminating in a marked shift from programmes and organisations to organising for change (Blickem et al. 2018, Bull et al. 2013, Foot & Hopkins 2010, Gantz 2005, Harrison et al 2019, Husk et al 2019, Kimberlee 2013, Morgan et al. 2010, Rütten et al 2009). The Inquiry explores the tension this raises for current reality on the ground in addressing health inequality and health inequity, and between coproduction and asset-based models and ‘prescription’ and expert-led models in the NHS. Despite the growing interest in social prescribing, initiatives have not resulted in stronger communities and voluntary sector front line services, and this has prompted the Inquiry to assess what are the systemic and structural/policy opportunities and barriers that determine what how health and social inequalities are addressed.

The increasing prevalence of social prescribing in national policy, and academics, has led to calls for new inquiries into the use of this concept, its impact and how it addresses the current challenges facing health and care (Wiley 2019, Husk et al 2019). This literature review explores social prescribing from an asset-based approach to social change and the policy tensions and contradictions on what this means in practice. Asset-based approaches to addressing health and wellbeing are beginning to find prominence in research and policy studies despite the negative impact of social and economic

decline (Blickem et al. 2018, Bull et al. 2013, Dixon-Woods et al 2014, Foot & Hopkins 2010, Ham et al 2017, Harrison et al 2019, Husk et al 2019, Kimberlee, 2013, Morgan et al. 2010, Rütten 2009). These stark budgetary conditions have resulted in an unsettled policy and political environment yet there remains a strong emphasis on identifying models of health and care that deliver the best outcomes for residents to shape the discussion on approaches that make a real difference to experiences on the ground (Blickem et al. 2018, Bull et al. 2013, Dixon-Woods et al. 2014, Foot & Hopkins 2010, Ham et al 2017, Harrison et al 2019, Husk et al 2019, Kimberlee 2013, Morgan et al. 2010, Rütten et al 2009). Within this context there exist a growing interest in social prescribing as a meaningful approach to secure community-based health and well-being services as well as its potential to drive a different conversation on grassroots bottom-up change.

The increasing prevalence of social prescribing in national policy, and academics, has led to calls for new inquiries into the use of this concept, its impact and how it addresses the current challenges facing health and care.

Structure of the Literature Review

The literature review is structured into two phases. The first phase seeks to set the context for the Inquiry in terms of the changing national policy context and explores different meanings and interpretations related to social prescribing. The second phase is a continuous iterative and reflective process that begins to tackle emerging themes from the fieldwork.

Research Questions

a) Context:

- What is the current context to place-based ways of working to address health inequality?
- What approaches are used to tackle these issues?
- What are the successes, obstacles, problems, and solutions?
- What opportunities exist to work across traditional organisational boundaries with communities?

b) Spread and innovation

- What is innovative about the social prescribing approach?
- Is there scope for replication, or broader application, where appropriate?
- What are the challenges of spread?

c) System challenges and opportunities

- To what extent has the social policy environment helped to social prescribing activities on the ground?
- What infrastructure exists to support social prescribing (the cost and benefits and funding)?
- What is known from our work on volunteering and coproduction?

d) Personal story of change

- Leadership in terms of mind-sets, knowledge, strategies, and actions

There exist a growing interest in social prescribing as a meaningful approach to secure community-based health and well-being services as well as its potential to drive a different conversation on grassroots bottom-up change.

Social Prescribing Context: What do we know about social prescribing?

The idea of social prescribing – that medicine needs to embrace solutions that are more than just transactions involving pharmaceuticals – is hardly new (Dixon & Ham 2010, Kimberlee 2013, Kings Fund 2017, 2018, Marmot et al 2010). It goes back, particularly in mental health, to the work of pioneering doctors a century ago – like Helen Boyle in Hove (Lucy 2015), (aware that many of the women presenting to her needed a rest rather than drugs), or Alfred Salter (Brockway 1949) in Bermondsey (the health effects of unemployment), or Pearse (2007) in Peckham, and other doctors that in different ways were inspired by the public health movement and their local understanding of the social determinants of health.

The increasing interest in social prescribing comes from the perceived growth in the burden of mental illness and the economic costs this entails

Innes Pearse and husband George Williamson were particularly important in the story, as co-founders of the Pioneer Health Centre, which tried to provide some of the space and equipment to encourage people to take responsibility for their health. The so-called Peckham Experiment closed in 1950 because it had become clear that it was incompatible with the new NHS and its emphasis on treatment over prevention. This also provides a source of at least one strand of influence in the current social prescribing movement, via the Bromley-by-Bow Centre and the brief flowering of healthy living centres. Other strands include the coproduction ideas of Elinor Ostrom (1996, 1973) and Edgar Cahn (2001) in the USA, and from the designing services ideas of Hilary Cottam (2018), and the hospice movement and end of life care in the UK. These different influences use different language but they seem to converge around similar values.

The increasing interest in social prescribing comes from the perceived growth in the burden of mental illness and the economic costs this entails; the growing strain exacted on primary care services and GP services in particular and the modernising mental health agenda which is seeking to review the delivery of mental health services (Kimberlee 2013). The Low Commission reported that 15% of GP visits were for social welfare advice, (Parkinson and Buttrick 2015). An estimated 20% of patients consult their GP for what is primarily a social problem (Torjesen 2016). The work of the London Primary Care Quality Academy estimates that 40% of people who attend frequently are struggling with life (Malby 2018) and more recently NHS England report that this has shifted to 50% (NHS England 2019). There is growing acceptance that GP services are facing social and economic pressures that they are ill equipped to manage on their own and this has resulted in what is being described as a state of crisis (Lacobucci 2018). The focus on personalisation movement, the pressing need to address health inequalities, mental health, whole population issues, and prevention requires a different approach, different mindsets, attitudes and behaviour (Polley et al 2017(1)). Within this context, asset-based approaches to tackling the challenges facing super output deprived areas where health inequality and health inequity are at the highest levels are beginning to take centre stage. Instead of communities in deprived areas being

seen as problematic no go areas, they are being turned around by reframing solutions to the everyday challenges local people face. The health and care system is unable to cater for the combined physical and mental health care problems that present due to the traditional professional and funding/regulatory boundaries that prefer to separate out treatment. These challenges are compounded by the 'inverse care law', whereby the availability of health and social care tends to be inversely associated with the level of need (Beeston et al 2014, Mercer et al 2018).

Within this volatile context, NHS England plans to recruit 1,000 social prescribing 'link workers' with an intention to appoint 4,500 in the next five years as part of the NHS Long Term Plan (2019). The NHS Long Term Plan will see GPs surgeries work to support each other in around 1,400 Primary Care Networks covering the country. Primary Care Networks consists of local GP practices working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local area network. Each network will have access to a social prescriber link worker and NHS England has agreed to fund their salaries in full. NHS England has presented case study evidence that Primary Care Networks are already beginning to make a difference to and experiences (BMA & NHSE 2019). By 2023-24, it is estimated that social prescribers will handle around 900,000 patient appointments a year (BMA & NHSE 2019). Simon Stevens, the chief executive of NHS England states that this:

".. allows us to keep all that's best about British general practice while future-proofing it for the decade ahead"

NHS England 2019

NHS England (2019) states that this change agenda is more than a bolt on to existing provision but what does this mean in practice? The commitment is that by 2024 social prescribing link workers are said to be one among many services that will play an integral part in the core general practice model throughout England – not just 'wrap-around' (BMA & NHSE 2019). The Investment and Evolution: A five-year framework for GP contract reform to implement the NHS Long Term Plan describes this as the biggest reform to GP services for the last decade (BMA & NHSE 2019). This builds on the commitment made in the Five Year Forward View (NHSE 2014) to remove the traditional divide between primary care, community services, and hospitals which is seen as a key barrier to addressing personalised and coordinated health services patients need. This strategy sets out a model of care that emphasises prevention and wellbeing, patient-centred care, and better integration of services, as well as highlights the role of the third sector in delivering services that promote prevention and wellbeing. The merging of social care and mental health care services and community-based services form part of this move towards integrated, cost-effective patient-centred care.

The emphasis is on what happens in communities and primary care settings and there is a mounting concern that the infrastructure and commissioning incentives are not yet in place to respond to current national policy changes. The National Audit Office points to the lack of data on GP consultations, and stark variation across deprived and rural areas compared to well to do and urban areas (National Audit Office 2015). These differences are unacceptable and the National Audit Office recommends that NHS England should improve the data it collects on demand and supply in general practice and research how different practices appointment-booking drive variation in access. This points to a deeper issue on the role of GPs in leading the transformation of primary care services. If there is

no uniform approach to collecting data that could be used to support social prescribing then it is difficult to assess the wider impact social prescribing is having in primary care. The range of evaluations into social prescribing clearly shows their impact (Kimberley 2013, South West Academic Health Science Network 2018, Aesop 2017, NHS Health Education England 2016, Pratt et al 2015). GPs now have a meaningful opportunity to embrace the full value these services offer, and begin to align their data collection processes and organisational practices to support this movement. This seems to be a missing link that could turn the tide in relation to the cultural change needed in primary care services.

The Kings Fund (2017) asserts that prior to NHS England's recent announcement of funding social prescribing this year, there have been attempts to introduce different social prescribing models and approaches, and continued attempts to encourage systems and organisations to work in a collaborative

Instead of being a bolt on to existing care models this space could open new opportunities to redress health inequality, however, this will require tackling the challenge of spreading innovation in a complex and risk-averse health care system.

and networked manner. It was highlighted as far back as 2006 in the White Paper 'Our Health Our Care' as a mechanism for promoting health, independence, and access to local services. The objectives of social prescribing support the principles set out in subsequent NHS policy documents. The General Practice Forward View (2016) acknowledges the role of voluntary sector organisations – including through social prescribing specifically – in efforts to reduce pressure on GP services. In addition, social prescribing contributes to a range of broader government objectives related to public health and the wider social determinants of health for example employment, education, volunteering, and learning.

There are several challenges to ensuring the infrastructure is in place to support this agenda. This emerging 'liminal space' in which social prescription now takes place straddles the boundary between the formal world of the NHS and the informal lived experience (Pratt et al 2015). The infrastructure and social relationships necessary to make this happen have received less attention (Baird 2019). Common references to coproduction, collectivism, and collaboration in national policy documents form a key part of understanding this 'liminal space'. Further exploration and clarity are needed on how this change agenda impacts on complex organisations, systems, and communities, and how it fits alongside wider policies shaping the future reorganisation and transformation of the NHS. Instead of being a bolt on to existing care models this space could open new opportunities to redress health inequality, however, this will require tackling the challenge of spreading innovation in a complex and risk-averse health care system.

Social Prescribing – a search for a meaningful definition

There is no single authoritative definition of 'social prescribing' and as such the concept is considered nebulous and open to different interpretations (Kimberlee 2013, Husk et al 2019, Polley et al 2017 1 & 2). The following provides a range of definitions used to understand the concept:

"Social prescribing... enable(s) GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services."

The Kings Fund, 2017

"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 'within the community and for the individual'."

Kimberley 2013 p. 14

"...link worker' who would connect the patient with relevant non-medical interventions in the third sector."

Polley et al 2017 p. 4 (2)

"Enabling healthcare professionals to refer patients to a link worker, to co-design a non-clinical social prescription to improve their health and wellbeing."

Report on the Annual Social Prescribing Network Conference 2016 p. 19

"A mechanism enabling healthcare professionals to refer patients to a link worker, to co-design a non-clinical social prescription to improve their health and wellbeing."

Natural England Commissioned Report 2017, p. 13

"A clear, coherent and collaborative process in which healthcare practitioners including GPs, practice nurses and community matrons work with patients and service users to select and make referrals to community-based services... Social prescribing is a tool for clinicians to work with patients to address wider social and lifestyle aspects of their health."

Langford et al 2013 pp. 7-8

"Social prescribing is a way in which people living with long term conditions can get access to a variety of support they need but that doctors and nurses are not equipped to provide. Things like help with getting a job, housing, debt management, and social contact. Help with these things is often available through local authorities, charities, and local community organisations, but few people know about the full range of support available."

Healthy London Partnership, 2017 p 4

"A social prescribing service – refers to the link worker(s) and the subsequent groups and services that a person accesses to support and to manage their needs."

The Social Prescribing Network 2016 p. 3

There are some common elements to social prescribing yet different interpretations, meanings, and assumptions to what it means in practice as the examples below show:

- A link worker – link workers have a variety of names e.g. health advisor, health trainer, facilitator or community navigator. Usually, a non-clinically trained person who works in social prescribing service and receives the person who has been referred to them. Link workers are responsible for assessing a person's needs and suggesting the appropriate resources for them to access (Natural England Commissioned Report 2017 p. 20).
- Community Connectors and Practice Health Champions – The 'Wellbeing Exeter' Integrated Care Exeter Social Prescribing Project refers to social prescribers as Community Connectors. Altogether Better provide an approach called Collaborative Practice where Practice Health Champions work with practice staff using an asset-based approach to design, deliver and increase the number and range of offers and activities available to meet the needs of patients. Community Health Champions are volunteers who work in the community to promote health and wellbeing.

The Kings Fund (2018) states that social prescribing, or community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. The non-clinical aspect of social prescribing is the most common denominator among different definitions.

This recognises that most people who present at primary and secondary care come with a non-medical/clinical issue. The health care system is part of a wider ecosystem and now needs to connect to the local community to find solutions to commonly experienced problems (Berototti et al 2017).

Some writers acknowledge that clinicians and front line staff need to pay more attention to what is happening beyond their organisational walls and think about people-based values and assets. This is where social prescribing started with a collaborative approach and as it began to take centre-stage in national policy it has become formal and professional. The question is how can this way of thinking be modelled in GP practices where non-clinical solutions to health and care in communities are not taken seriously?

In 'Social Prescribing at a Glance' (2016) NHS Health Education England argues that the social prescribing language is problematic. Among the scoping interviews undertaken interviewees pointed out about social prescribing:

"...they read as one thing but are often taken to mean something quite different'; i.e. what was described as the social prescribing oxymoron, with the apparent contradiction between an approach which sees more patient engagement and control as central to success but which still uses language which implies patient subjugation."

NHS HEE 2016 p.11

The scoping report states that the "in use policy language" needs to be reframed away from the dominant paradigm and debate about illness treatment services and towards health and wellbeing.

The scoping exercise pointed out that there are several common elements of social prescribing:

- The central role of an asset-based approach to development
- A stronger focus on wellness not illness
- An emphasis on the importance of personal choice and control in achieving and maintaining wellbeing
- The need to re-imagine future workforce development and training needs with new kinds of bridging roles
- The value of this approach in terms of the potential to contribute to the real transformation of health and care systems through joint endeavours (NHS HEE p. 26).

Models of social prescribing

The social value of social prescribing calls for a new focus on what is making a difference on the ground in terms of meeting the needs of people with a range of emotional, mental and practice needs (Wood & Leighton 2010). Several examples of social prescribing initiatives exist across the UK and the challenge is to begin to categorise these in a meaningful way. There are more than 100 social prescribing schemes in the UK and according to the Kings Fund, 25 of them are based in London (Husk et al 2019). Most social prescribing services rely on a primary care referral system that provides GPs with a non-medical referral option to enable patients to easily access health resources and social support from outside the NHS (Kimberlee 2016, Polley et al 2017 1& 2). Although the social prescribing schemes operate jointly by primary care providers and the third sector, the social prescription element in these studies is predominantly delivered by the third sector. The diversity of models and perspectives on social prescribing arguably contributes to the challenge of defining what it is in practice. Most schemes target a range of different beneficiary groups. A review of social prescribing services found that the majority of services could be described as generalist or generalist plus mental health (Kimberlee 2016). The following presents a typology of different models of social prescribing.

Towards a typology of asset based approaches

The following table is an asset-based typology

	Level 1	Level 2	Level 3	Level 4
Social prescribing approach	Social prescriber /link worker introduced with no clear role and relationship to GP practice and local community, short term funding	Awareness of social prescribing /link worker but no investment in role and business as usual culture	Social prescribing /link worker has strong links into primary care network Increase number of community referrals Database of referral organisations which is updated and quality checked	Community Centred primary care service fully integrated into existing community. Shared referral and networked approach to meeting local needs
Context (geography, deprivation etc.)	Social prescribing covers defined area, funding context is not clear	Social prescribing restricted to particular vulnerable clients	No target group – general referral to wider network	Social prescribing falls across different areas, geographies, is place based in local communities and known to be making an impact.
Community-centred orientation vs. other allegiances	No real focus on community and a tendency to let private interests drive orientations	Professional or organisational interests drive orientations	Moving towards community orientation	Community-collaboration orientated
Volunteer	No role for volunteers	Volunteers are invited in with little capacity to train and support Roles are restricted and micro managed	Increase in size, staffing, funding, recruitment and retention strategies	Volunteers integrated into non clinical aspects of service delivery and feel strong sense of purpose

	Level 1	Level 2	Level 3	Level 4
Organisational skills and culture (innovation and continuous learning)	Maintain status quo No inward investment in skills and cultural development Lack of trust Sporadic, fragmented expertise	Hidden agendas get in the way of progress and business as usual culture Sporadic, fragmented expertise	Investment in trust relationships Open and honest dialogue across stakeholders Examples of inclusion, diversity of thought and practice Trust is conditional, is taking shape.	Collaborative – coproduction and partnership working Common and shared change agenda Grounded trust Expertise fosters introduction of non medical approaches to health and care using collaboration and innovation
Shared goals	Conflicting goals or absence of shared goals	Some shared ad hoc goals		Consensual, comprehensive goals
Leadership	Dominant leadership approach in place is hierarchical, silo, hero, non-consensual, monopolistic leadership	Unfocused, fragmented leadership that has little impact	Collective (mix of informal, shared responsibility and followership mindset and behaviours) Willing to test new forms of leading change	Shared, consensual leadership and followership in key aspects of change taking place.
Evaluation and continuous learning	Quantitative outcomes are measurable against cost efficiencies	Incomplete information-exchange that does not meet needs and/or is used/interpreted inappropriately	Introduce soft measures Willingness to test new ideas and practices	Common infrastructure for collecting and exchanging information Social return on investment achieve a mix between qualitative and quantitative measures and outcomes

Table 1: Typology of different models of social prescribing using an asset based approach – a list of key social prescribing models and approaches that are leading the way on asset based community development (D'Amour et al. 2008)

Social prescribing and theories of change approaches

How does meaningful social change take place? What ideas dominate and drive change at the grassroots level? What lessons can we learn from this and how can this be applied to complex system challenges facing the transformation of primary care services?

In this examination of social prescribing, some important theories and concepts underpin the social and cultural processes at play. These tend to focus on coproduction and collaboration, community asset-based approaches, and power (Blickem et al 2018, Bull et al 2013, Dixon-Woods et al 2014, Foot & Hopkins 2010, Ham et al 2017, Harrison et al 2019, Husk et al 2019, Kimberlee 2013, Morgan et al 2010, Rütten et al 2009). These concepts are not well defined and are far from straightforward, yet they provide a contextual grounding to the review of the literature and address further questions on what this means for asset-based community development approaches, as well as leadership and organisational change. Social prescribing relates to these concepts, in particular, the discussion on what works and for whom? The Inquiry seeks to uncover why social prescribing continues to struggle against other competing agendas for change that seek to adopt similar approaches to working on personalised care, and community engagement. If there is widespread agreement that we need coproduction, collectivism and collaborative ways of working then why is the current health and care system pushing against the tide and 'designing-out' these approaches in large-scale change programmes? A critical discourse approach is needed to uncover the underlying and deep-rooted drivers of change and compare these to the lived experience of working on the ground.

- What do we mean by asset-based approaches to health and care?
- What social processes are used to determine the success of this approach?
- What does this mean for social prescribing?
- What does this mean for leadership and social change?

Self-determination theory

The self-determination theory begins with the question as to why is it that in certain social contexts people are highly motivated, energized and integrated and in others this is not the case (Ryan and Deci 2000) Self-Determination Theory (SDT) is a psychological theory concerning human well being, motivation and behaviour change (Ryan and Deci 2000). This theory is not focused on the medical model of change but the social-psychological points to the potential of us all as well as the social environments that optimise people's development, and health and well being. According to this theory, it is the social-contextual conditions that facilitate self-motivation and healthy psychological development. Individual resilience and self-determination require a careful balance between individual intrinsic motivation and the structural systemic social environment we live in (Choi & Ruona 2011, Duckworth 2016). This has often been missing from motivational theories that adopt a non-asset based approach to understanding human behaviour and personal choice (Oettingen 2014).

It's all about the approach – Asset-based approaches to health and care

Asset-based community development (ABCD), pioneered by Kretzmann and McKnight (2005) is often described as an innovative approach to community development, rooted in local assets and capacity building (Webber et al 2018). This approach is premised on the principle that in every community, there exist 'assets' in numerous domains: individuals, associations, institutions, physical space, exchanges, and culture – and is growing in popularity (Webber et al 2018). Community is another contested concept, and the differences in definition are as varied as the meanings and assumptions it is often associated with. From an asset-based approach community begins and ends

with people and the social values that shape on the ground experience and organisational practices (Blickem et al 2018, Bull et al 2013, Dixon-Woods et al 2014, Foot & Hopkins 2010, Ham et al 2017, Harrison et al 2019, Husk et al 2019, Kimberlee 2013, Morgan et al 2010). As Cormac Russell argues the starting point should not be on 'what is wrong' but what is 'strong' in communities and organisations (2010). In theory, social prescribers and other professionals adopt this model to connect local assets in communities. People from diverse backgrounds have a range of assets and a lifetime of experiences, skills, and abilities, learning that can all play an important role in addressing local health and care challenges (Blickem et al 2018, Bull et al 2013, Dixon-Woods et al 2014, Foot & Hopkins 2010, Ham et al 2017, Harrison et al 2019, Husk et al 2019, Kimberlee 2013, Morgan et al 2010, Rütten et al 2009). In the past deficit models of communities were once used to channel funding and policy attention to super output, and multiple deprivation areas (Harrison et al 2019). The side effect of this was the negative labelling of communities who lived in these areas as equally disadvantaged and dependent and pathological alongside the negative media imagery to give added emphasis (Harrison et al 2019). The growing unease with this way of understanding communities has resulted in a marked shift towards asset/strength-based community development approaches (Blickem et al 2018, Bull et al 2013, Dixon-Woods et al 2014, Foot & Hopkins 2010, Ham et al 2017, Harrison et al 2019, Husk et al 2019, Kimberlee 2013, Morgan et al 2010, Rütten et al 2009). The question is whether asset-based approaches become another policy rhetoric with no serious intent to encourage a different type of organisational and grassroots change.

Asset-based approaches to addressing the over-medicalisation of social and economic problems change the nature of power relationships, dominant institutional narratives shaping the way people think and feel about their role and relationship to communities (Bickerdike et al 2017, Blickem et al 2018, Bull et al 2013, Dixon-Woods et al 2014, Foot & Hopkins 2010, Ham et al 2017, et al 2019, Husk et al 2019, Kimberlee, 2013, Morgan et al. 2010, Rütten 2009). This approach begins to identify the social determinants

of health that for a long time have existed under the radar of policy and political attention (Harrison et al 2019). The balance between expertise that emerges through institutional practices and the expertise derived from lived experience are now beginning to be acknowledged (Husk et al 2019, Harrison et al 2019). The dominant organising narrative in bureaucratic organisations tends to focus on services and not people and this tension needs to be further explored (Harrison et al 2019, Russell, 2010). The investment in assets relies on the currency of relationships, trust, and reciprocity (Blickem et al 2018, Bull et al 2013, Dixon-Woods et al 2014, Foot & Hopkins 2010, Ham et al 2017, Harrison et al 2019, Husk et al 2019, Kimberlee 2013, Morgan et al 2010, Rütten 2009). These assets are finding prominence in national policy and also being used to understand disadvantaged communities who have been hit the hardest by the economic impact of reduced services and who also carry most of the socialized costs of corporate and market failure (Foot & Hopkins 2010).

Cormac Russell, the managing director of Nurture Development presents an alternative perspective on social prescribing. He argues that:

"(Social Prescribing's) current shortcomings are inevitable and that the prime reason for them is that too much emphasis and expectation is being placed on the doctor and CVS organisations and not enough support and animation is being offered to associational life of communities themselves."

Russell 2017

The plethora of social prescribing evaluations preoccupation with defining social prescribing, measuring impact, difficulty in measuring across different geographies, have masked some of the

Russell also asserts that the role of GPs is to advocate for greater participation and ensure that social issues are not medicalised, and community efforts are not devalued.

underlying issues that this agenda presents (Berototti et al 2017, Bickerdike 2019, Husk et al 2019, Kimberlee 2013, 2016). According to Russell, the emphasis should be on how to support people to create pathways towards a good life rather than the number of prescriptions or referrals. He argues that it is about walking alongside people in their life's journey to understand what is important to their health and wellbeing. Russell also asserts that the role of GPs is to advocate for greater participation and ensure that social issues are not medicalised, and community efforts are not devalued (Russell 2010).

The theoretical and conceptual understandings of asset-based working are not often made explicit or well understood (Harrison et al 2019). According to Harrison, a better understanding of the mechanisms through which ABCD operates, and the environmental conditions within which it is likely to be most effective, could increase its effectiveness at improving health and well-being and reducing inequalities (Clark et al 2014, Harrison et al 2019). It is often more an intuitive sense of what is right that drives the work in this area rather than a detailed theory of change. Harrison acknowledges that there is currently limited knowledge about the mechanisms underlying ABCD programs and the populations and contexts for which they are most suited.

According to Davidson et al (2019) ".....we know there's a lack of good quality research to show its efficacy and meet the exacting evidence requirements of health professionals" (2019, p. 2). In-addition, asset-based approaches to health and care often paint a rosy picture that can often obscure some of the tensions, challenges, and drawbacks of using this

approach to expand social prescribing. On the other hand, however, imposing service/evidence-based models on asset-based community organising can stifle type of innovation social prescribing relies on (Harrison et al 2019). The personal and individual approaches adopted, can make it difficult to track and measure impact in the same way as more structured, linear programme activities. The social prescribing activities we explored were not designed for an overly programmatic and structured assessment approach (Berototti et al 2017, Blickem et al 2018, Bull et al 2013, Foot & Hopkins 2010, Morgan et al 2010, Rütten et al 2009). Positive examples of communities working together to determine how local needs are met often challenge conventional design approaches to service provision (Kretzmann and McKnight 2005, Blickem et al 2018, Bull et al 2013, Foot & Hopkins 2010, Morgan et al 2010, Rütten et al 2009). People with lived experience come together from diverse communities to develop solutions that fit around their daily lives and to respond to that need. This strength-based approach can be applied to complex system challenges on leading change, community engagement, commissioning for social outcomes (Robertson et al., 2016). However applying strength-based principles to for example commissioning may also have the negative side effect of compromising the richness and diversity of community-based projects as the focus on measurable outcomes may not fit with the energy, fluidity and creativity people rely on to take action (Harrison et al 2019). Asset-based approaches rely on strength-based principles but the starting point is notably different (Russell, 2010). Instead of focusing on funded programmes and service-focused interventions this approach starts with the local context, local people in their communities, and the assets, skills, and talents that they bring (Blickem et al 2018, Bull et al 2013, Foot & Hopkins 2010, Kretzmann and McKnight 2005, Morgan et al 2010, Rütten et al 2009).

The lived experience of people in their local neighbourhood and community setting provides fertile ground for new skills and talents to flourish (Blickem et al 2018, Bull et al 2013, Foot & Hopkins 2010, Harrison et al 2019, Kretzmann and McKnight 2005, Morgan et al 2010, Rütten et al 2009). Harrison et al (2019) relies on

qualitative narratives to provide a way to understand individuals who volunteer their time and resources in order to make a difference in their communities. Although traditional participation and engagement methods play their part in transformational change, this agenda starts with what people want to see changed, often using non-traditional methods – narratives, to get their voices heard. Harrison et al (2019) describes asset-based approaches as building individual and community resilience, an ideology of the wisdom of the community, and a way to acknowledge the practical and 'hands-on' approaches people use to encourage change (Duckworth 2016, Harrison et al 2019). Instead of promoting a culture of dependency, communities develop their solutions and approaches and as a result, rely less on the administrative burden short-term funding often brings (Harrison et al 2019). Community organising focuses on local relationships, building trust and reciprocity that is key to making things work on the ground (Ganz 2010, Harrison et al 2019, South et al 2010, Russell 2010). Management, organizational and commissioning models often fail to recognise the importance of these intangibles and social capital (Blickem et al 2018, Bull et al 2013, Dixon-Woods 2014, Foot & Hopkins 2010, Kretzmann and McKnight 2005, Morgan et al 2010, Rütten et al 2009).

Instead of getting out of the way and allowing individuals to organise around their collective interests and health needs, public servants tend to focus on bureaucratic rules, and formal decision-making processes which not only stifle innovation but often damage important relationships within communities (Kretzmann and McKnight 2005, Blickem et al 2018, Bull et al 2013, Foot & Hopkins 2010, Morgan et al 2010, Russell 2010, Rütten et al 2009). Harrison et al's study begins to question whether it is possible to deliver an ABCD approach in the existing accountability and responsibility models and the specific methods and processes for it to work (Harrison et al 2019). The danger or fear of over professionalisation of voluntary activity or encouraging only service-related involvement are profound and not well yet well-articulated (Harrison et al 2019). Tension surrounds differences in values, reliance on rules, and risk-averse cultural ways of working that perhaps are at odds with the lived experience of change at the

grassroots level (Harrison et al 2019, Russell, 2010). Community development and empowerment models demonstrate how health care needs can be identified by community members, who then mobilise their networks and communities into action (Harrison et al 2019, O'Mara-Eves et al 2013). This not only enhances mutual support, and collective action, but also secures a wider positive impact on health and social care outcomes, such as tackling health behaviours and social isolation (Russell 2010).

The additional challenge is a tendency to over-romanticise a vision of a particular type of community—self-contained, self-sustaining, face-to-face, resilient—as a superior model of social organising and grassroots creativity that is best left alone, with little need to access accumulated knowledge, evidence, experience, and expertise coming from outside (Blickem et al 2018, Bull et al 2013, Foot & Hopkins 2010, Harrison et al 2019, Morgan et al 2010, Rütten et al 2009).

The propensity in many models of care is to lift what works in one area and context and spread to another area that is marked and significantly different in terms of the system and community challenges it faces (Blickem et al 2018, Bull et al 2013, Foot & Hopkins 2010, Harrison et al 2019, Morgan et al 2010, Rütten et al 2009). It might be the case that best practice asset-based approaches may not fit within organisational change models that are premised on a different set of assumptions about power, relationships, diversity and shared values. The quest to identify what works and how it can be applied to social prescribing must recognise these tensions. Systems rely on communities

The propensity in many models of care is to lift what works in one area and context and spread to another area that is marked and significantly different in terms of the system and community challenges it faces.

and communities rely on each other as well as systems (Harrison et al 2019). Although critiques of ABCD argue that the model relies on 'vague ideas' that do not produce a coherent approach to supporting deprived communities, there is evidence that it does hold conceptual and methodological clarity (Blickem et al 2018, Friedli 2013). Concepts such as skills, connectedness, collective assets, and knowledge, empowerment, and social capital feature widely in the literature on ABCD (Blickem et al 2018, Bull et al 2013, Foot & Hopkins 2010, Harrison et al 2019, Morgan et al 2010, Rütten et al 2009). According to Harrison et al

the problematic organisational concepts / change models don't fit within an asset-based approach to community development (Harrison et al 2019).

Building relationships of trust and trustworthiness, collective assets are described as key building blocks for ABCD approaches and there is clarity and evidence to show the importance of social capital, social networks, and reciprocity (Blickem et al 2018, Bull et al 2013, Foot & Hopkins 2010, Harrison et al 2019, Morgan et al 2010, Rütten et al 2009). These are summarised below in the following table:

Table 2: Key Criteria of ABCD to Improve Health and Long Term Conditions – Newly Identified Mechanisms

	Foundations/ building blocks	Method	Mechanisms	Outcomes
Key criteria and outcomes of ABCD	Personal assets of individuals. Physical assets of environment. Collective assets such as existing networks.	Asset mapping: Inventory of personal, physical, and collective assets. Encourage investment from community.	Building trust and trustworthiness. Developing relationships. Engagement with target population. Engagement with political powers Identifying collective goals.	Improved use of resources. Improved relationships and collective efficacy. Achieve collectively defined goals. Trust and trustworthiness Improved health.

ABCD = asset-based community development and LTC = long-term conditions (Harrison et al 2019 p 3)

From a practitioner perspective, the model is sustainable and it is only making explicit the processes at play, particularly how practitioners concede power, share their resources knowledge and skills so that a more shared understanding of this approach can be generated (Harrison et al 2019).

Inquiry Questions
What do we mean by asset-based approaches to health and care?
What social processes are used to underpin this approach and how can we make this more explicit so that it can be shared?
What does this mean for social prescribing?
What does this mean for leadership and social change?

New forms of organising for change – coproduction, collectivism, and collaboration

New ways of organising and mobilising people are needed (Ganz 2010). Approaches that rely on coproduction, collectivism and collaboration help us to understand the hidden assets in local communities and organisations and to work creatively with individuals, communities, and frontline staff to address the wider determinants of health (Kimberlee 2013, Ganz 2010). The evidence suggests that social prescribing depends on the investment people are willing to make, and approaches to working with a range of individuals, groups and organisations, some of which have very different organisational cultures (Husk et al 2019). Commissioners who invest in building relationships across systems and with the voluntary sector play a key role in creating the right climate to build social prescribing interventions (Dixon & Ham 2010, Kings Fund 2017 2018, Robertson et al 2016). Whole system change requires open communication, trust and new ways of doing working with communities (Clark et al 2014, Dixon & Ham 2010, Kimberlee 2013, Robertson et al 2016). Perhaps this starts with modelling a different type of behaviour and adopting a different mind-set to meaningfully explore what it means in practice to collaborate across organisational and cultural and professional differences (Dixon & Ham 2010, Kings Fund 2017, 2018).

What do we mean by coproduction and collaboration?

Most evaluations of social prescribing point out that the model relies on collaborative coproduction and partnership work with communities to support (rather than build) capacity (Kimberlee, 2013 2016, NHS Health Education England 2016, Aesop 2017, South West Academic Health Science Network 2018, Pratt et al. 2015, Bertotti et al 2017). These evaluations illustrate the value of social prescribing as well as the tensions in attempts to evidence what it is, who are the producers and co-producers, and differences in how it is used in practice (Nesta 2013, Cooke et al 2017, Webber et al 2018).

Definitions of coproduction include:

Coproduction is defined in the Care Act 2014 as: "... when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered."

Department of Health, Care and Support Statutory Guidance Issued under the Care Act 2014, p.16

"co-production (is) engaging 'the right people' (service users, practitioners, NHS and care managers, and academics from a range of disciplines) to make decisions and support the conduct of projects and activities on issues that are important and matter to them."

Cooke et al 2015, p. 3

"co-production relies on 'authentic collaboration, partnership and engagement as the context for action'."

Cooke et al 2017, p. 221

“Working with communities as well as within communities and the importance of connections or links to assets toward not only reducing a culture of dependency upon statutory services but also improving quality of life.”

Harrison et al 2019, p. 5

“Delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change.”

Boyle 2013, p. 22

The purpose of coproduction is to:

“Seek to make visible the activities that mobilise and coproduce knowledge and the coproduced knowledge itself, throughout and beyond the project, thus, exemplifying the nature of meaningful and authentic collaboration” (Cooke et al 2017 p.346).

Coproduction is uniquely different in its practice and ability to address unconscious bias (Sweeny, 2016), power and control, diversity and inclusion (Boyle 2013). Coproduction is essentially about power, how it is understood, used, shared or distributed (Blickem et al 2018, Boyle 2013, Bull et al 2013, Foot & Hopkins 2010, Morgan et al 2010, Rütten 2009). This strikes at the heart of traditional participation and

engagement mechanisms and structures that often fail to explicitly address power dynamics (Blickem et al 2018, Bull et al 2013, Foot & Hopkins 2010, Morgan et al 2010, Rütten et al 2009). Creativity and innovation are “designed in” alongside a real-time commitment to taking meaningful action. Traditional engagement and participation approaches, on the other hand, tend to rely on hierarchical bureaucratic decision-making processes that often filter out the voices and experiences of people it seeks to engage. The process of coproduction includes co-discovery of the causal issues, as well as co-design, co-delivery and co-evaluation of the solution (Malby 2016). Coproduction differs from two other dominant approaches to citizen participation in the NHS – Voice (giving feedback or as owners contributing to strategy) and Choice (as consumers) (Dent and Pahor 2015). This approach brings people and professionals together over a period of time to produce something together. According to Cooke et al (2017) it consists of:

- “Being listened to and ideas acted on in a tangible way.
- Welcoming conflicting views and diversity.
- Addressing real lived problems/issues.
- Potential to change the way of thinking, promote decision-making, or instigate action around an issue.
- Raise awareness of reciprocity in relationship building”.

(Cooke et al 2016, p. 221)

Boyle, (2013) argues that this consists of:

- “Recognising people as assets.
- Building on people’s existing capabilities.
- Promoting mutuality and reciprocity.
- Developing peer support networks.
- Breaking down barriers between professionals and recipients.
- Facilitating rather than delivering”.

(Boyle 2013 p. 4)

The following summary provides a useful framework to bring together different interpretations of coproduction:

- Coproduction is a practice – individuals learn from doing (Boyle, 2010) not just studying it.
- Co-design process is not optional, it is a critical user involvement process (Vink, 2016) but on its own it is not coproduction.
- Knowledge user and knowledge producer (making things is collective and shared not the preserve of power holders/stakeholders).
- Power is mediated through language – how to find a common language across different divides

(Bushe et al 2016, Oswick 2017).

Coproduction as a concept is not without contention. Despite its populist appeal, it continues to straddle different theories premised on consumerism and participatory governance. This has raised doubt as to the intention of coproduction. Is it an opportunity to enforce hierarchical compliance or is it a genuine opportunity to question institutional practices and cultures that are averse to committing in a serious way to the voice of end-users (Ewert & Evers 2014). The introduction of patients and carers as experts by experience is taking centre ground in policy. They are being seen as producers as well as consumers of service, with a rich contribution to discussions on what a modern health care system looks and feels like. This needs to be carefully narrated to reveal what it means for users to act as citizens, patients, consumers, and coproducers all at the same time (Ewert & Evers 2014). Like social prescribing, the volunteering aspects of these roles are becoming mandated, and the consequence of this new trend needs wider exploration (Ewert & Evers 2014).

Pay attention to the informal social processes that underpin coproduction

The informal social processes that underpin collaborative, relational ways of doing change are often open to conflicting meanings, assumptions, interpretations, and tensions that once identified

should not simply be ironed out (Clark et al 2014, Fillipe et al 2017; Griswold, 2013; Hunt et al., 2015; Llopis, 2016; Reynolds & Lewis, 2017; Viljoen, 2015). They point to a creative process where negotiation, knowledge production, diversity of thought and ideas emerge that were unthinkable at the design stage of most change initiatives (Fillipe et al 2017; Griswold 2013, Hunt et al 2015, Llopis 2016, Reynolds & Lewis 2017, Viljoen 2015). Conflicting ideas, meanings, and political positions are inherent in coproduction practices. Questions that illuminate what is meant by ‘adding value’ and the ‘patient perspective’ and what counts as knowledge, labour, productivity, and value in social prescribing shape how meaningful the coproduction process actually is (Fillipe et al 2017).

Social relational ways of doing change lie at the heart of an asset-based approach. The ability to harness goodwill, build new trust relationships and develop a collaborative, shared agenda for change across social and professional divides, all resonate with this approach (Blickem et al 2018, Bull et al 2013, Dixon-Woods et al 2014, Foot & Hopkins 2010, Morgan et al 2010, Rütten et al 2009). According to Cooke et al (2017) authentic collaboration takes time, tolerance and a form of leadership that is sufficiently flexible and adaptive. There is an acknowledgment that there is not much give in the NHS system in terms of cost, and time to engage communities in authentic conversations about what matters, and the contribution communities offer to deliver health and care solutions (Harrison et al 2019). Taking time to invest in relationships at different community levels does not fit with the fast pace of commissioning

The ability to harness goodwill, build new trust relationships and develop a collaborative, shared agenda for change across social and professional divides, all resonate with this approach.

and delivery decisions. The untapped wisdom and potential of users, patients, carers and communities can only be harnessed by flipping the script and encouraging GPs to engage in open-agenda conversations that is less about time and more about a relationship.

Open dialogue, reflective practice, and organisational culture of continuous learning are not only an approach, but it also a way of being (Senge 2006, Lipmanowicz & McCandless 2014). This points to a new way of organising when change in itself becomes personal – a personal commitment, a sense of grit and resilience (Duckworth 2016), an awareness

Identifying the assets local communities requires a cultural and mind shift in the way we tackle social justice, inclusion and health inequalities.

of social psychology (Lucas & Nacer 2015), and the need for psychological safety (Land & Hex, 2013) and a willingness to take action (Ganz, 2010, Jarcho 2016, Pedler 2017). Dialogic approaches to change allow us to explore different meanings and positions, through a process of framing and reframing as well as providing a safe space for a diversity of perspectives to emerge (Bushe and Marshak 2016, Oswick 2017).

According to Jackson (2016) “one of our greatest assets as a human being is to be able to create mental spaces for us to think about our past experiences and interpret and draw meaning from the memories we reconstruct. Our ecologies for learning provide the mental space for us to look back on the past and imagine possibilities for the present grown from experiences of the past and our encounters with the present” (Jackson 2016, p.7). Social processes such as these are often ignored in favour of fast-paced conversations and predefined agendas, and minute taking (Fillipe et al 2017). Identifying the assets local communities requires a cultural and mind shift in the way we tackle social justice, inclusion and health inequalities (Fillipe et al 2017).

Tensions and dilemmas to adopting an asset based approach through social prescribing

There are several reported benefits of social prescribing across different schemes that hold important lessons for ways of adopting asset-based ways of working with GPs, volunteers, communities and organisations (Kimberley 2013 2016, Pratt et al 2015). The evidence shows that this results in better outcomes for health and social care; improvements in the mental health and wellbeing of patients; cost-effective use of NHS resources; and more effective use of GP time (Natural England Commissioned Report 2017, Pratt et al 2015). As a result, social prescribing is beginning to make a substantial difference and has adopted several impact measures including a low number of patients being referred to A&E (Polley et al 2017 1 & 2, Kimberlee 2016).

Tensions on how coproduction is understood in practice

Coproduction and collaboration are not just academic concepts; their meanings are shaped by a strong evidence base of practice on the ground (Boyle 2013). Whole systems change relies on collaboration and coproduction as people begin to work as an organism rather than an organisation. GPs engaged in whole systems work require particular skills, attitudes, and behaviours to be able to embrace diverse perspectives, interests, and opinions. The challenge is that GPs may be unaware of collaborative ways of working and coproduction, and the paradoxes this creates. The tendency to revert to traditional ‘old power’ leadership and organisational change models could undo the potential social prescribing has to offer. Nick Timmins states that this starts with the coalition of the willing (Timmins 2015). He argues that the level of paradoxes in system leadership requires constancy of purpose as well as a degree of flexibility in precisely how the goal is to be achieved (Timmins 2015).

The ‘coalition of the willing’ relies on a different way of seeing social change and communities. Altogether Better invests in collaborative practice and uses liminal space to refer to a process of constantly not knowing, becoming and transforming. A linguistic analysis was commissioned by Altogether Better to investigate this work and the findings identified

a range of tacit understandings of the challenges champions and local teams experience of operating in this liminal space. In particular, it revealed that a few people firmly occupied the discourse and worldview of the institutions, while some others securely occupied that of the informal world. Most, however, flipped backward and forwards between them with some sense of discomfort (Pratt et al 2015). The question is what does this mean in relation to organising for change; and for leaders in community and systems who use this space to bring about change (Pratt et al 2015, Pearce 2013, Petrie 2014, Polyani 2009, Ryan & Tuters 2017).

This way of understanding change sees opportunities to establish common ground between diverse interests as a meaningful way of valuing the assets of local people, their everyday social interactions and social experiences. To do this effectively requires adopting different social, cognitive and behavioural norms. What we may consider as ‘truth’ – one way of seeing and doing change that engages communities, varies historically, cross-culturally, organisationally and professionally (Harrison et al 2019, Kimberlee 2013, 2016; Land & Hex 2013). There are no static or objectively accepted ways of understanding the world but a constantly iterative, changing, emergent and fluid way that is open to construction and coproduction (Burr 2003). Accepted ways of understanding change in organisations and communities are often a product of dominant

The tension lies in introducing change when these conditions are not in place and instead they are replaced with a tendency to rely on siloed institutional ways of doing change, and deficit relationships with communities.

cultural and social processes and social interactions in which people are engaged in, rather than a result of objective observation or rational objectivity (Harrison et al 2019). Instead of overly focused on 'top-down' or one size fits response to implementing and scaling social prescribing, the complex nature of the task requires a multi-dimensional approach that is 'bottom-up', 'inside-out' and 'outside-in' (Harrison et al 2019, Kimberlee 2013, 2016, Polley et al 2017 1&2). Leaders at the top of hierarchies play an important role in social prescribing, however, they very much depend on their ingenuity and willingness to act as boundary spanners, as well as unleashing the creativity of people in communities and on the frontline (Dixon-Woods et al 2014). The untapped assets and resources available to social prescribing include ground-level intelligence of what works and for whom; the creativity, energy of local people who can be mobilised at scale; and the opportunity to deliver innovative solutions and approaches that provide the conditions for meaningful change to take place (Harrison et al 2019, Kimberlee 2013, 2016; Land & Hex 2013). The tension lies in introducing change when these conditions are not in place and instead they are replaced with a tendency to rely on siloed institutional ways of doing change, and deficit relationships with communities (Kretzmann & McKnight 2005, Russell 2010). Patients, citizens, and communities don't work in the same way as top-down services and systems work (Harrison et al 2019, Russell 2010). The challenge for GPs and primary

care is knowing how to unlock this resource and build on the vested interest, energy and commitment communities have to make change happen.

Power – how can we begin to talk about it?

There are underlying power dynamics in any organisations and this shapes the dominant discourse on how change takes place (Bibby et al 2009, Boyle 2010, Dixon-Woods et al 2014). If GPs as change leaders are to meet the organisational requirements of organisations with complex bureaucracies, multiple stakeholders, multiple professional practices, politics (with small and big 'p'); working across boundaries within and across communities and organisations; then a more comprehensive understanding of what this entails in practice is required (Pratt et al 2015, Pearce 2013, Petrie 2014, Polyani 2009, Ryan & Tuters 2017). Organisational, position and personal power are often used by change leaders to conform as well as challenge the status quo and this demonstrates the often-difficult choices individuals face. It is only by applying an asset-based inquiry lens to cascade across these either/or paradigms and organisational behavioural norms, that a fully comprehensive account of the impact of integrated, collaborative ways of working at a local level can emerge. Integrated way of working across organisations and communities depends on how prepared individuals are to collaborate around common wicked issues and to share-decision making. English (2008) argues that this requires unmasking layers of power previously unrecognised "to reconstitute the world in less oppressive ways" (Davies et al 2006, p. 89 in English and Irving 2008).

Communities often hold important intelligence on what works and what interventions they need to resolve complex problems they experience (Dixon-Woods et al. 2014, Russell, 2010). As Bolman and Deal argue (2017), we often shy away from talking about power although it is an inescapable by-

product of collaborative, co-operative activity. This may be due to the corruptive aspect of power in organisations and communities (Zaleznik 1989, cited in Buchanan and Badham, 1999). Social interactionists are interested in who decides what needs to change and the change methods to use, as well as how is this negotiated, shared and understood. Common attempts to understand power in organisations focus on the zero-sum game, which is difficult to apply to integrated whole systems collaborations.

This can be compared to Bourdieu (1963, cited in Wolf and Yang, 2018) who argues the importance of habitus – common sense ways of understanding power in organisations conditions, the culturally dominant ways people think, feel, speak, dress and act (Wolfreys, 2000, cited in Wolf & Yang, 2018). The pressure to conform, and to get along may compromise the ability to speak up, have a voice, see 'beyond the grasp of consciousness' (pg. 93 in Wolf & Yang 2018).

There are different types of power:

- a) Visible power – this is the most obvious type of power. It's the people in the boardroom making decisions.
- b) Hidden power – this is the step behind visible power. This is the people who decide who sits in the boardroom in the first place and whose agendas are therefore less transparent.
- c) Invisible power – this is the most difficult power to pinpoint. Invisible power is the ideologies and norms that we as individuals believe and that often prevent us from exercising agency.

Recognising the discretionary power individuals have at the front line, in communities and organisations is a key aspect of change agency and this Inquiry. The use of discretionary power is often downplayed in research, yet it is the social energy it creates that becomes the driving force for change within and outside formal respective roles. Pearce and

Crocker (2013) argue that non-dominating power is potentially transformative and could be the key to agency for change without reproducing dominant power (Pearce and Crocker 2013). These include everyday actions that support social justice and tactics described as 'keep(ing) it on the down-low' (Marshall pg. 143, 2009, cited in Ryan & Tuters 2017). One example of non-dominant power is the ability to 'speak truth to hierarchy' – a social movement metaphor that refers to the ability to use voice to challenge upwards in organisations. This is not without contention as Barsamian (2012) argues that the concept of 'speaking truth to power' – a Quaker slogan, is problematic as it makes no sense. 'There's no point in speaking the truth to Henry Kissinger – he knows it already. Instead speak truth to the powerless – or better, with the powerless. Then they will act to dismantle illegitimate power' (Barsamian 2012, p. 31).

This is more difficult to do in practice than what might be assumed. Collaborative ways of doing change seeks to build a more democratised interpretation of power that goes beyond silo organisation priorities and practices (Clark et al., 2014; Dixon & Ham 2010). Individuals working across different systems, at multiple levels, and across multiple organisational

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boundaries often adopt a more collaborative interpretation of power. Instead of dominant 'power over' – 'power with' is a 'jointly developed' power that is co-active rather than coerced (Follett 1940, cited in Pearce 2013). This form of power "rests on the ability to shape the preferences of others" (Nye 2008 p. 95 cited in Ryan & Tuters 2017). This reduces the need to use dominant power and 'de-normalises' its use and harmful effects on change agency. Power is therefore not necessarily given or shared but a way of being, yet it is open to challenge and conflict. As ordinary people are encouraged to discover their extraordinary abilities to get things done, they learn to enact what has been described as 'coactive power' (Clegg et al., p. 7 cited in Pearce 2013). The challenge is that within complex organisations with command and control cultures, it is difficult to shift towards non-dominant power that is inclusive and value-centred.

New understandings and practices of power and how it is applied to collaborative coproduction are under constant experimentation (Pearce 2013). Constantly bringing attention back to how social prescribing works in practice and applying concepts that underpin this national agenda ensures that leaderful voices and experiences on the ground are not forgotten (Pearce 2013). Heimans and Timms re-conceptualised power and agency in organisations as 'old power' and 'new power'. These ideas on power are beginning to shape change conversations in the NHS (Bibby et al 2009, Boyle 2013, Polley et al 2017 1 & 2). Heiman and Timms argue that change agents need to know how to harness the energy and resources that both old and new power offer (2018). In their recent book called 'New Power: How Power Works in our Hyperconnected World' (2018) they outline the difference between 'new power' and 'old power' as set out below:

Old Power	New Power
Currency	Current
Held by few	Held by many
Pushed down	Pulled in
Commanded	Shared
Closed	Open
Transaction	Relationship

In large complex organisations such as the NHS, power can be experienced as being held by a few people who are the decision-makers, commissioners, people who use command and control levers to direct change pushed down from on high. It is argued that in a modern social era, power takes on a different form. 'New power' is concerned with creating new capacity for change regardless of where people are positioned in an organisation. 'New power' is described in social movement theory and operates more like a force of energy or current. It is compared to electricity or water as it cannot be hoarded and is most forceful when it surges. According to Heimans and Timms 'old power' is closed, inaccessible and leader-driven. This is compared to 'new power', which is described as open, participatory and peer-driven.

These forms of power are becoming increasingly important in organisational development theories that support a complex integration change agenda (Ospina 2017). One of the challenges with discretionary/soft/new power is that it encourages romanticised notions of agency and encapsulates the ability to act without considering policy, system and social structural constraints. On the other hand,

change agents located in organisations, networks, and communities need to know how and when to navigate within and between old and new power to introduce and sustain meaningful change. This seems to be a key aspect of why change efforts fail (Kotter 1995). Most leaders exercise one form of power or veer to one or the other side and fail to master the skills required to achieve a balance or appreciation of both. As power shifts from leader to follower, organisations to communities, it becomes paradoxical and often contradictory, as it mutually constitutes and coproduces (Collinson, 2005). This dynamic is tested in old and new power as change leaders skilfully adapt to different systems and juxtapositions (Pratt et al 2015, Pearce 2013, Petrie 2014, Polyani 2009, Ryan & Tuters 2017). In-addition, the way organisations are organised, the decision-making structures and rules of the game are built around a command and control culture and a Taylor and Ford traditional division of labour model (Dixon & Ham 2010, Dixon-Woods et al 2014). Leaders may have to adopt low key or discreet strategies if they are to successfully promote their change agendas and be conscious of the power differentials in their contexts (Ryan & Tuters 2017). Although distributed/shared power is commonly referred to, this does not reflect the reality and practice on the ground (Ho & Ng 2017). In some respects, integration policies have been too quick to develop consensus models of power (Pearce 2013). For example, most community engagement plans aim to empower individuals at the front line and communities, as well as introduce change through a national policy change agenda. What this agenda does not question is that communities already do engage with each other, and already hold a sense of personal and collective power. Empowerment is an 'old power' concept and in practice it is problematic. It tends to be experienced in a uni-directional way rather than a critical, multi-dimensional collaborative way of supporting change at the service or people level. As Hill-Collins states:

"...Domination operates not only by structuring power from the top down but by simultaneously annexing power as the energy of those on the bottom for its own end." In short, "domination cannot operate with submissive, complicit consent when people begin to authentically engage in a process of self-awareness and self-definition."

Hill-Collins 2004, p.542

Jo and Park (2016) go further to argue that empowerment involves rejecting the dimensions of knowledge, whether personal, cultural, or institutional, that perpetuate objectification and dehumanisation. If social prescribing and integration are to work on the ground a new asset-based language of working in and with communities is needed. "Old power" language that is comfortable leading change that is 'doing to' communities rather than with 'doing with' communities will not support the change on the ground that social prescribing relies on.

Social Prescribing recognises the need for shared decision making, shared approaches to tackling the wicked issues facing the UK National Health Service (NHS). This encourages the promotion of change agency and change leadership across sectors and organisations and communities, at all levels and irrespective of professional role and specialism (Dixon-Woods et al 2014, Dixon & Ham 2010). Such aspirations form a key component of social prescribing and are beginning to be a common feature in the UK public sector more generally and in health care sectors in other parts of the world (Martin & Learmonth 2012, Bolden 2011).

The short term nature of funding generates concern as to whether this is a genuine turnaround towards connecting communities with an integrated health care system or another attempt to divert attention away from what is making a difference on the ground.

Social prescribing relies on a theory that supports 'distributed', 'shared' or 'dispersed' power. As well as power, most social prescribing examples rely on social interactions of a network of individuals, resulting in collaborative as well as individual agency (Axelrod 1997, Ho and Ng 2017). These approaches encourage difference in terms of perspectives, ways of working, knowing, that are diverse and emergent. Advocates of distributed, shared or concerted approaches to working in teams argue that it is more appropriate for organisational cultures that are flat, relational, inclusive, and collaborative (Fitzgerald 2013; Wilcocks and Wilberley 2015). Social prescribing initiatives that promote effective teamwork also report on the tensions of working in complex and changing contexts at the grassroots and front line (Wang et al 2014). There are tensions between what types of knowledge and expertise are valued and socialised, and how to address hierarchical power relationships and struggles for dominance between different professional and lay groups (Dixon-Woods et al 2014, Wang et al 2014). There is a tendency to assume that social prescribing, social action or volunteering starts on the basis of consensus. This has been critiqued

for failing to take account of tensions and struggles for power and control particularly when multiple stakeholders pursue different objectives (McCann and Grey 1996).

Another source of tension is the growing funding opportunity this agenda attracts both from national government to charities. Without a coordinated policy on health and wellbeing across professions and the voluntary sector it is likely that new funding will not reach the parts of the system that could make a significant difference (Davidson et al 2019). Funding holds the potential to move voluntary services towards a whole population approach to unmet need as well as to fill an emerging evidence gap in capturing the full value of social prescribing (Davidson et al 2019). Social prescribing increases demand on already strained frontline voluntary sector services and there is a lack of sustainable funding to generate effective referral and care pathways that takes time and trust to develop. The short term nature of funding generates concern as to whether this is a genuine turnaround towards connecting communities with an integrated health care system or another attempt to divert attention away from what is making a difference on the ground (Davidson et al 2019).

Research Questions

How is power and control used/shared to encourage collaborative ways of working?

How to overcome challenges between professional practice, organisation culture, and diverse governance arrangements?

What infrastructure is needed to support sustainable funding, and communities that are connected to their health and care?

Leading Change: who are the change agents?

The urgency for a different way of leading has been created by what has been described as the 'perfect storm'; the deepening impact of austerity measures on public and community services against a drop of failed attempts to deliver preventative, whole population approaches to health and wellbeing (Arnold et al 2018). When we think about asset-based approaches to delivering innovate change, social prescribing is one among a number of important lens to begin to explore what is happening in GP practices, local communities, and commissioning organisations.

People who are at the forefront of developing cultural change in complex organisations and primary care hold important lessons for leading change in this Inquiry (Kimberlee 2016). Stories collected through evaluations tell of their leadership behaviour and mindsets, as well as an open and inclusive organisational culture, a precondition for social prescribing to move from a medical model of care to a more holistic model of care (Berototti et al 2017, Fickes 2011, Kimberlee 2016; Pratt et al. 2015). Asset-based approaches to social prescribing embrace a different way of thinking about leadership, leading change, organising and working with people from diverse backgrounds (Russell 2010). People who gravitate towards a different type of thinking about patients, carers and communities tend to adopt a different understanding of what works, why and for whom (Husk et al 2019; Kimberlee 2013, 2016). The everyday stories people share demonstrate how communities mobilise, connect together, build networks and movements with little resources or attention from policy makers (Husk et al 2019; Kimberlee 2013, 2016). These individuals are leaders. They are often called agitators, positive disrupters,

activists or change agents (Bibby et al 2009). They are often motivated by their values, self-belief, sense of purpose and willingness to take small actions (Bibby et al 2009, Harrison et al 2019). Their stories and lived experience of tackling everyday health and social care challenges hold important lessons for Primary Care as well as the wider health and care system (Greenhalgh 2016, Harrison et al 2019).

Change agents are people who are willing to exercise their autonomy to organise in a way that suits their interests. Näre (2014) describes agency as the intrinsic capability for movement, agency, and change. Organising for change relies on an ability to cultivate relationships with diverse change agents, engage in dialogic forms of sharing and conversing, an openness to learn and take action (Ganz 2005, Oswick 2017, Pedler 2017). Leadership in this context requires agency. Agency is not only concerned with individual motivations for change but also collective responses to change (Gantz 2005, Saunders & Mulgan 2017). Learning by doing the change rather than passive compliance creates an organising culture where people collectively engage in the change they want to see and experience (Ganz, 2005, Lipmanowicz & McCandless 2014, Pedler 2017, Thaler and Sunstein 2009, Vince 2004). The challenge is how to activate new ways of organising for change in General Practices that are averse to working with communities in this way (Heifetz, 2004, Lipmanowicz and McCandless, 2014). There are several examples of General Practice leading this change agenda, and there is room for it to become a national movement for change (Pratt et al. 2015).

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Arena and Uhl-Bien 2016, go further to argue that asset-based approaches rely on social-based approaches to leading change. Social capital secures a competitive advantage as this is based on the way individuals collectively connect.

System change and leadership are often misunderstood in this context. If relationships across systems and communities are important to an asset-based approach then a new and shared understanding of what this entails is needed. Lucas and Nacer set out several interlocking habits that leaders working with communities and complex hierarchy need to be aware of (Lucas & Nacer 2015). This includes reframing conversations, and a willingness to learn and take an informed risk (Kimberlee 2013, 2016). There is emerging evidence on how emerging leaders are catalysed to do things differently (Petra 2015). According to Sniehotta et al (2017) systems are all about people, actors doing things differently through the conscious use of their agency and personal power. It is the multiple actions, practices, and patterns of behaviour that pivot around a set of shared values that brings about social change. Sniehotta et al argue that upstream and downstream metaphors rely on either/or binary positions, (medical model versus social model) that assume a passive linear flow of ideas, people, decision-making processes and agency. This is inappropriate to an asset-based leadership model as it fails to embrace the complex context most people strive to deliver change. Communities and systems interconnect in complex, formal and informal ways that are often unstructured, non-prescribed, fluid and emergent (Sniehotta et al 2017).

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secures a competitive advantage as this is based on the way individuals collectively connect. The everyday interactions of people based on trust, willingness to share information, and to innovate, creates competitive advantage. Sanders and Mulgan refer this to a form of collective leadership where there is shared responsibility for delivering change (2017).

Social-relational leadership builds on an asset-based approach as it focuses on how change conversations are framed (Arena and Uhl-Bien 2016; Clark et al., 2014). Most system leaders including GPs work within this contested space, that relies on an operational system and an entrepreneurial system (Arena and Uhl-Bien 2016). Arena and Uhl-Bien argue that these systems function in dynamic tension with each other (2016). GPs work within an operational system driven by formality, standardisation, business performance, and national targets, as well as an entrepreneurial system that strives for innovation, creativity, learning, and growth (Arena and Uhl-Bien 2016). GPs need to be able to broker different relationships, across different systems, adapt where necessary and encourage positive change ideas to come through (Arena and Uhl-Bien 2016, Senge 2006). The entrepreneurial lens moves the focus from asset-based forms of leading change, although it is the litmus test to surviving for most GPs. Once the business model is stable the next tension is to understand this new collaborative space where systems, organisations and communities co-exist (Arena and Uhl-Bien 2016, Senge, 2006).

Organising for change in this way shifts the narrative and meaning commonly associated with leading and leadership (Goleman 2014, Timmins 2015, West et al 2017). Formal, organisational and positional authority continues to play an important role, although influence and informal networks and communities triumph (Timmins 2015, West et al. 2017). Collective asset-based approaches to leading change where everyone takes responsibility to improve the quality of care delivered to patients and users, demands a different mindset, attitude and behaviour (Malby 2018, Timmins 2015, West et al. 2017). An emergent leadership model is being developed that is not

There are important lessons to learn as we venture into this new reality. Working at the grassroots level to develop trust takes time and the path is not linear.

restricted to organisations and hierarchical position, as it exists everywhere there is potential for change (Arnold et al 2018, Banaszak-Holl et al 2010, Bibby et al 2009, del Castillo et al 2016, McKee et al. 2008). There are important lessons to learn as we venture into this new reality. Working at the grassroots level to develop trust takes time and the path is not linear. The importance of developing relationships and working out who needs to be involved means there might be many false starts. It slower than most funding national programmes and commissioning projects allow for. This should not mean that we shy away from the challenge as once the investment is made and the conditions are in place, progress accelerates significantly. The second point to be aware of is that this way of working is still deeply counter-cultural and counter institutional, even when a formal system might claim to have embraced it at the policy level. Senior leadership is needed to act as a buffer between the activities taking place out there in the community and the governance and accountability system that is needed to complement, amplify and spread this work (Pratt et al 2015).

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